MASTER THESIS

Shifting towards a more risk- and data- driven supervision of the Wmo and youth care within the municipality of Enschede

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Preface

Within the team of subsidy, contracts and supervision from the municipality of Enschede the question arose for a more for risk-driven supervision for supervisors of the Social support act (Dutch; Wmo) and youth care.

The research is done from September 2020 until April 2021 under supervision from; Dr. S.F. Oude Wesselink as first supervisor and B.J Voorthuis MSc as second supervisor from the University of Twente. And M.J. Oudejans and J.R.F. van Heuven from the municipality Enschede.

Abstract

Background: Since 2015, the responsibility for the performance and the supervision of quality and lawfulness of the Social Support Act (SSA; Dutch: Wmo) and youth care has been the municipality's. To improve supervision on inadequate quality and unlawful healthcare it is necessary to examine different forms of supervision and the risks that cause these inadequacy and unlawfulness. The aim of this study is to determine the risks municipalities should consider in a more risk-based data-driven supervision. The following research question was formulated for this purpose:

Which risks and which tool should municipalities in the Netherlands consider in risk-based supervision of the quality and lawfulness of care to reduce inadequate quality and unlawfulness of healthcare providers in the context of the Wmo and youth care?

Methodology: To answer the research question, literature research was conducted and interviews were held to for which supervisors of Wmo and youth care were interviewed.

Results: Eleven risks were mentioned in both literature and the interviews, indicating that these risks lead to inadequate quality and unlawfulness of healthcare. The overarching themes of these risks are, money is not spent on care and transparency of the provider for lawfulness, and, efficient, effective, safe, and client-oriented for quality. For these eleven risk indicators have been determined, and for three a limit value could be set. This is the basis for creating a dashboard for risk-based data-driven supervision.

Conclusion: Based on these results, using these eleven risks in a data-driven supervision is recommended. Possible follow-up research could focus on risks only mentioned in the interviews and the implementation of a dashboard using these risks to gather more insight on different risks.

Keywords: Social Support Act (SSA; Dutch: Wmo), youth care, municipality, Zorg in natura (ZIN), risk-based, data-driven, supervision, dashboard.

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1. Introduction

1.1 Background

In 2007 and 2015, a transition occurred in the social domain. The decentralization of tasks and responsibilities in these years regarding social care and support caused a major reform of the welfare state in the Netherlands. The decentralization was central to local government, as well as to citizens and their social environments [1]. Decentralization means competition between health insurers and healthcare providers, leading to an increase in efficiency and therefore lower costs of care [2]. Since this transition is accompanied by significant cutbacks, it is important to implement a transformation in the social domain. Within the transformation, different thought processes and behaviours are required from residents as well as civil servants [3]. The decentralization resulted in a newly introduced law in 2007: The Social Support Act (SSA; Dutch: Wmo).

In 2015, the Wmo was extended and is now called the Social Support Law 2015 (Wmo 2015). Municipalities have been given a number of additional tasks in the field of care, participation and self-reliance, work, and youth assistance. These tasks are outlined in the following laws: Social Support Act (Wmo 2015), Participation Act, Youth Act, and Municipal Debt Assistance Act [3]. The social domain has become the largest within the range of tasks of municipalities, both financially and in terms of content. Possibly the most impactful of these changes shifted the fields of care, self-reliance and participation, work, and youth assistance, which changed from a national responsibility to the responsibility of the local municipality [4]. This decentralization demands a major cultural change as healthcare in the Netherlands is evidently moving toward a participation society [3].

To cope with the increased complexity of social care, the municipalities themselves do not offer social support. Agreements with healthcare institutions are often chosen to provide social support for them. According to the new laws, the municipality needs to supervise the quality and regularity of these healthcare providers. As a result, municipalities have not only become responsible for the performance of care tasks but also for the quality and legality of care.

All the changes in the Social Support Law 2015 presented huge challenges for municipalities [5]. First, a municipality is obliged to appoint an officer solely for supervision. For many small municipalities, there are no financial means to support this appointment. As a result, civil servants are required to fulfil dual tasks, eventually leading to too little time spent on their supervisory tasks. Second, the demand for supervision has increased drastically over the past five years. Figures indicate that more healthcare providers register on the market every year, where the municipality is responsible for whether to contract the providers [6]. Third, practice provides many examples of the deployment and scope of municipalities' power and the present difficulties in performing supervisory tasks [7]. E.g. the research of Fenger et al. demonstrated that municipalities do not have the legal options to prevent overtreatment. Fourth, there are a number of risks associated with the switch from national to municipal supervision. In recent years, reports about abuse, improper use, and fraud involving healthcare funds have appeared regularly [7]. In 2018, signals of fraud were received about 475 healthcare providers nationally [8]. Risks of fraud, errors, or improper use arose primarily through the actions of the healthcare provider [7].

These four points are interrelated. The increasing market size of healthcare providers, as well as a limited number of personnel, presents municipalities with the challenge to perform a multitude of tasks with few resources. These challenges result in an increase in risks for contracting providers regarding quality and lawfulness that do not meet the minimum requirements.

In this study, one municipality was examined: Enschede. In Twente, there is cooperation between 12 municipalities in the field of Wmo and youth, called Samen14. By efficiently organizing purchasing, contract management, monitoring, and expertise, Samen14 ensures that all 12 municipalities can realize a sustainable and affordable healthcare system [9]. One measure Samen14 has taken is to develop the barrièremodel. This model includes a first check for all newly registered healthcare providers. This

check consists of 13 questions, the answers to which lead to a classification in different risk groups. On the basis of this classification, investigations are started earlier with high-risk groups than with low. This model assesses healthcare providers before they are allowed to the market. Samen14 started this approach in October 2018, which is the first form of risk-based supervision within these municipalities.

Enschede wants more risk-based supervision, but to discover on which risks this supervision should be based, research is needed. Therefore, this study focuses on the risks that indicate inadequate quality and/or unlawfulness of the care provided. The main types of supervision were analysed and are discussed, as is their applicability to different situations. The model created will help reduce the workload for the officials and provide easier and earlier indications of provider risks.

1.2 Research relevance

When the providers are contracted and the investigation and surveillance of their risk profile has been completed, supervisors of Wmo and youth care only return when they receive a signal or a calamity occurs [10]. A calamity is an unintended or unexpected events that relate to the quality of a facility and that led to a serious harmful consequence or death of a client. However, preferred is identifying the risk of a calamity so an actual calamity does not occur. Late trading results in preventable calamities and inadequate care arise and most investigation and surveillance being unnecessarily time-consuming. By noticing signals earlier and intervening earlier, inadequate quality and unlawfulness of care can be prevented. The barrièremodel has already helped accomplish this goal, but improvements are needed because more providers are entering the market.

This study builds on the studies of risks and maps risks that lead to inadequate quality of care and lack of lawfulness in the Wmo and youth care services. By focusing on risks that indicate inadequate quality or unlawfulness, "bad" providers will be noticed earlier, and investigations can be started earlier. As a result, these investigations will be less time consuming and calamities can be prevented, which is more favourable for clients and supervisors. This study links the literature to the workplace and develops a list of risks that should be taken in to account with more risk-based supervision.

1.3 Main research question and sub-questions

To determine a solution to this problem, the following research question is proposed:

> Which risks and which tool should municipalities in the Netherlands consider in risk-based supervision of the quality and lawfulness of care to reduce inadequate quality and unlawfulness of healthcare providers in the context of the Wmo and youth care?

The following sub-questions were formulated:

1. What has changed with regard to supervision after the transition into the social domain?
2. What problems are municipalities in the Netherlands currently experiencing with this transition?
3. What types of supervision are possible for municipalities?
4. What are municipalities' current activities in Enschede, what structure of investigations are they currently using?
5. Which risks lead to inadequate quality and unlawfulness of care…
    a. According to the literature?
    b. According to supervisors?

1.4 Thesis outline

This thesis consists of five chapters, including this introduction. Chapter 2 provides an overview of the literature on the transition of the social domain, types of supervision, difficulties municipalities experience and the structure of investigations currently used by Enschede. In Chapter 3, the research method is discussed. Chapter 4 describes the risks found in literature and interviews and the findings of the analysis. Finally, in Chapter 5, the research findings, implications, limitations, future research directions, and the conclusions are presented.

2. Theoretical framework

This chapter considers all the relevant literature related to supervision of Wmo and youth care. First, Section 2.1 presents the background of the change of the law in 2015. Then, Section 2.2 describes the difficulties municipalities experienced because of these changes. Section 2.3 discusses the literature that describes the forms of supervision municipalities can use. Finally, Section 2.4 provides a description of the challenges that the municipality of Enschede faces with their supervision.

2.1 Transition into social domain

The Wmo 2015 is focused on social care service, which aims to support individuals' needs and encourage them to participate in society and improve their self-reliance [11]. Since 1 January 2015, changes have been made to the Wmo. These changes led to the new Wmo and youth act as they are today. In addition, changes in the legislation and regulations concerning supervision for healthcare providers occurred. Thus, municipalities are no longer only responsible for the implementation but also for the supervision and enforcement of the quality of healthcare delivered [4]. To adapt the policy according to the composition and demands of its inhabitants, municipalities have significant freedom in developing policy [12]. The municipality is obliged to appoint a supervisor but is free to determine the size (in fulltime-equivalent [FTEs]) and position in the organization.

2.1.1 Developing policy

For municipalities, the supervision of quality and lawfulness are major changes in arrangements. Since the changes came rather quickly, many reports and newspaper articles indicate that municipalities are still developing and adapting. The freedom in developing policy has benefits and drawbacks. A benefit is that every municipalities can adjust its policy to its own inhabitants [13]. However, in addition to freedom in developing the policy, a number of issues are also established by law which the municipality must enforce. The policy distinguishes between two types of supervision. First, there is supervision of compliance and quality, which involves the supervision with the (quality) requirements set in the legislation and regulations [14]. Good quality is determined by the Dutch law an safety, effectiveness, efficiency and client-oriented care [10]. Second is the supervision of lawfulness and legality. Municipalities can set their own priorities, considering the susceptibility to unlawfulness of certain facilities and companies (this supervision type is discussed further in Section 2.2). The distinction made between quality and lawfulness is important to understand because it sets the rules on how the surrounding laws and regulations determine the municipalities' actions. The supervision of the municipality focuses on the Wmo and youth care. The supervision of the quality of youth care lies outside the municipality. The health and youth care Inspectorate (Dutch: *inspectie gezondheid en jeugd* [IGJ]) supervises the quality, safety, and accessibility of healthcare regarding youth care [15]. The municipality supervises the quality and legality of care for the Wmo and the legality of youth care.

2.1.2 The differences between ZIN and PGB

Clients in the Netherlands have a personalized provision that can be provided in two ways: A non-monetary form named care in kind (Dutch: *Zorg in Natura* [ZIN]) and a personal healthcare budget called personal budget (Dutch: PGB). In addition to the differences between quality and lawfulness, the distinction between PGB and ZIN is important to understand. For ZIN, the municipality, health insurer, or care office contracts a healthcare provider. For PGB, the client chooses the healthcare providers, concludes contracts with them, makes a schedule, and arranges the payments. The major difference from ZIN is that, for PGB, the administration is completed by the client [16]. The supervision is different for these two forms. For PGB, less control is possible because people enter into the contract themselves, but for ZIN, more control occurs because the municipality enters into a contract and can therefore set more requirements. In 2019, Wmo expenditure had a growth of approximately 6%. For example, the number of clients of customized facilities rose by 5.3% in 2019 to more than 1.1 million. The number of clients with household help increased by 12%. In addition, municipalities paid higher rates to providers of Wmo care for help with household and daytime activities [6]. This study only examines

ZIN because this form has more and larger providers than PGB, and more data. And thus more profit is expected to be gained for risk-based supervision.

The next section reviews the changes in the Wmo since the transformation and explains how the municipalities are currently working.

2.2 Supervision of Wmo and youth care

This section first defines supervision and then explains how supervision can be arranged within the Wmo and youth care. The purpose of the supervision is the promotion of compliance with the law, the ordinance, and the rules imposed by the municipality to combat and prevent errors and fraud [10]. To determine what change or addition to supervision is possible, understanding how the supervision of providers is currently arranged is necessary.

2.2.1 Supervision of providers

Policy and supervision are closely intertwined. Over the past two hundred years, the vision and working method of state supervision has shifted from a social medical approach to public health to government supervision of institutions and professionals as they are known today [17]. Fukuyama, in his book Building a State, indicates that monitoring performance in various areas of the public sector is significantly more complex than in financial markets. As the number of decisions increases, supervision becomes more complex. In Fukuyama's terminology, high specificity requires separate supervision, especially when there is low transactional intensity [18]. A supervisor is an independent and impartial institute appointed by the government that monitors organizations' compliance with laws and regulations. Supervision is the collection of information that determines whether an action or matter meets the requirements set for it and then forms an opinion and intervenes if needed [14]. Since 1 January 2015, municipalities have been responsible for supervising the providers that provide care in the Wmo and youth care. This poses a number of practical questions, especially about the structure of that supervision. Some municipalities instruct the Municipal Health Services (Dutch: *Gemeentelijke Gezondheidsdiensten* [GGD]) to perform the supervision or have the supervision performed by an external agency [19]. Some municipalities complete the supervision themselves. Municipalities can also implement Wmo supervision in collaboration with other municipalities, in part, because most care providers work regionally, so a regional approach is well suited [20].

The Association of Dutch Municipalities (Dutch; *De Vereniging van Nederlandse Gemeenten* [VNG]) issued a guide that provides the municipalities with guidelines for the supervisory organization. The guide outlines municipalities' choices, possible design forms, and the powers of a Wmo and youth care supervisor [19]. To prevent a regulator from having intertwined interests, for example, incorrect accountability information, inadequate interventions, abuse and improper use, fraud and conflicts of interest and bias, supervision must be clearly distinguished as a separate, independent function [7]. Therefore, the supervisory function must remain separate from other functions, such as policy, regulations, implementation, and advice [21]. Despite the segregation of duties, a clear relationship must remain between policy, implementation, and supervision.

2.2.2 Authorizations

The powers of the Wmo and youth care supervisor are included in the General Administrative Law Act and Wmo 2015. These laws state that everyone is obliged to cooperate in an investigation by the supervisory authority and that all information deemed necessary in the context of the investigation must be provided. Furthermore, Wmo supervisors have the power to enter places and demand information and access to files to test the quality of care and the legality of providers. Additional powers can also be included. To use all powers, one must comply with the principle of proportionality: the use of a power is only legitimized if it is proportionate to the aim being pursued [22]. When collecting information for supervision, a distinction should be made between "information provided" and "information obtained". If the supervisor uses information provided by the investigated organization, this information must be validated. If the supervisor obtains information him- or herself, he or she must have sufficient powers

to obtain the information necessary for the performance of the supervision [22]. Surveillance practices are as old as human history. In the modern world, however, they have specific routine and systematic forms [23]. Recent studies suggest that, in practice, supervision is not always sufficiently geared toward fulfilling ministerial responsibility. The implementation of supervision often leaves much to be desired, and there are differences of opinion on elementary matters, such as the scope of the ministerial responsibility, the product, and the function of supervision [22].

2.2.3 Different types of supervision

Two types of supervision exist: reactive and proactive. Reactive supervision is supervision as a result of a report or a signal. Proactive supervision is based on, for example, risk analysis [19]. Various mutually influencing sub forms of supervision exist under these two types: data-driven and risk supervision, calamities and signal-controlled supervision, quality supervision, and thematic supervision [19][24][25]. In data-driven and risk-driven supervision supervisors analyse, for example, connections in reports over recent years or striking cases in providers' financial statements. For this type of supervision to work, data-driven monitoring and data management is required, preferably in collaboration with other regulators and municipalities [20]. Risk supervision is based on the proactive and periodic collection of both internal and external information to gain insight into risks that apply to quality and lawfulness of healthcare [26]. The difference between repairable or non-repairable risks also plays a role. For instance, for documents, the impact of risks is often lower because documents can be requested quickly. In risk-based supervision, inspection capacity is mainly deployed at companies that pose relatively high risks and entrepreneurs who have previously shown that they do not properly comply with regulations. The scope and risks of the activities performed differ per company. Therefore, in risk-based supervision, companies are divided into categories depending on the following criteria:

1. The extent to which risky activities are performed
2. Compliance behaviour
3. The effects (for society) if mistakes or errors occur.

Risk-based supervision means that the supervisory capacity can be used effectively at companies that pose relatively high risks [27]. Therefore, estimating the level of risk based on the above points is essential as these estimations will be made specific to quality an lawfulness risks.

Pursuant to Article 3.4 of the Wmo, providers are obliged to report every calamity and every violent incident that occurred during the provision of the facility [10]. A calamity or incident of violence cannot always be prevented. Calamities and incidents of violence must therefore be seen as opportunities for improvements. A thorough analysis of mistakes and errors, as well as how they can be prevented in the future is of great importance. After a report, the supervisor focuses not only on the calamity or the incident of violence itself, but also on the learning capacity of the provider. Signals about the quality or lawfulness of a Wmo and youth care provision can reach the supervisor through various channels: clients, professionals, and civil servants at the municipality [25]. With calamity- driven supervision, citizens are used as a warning sign. Citizens are the object of supervision but are increasingly supervising themselves in institutions and the regulator itself. The Inspectorate has taken various initiatives in recent years to involve citizens more in its supervision. The citizen's perspective can be implemented in its supervision by informing (i.e., the inspectorate informs the citizen), stimulating (i.e., the inspectorate encourages institutions to involve the citizen, for example, in investigations after calamities), and listening (i.e., the inspectorate includes citizen input in the supervision to further develop the involvement of citizens) [28]. However, the trade-off is complicated. Citizens must be able to rely on supervised organizations to comply with the law. Citizens are still important informants in this regard, but counting on the citizens' perspective and horizontal accountability is not without challenges. Both increased and decreased supervision are demanded, as well as prevention of all incidents and supervision in general terms and room for company and organization and strict regulation. This situation called the "supervisory paradox" [29]. Upon receipt of the signal, the supervisor, sometimes in consultation with the municipalities, determines whether an investigation is necessary. Based on the severity and gravity

of the signal, the supervisor assesses whether an investigation into the quality is necessary. With this type of supervision, the investigation process may differ greatly from case to case. Several factors influence the form and duration of the investigating and surveillance process. For example, if agreements have to be made with one or more clients, if several supervisors (IGJ) or chain partners are involved, or if there is social unrest, the supervisor's aforementioned method may not be used. If the supervisor (and municipality[s]) establish that improvement is necessary, the supervisor can conduct a follow-up investigation within a certain period of time [25].

Quality supervision focuses on the quality of a provider's care. Based on the assessment framework requirements, the supervisor assesses whether healthcare providers deliver adequate quality. The findings are described in an investigation and surveillance report.

Thematic supervision is supervision of the operation of a system around a specific theme. Based on the experiences of various stakeholders, the supervisor provides a broad view of the system around one theme. This form of supervision is often exploratory. If necessary, the supervisor can make recommendations to improve the system. The theme is always determined in advance in consultation with the commissioning municipality(s) [19].

A municipality has to choose between these types of supervision or a dual form. The choice depends on several factors, including which policy a municipality wants to pursue and what data are available. The next section further discusses the difficulties that municipalities experience with supervision and with these various forms of supervision.

2.3 Problems municipalities in the Netherlands experience

This section describes the problems that municipalities experience according to the literature. To determine possible change and risk-based supervision, it is important to know the difficulties, the municipality's abilities, and the achievable benefits.

2.3.1 What municipalities find difficult

Various articles and papers suggest that municipalities faces obstacles due to the shift of responsibilities to the municipality. At first, municipalities are sometimes too dependent on providers, especially when there is little local competition. Due to the dependency relationship, the situation can arise that if a contract of a provider is dissolved, there are no other providers to accommodate these clients. This means that a municipality cannot choose to dissolve a contract, despite possible quality and lawfulness problems. However, municipalities also struggle with the increasing number of providers that must be checked entering the market. To do this properly and extensively takes a lot of time and personnel for which municipalities do not always have the budget [11].

Second, there are some obstacles surrounding policy. Every municipality has the freedom to make its own policy in line with its residents. In contrast, the VNG allows municipalities in the Netherlands to have the same resources and, on a small scale, communicate with each other. However, the communication is difficult because every municipality develops its own policy. Furthermore, since all municipalities can make their own policy, the freedom in choice of FTEs is the danger of a lack of developing expertise, especially in smaller municipalities [30][12]. Fenger et al. states that sharing knowledge about fraud, errors, or improper use and increasing the medical knowledge of healthcare consultants is necessary [7]. Moreover, the ability to learn, take the initiative, and have sufficient time to achieve goals are crucial for real changes [1]. In addition, the VNG states that legality enforcement is not a department, it is the obligation of all employees. In the implementation of the Wmo, the underlying work processes are complicated, and there are different roles and employees involved. Enforcement is therefore an integral process that runs throughout the organization and touches many employees [31].

Third, since the decentralization in 2015, municipal costs for the social domain and for youth care in particular have increased. Municipalities are inclined to perform the minimum supervisory function for

cost reasons. From the perspective of the client, however, thorough investigations are desirable for quality improvement [32].

Fourth, the relationship between the municipalities and the healthcare provider has two characteristics of a classic principal-agent relationship. The first characteristic is a conflict of interest between the principal (client) and the agent (contractor). The second is information asymmetry: the agent has more information about his or her activities and goals than the principal. These two attributes allow the agent to set his or her own goals above those of the principal and maximize his or her own returns. To reduce these principal-agent risks, clients can, on the one hand, try to minimize the conflict of interest in the design of contracts; on the other hand, they can increase their information position vis-à-vis the agent through monitoring [7]. Obtaining information is a challenge within municipalities. Municipality ensures that all information is correct on paper: as long as the items and hours are checked. There is little known about the actual quality and provision of care. The information municipalities do have can also be better organized, but setting consequences when healthcare companies cross the line appears difficult since contracts do not always set clear boundaries [33]. Inquiries from journalists demonstrate that the companies are rarely checked. The Dutch Healthcare Authority mentions that investigations are complicated and time-consuming and that choices have to be made due to limited capacity [34]. To counter the shortages in the social domain, especially those in youth care, municipalities should more successfully obtain the information provision [33]. For example, the annual accounts are poorly audited and shareholders pocket millions in dividends [35]. To work in a data-driven way, monitoring and data management is necessary, preferably in collaboration with other regulators and municipalities [20].

Fifth, the integrated social domain-wide approach means that providers are approached in an unambiguous manner and expected is that links are quickly established from the various laws. In addition, different policy components within the municipalities should speak the same language to providers, which is not yet the case everywhere. Furthermore, not all municipalities perform an evaluation after an investigation and surveillance process between the municipality and the supervisor to include the lessons learned in the policy cycle of the municipality and at the same time to improve supervision [20].

And finally, within the social domain and the department of the supervisors, demonstrating intentional action and personal gain is a stumbling point. For instance, the law requires periodic reassessment, but the frequency of these investigations is not regulated in the Wmo 2015. Municipalities will continue to pay considerable attention to tightening policy. In Rotterdam, they are currently working on a much better definition of what support must meet, such as the exact definition of “daytime activities”. If this step is not completed this can cause difficulties if in an investigation civil proceedings will follow [36].

While this section highlighted the problems municipalities experience, the next section examines what type of supervision Enschede currently uses.

2.4 Enschede

This section discusses how supervision is currently arranged in the municipality of Enschede. In order to determine where and how risk-based supervision can be applied, it is important to first know where the municipality now stands. Therefore, the section explains which forms of data-driven and risk supervision, calamities and signal-controlled supervision, quality supervision, and thematic supervision are currently used. The structure of the investigations is discussed first, then the internal and external data used for supervision is outlined.

2.4.1 Structure of investigations

The Organization for Care and Youth Assistance in Twente (OZJT), also called Samen14, is the collaboration between the 14 municipalities of Twente in the field of youth assistance and Wmo care [9]. These municipalities do not work together in all areas: 2 of the 14 conduct their own investigations

and surveillance and 12 work together on investigations and surveillance. Enschede has its own department of surveillance and enforcement that currently consists of 3.5 FTEs.

2.4.2 Data-driven and risk supervision

New providers can register to the Wmo and youth care every six months. At the time of registration, providers are tested for a number of quality requirements. Based on the registration, a risk assessment is made for supervision of the contracted providers. A traffic light model is used: red means a greatly increased risk, orange a (slightly) increased risk, and green a low risk of problems in the field of legality and quality. This model works on the basis of a list of 12 questions about risk indicators. Healthcare providers are asked, among other things, about the ratio between their turnover and their personnel costs, about their interests in other companies and real estate, and about their own training and experience in healthcare. For each question, they can score 1, 2, or 3 points. Any organization that scores more than 5 points is "red" and can count on extra investigation and surveillance. This estimate is updated during the contract period, not systematic but if calamities or incidents occur at a provider. The risk can therefore be estimated lower or higher based on new information. This information is obtained from public sources or by requesting documents from the provider, possibly followed by a visit. However, this model is only an assessment. A red colour does not mean that it is certain that the provider has (serious) problems. Rather, the assessment indicates this provider is subject to a check or a visit by a supervisor. Supervisors do not operate solely on the basis of this risk assessment. Serious signals about providers can also be a reason to conduct an investigation [9]. In addition to these internal data and to properly fulfil this role, the municipality has access to considerable medical and sensitive personal data from health insurers, tax authorities, benefit agencies, and healthcare providers, among others. Information is also collected about the housemates of the person in need of care. This information may entail benefits, debt counselling, rehabilitation, or diagnostic information from the Institute for Employee Insurance (Dutch; UWV)[10].

2.4.3 Calamities and signal-controlled supervision

Residents, care providers, and employees of community teams or local teams who wish to report (suspected) fraud, financial errors, quality problems, or a care organization’s undesirable method of working can do so to supervisory authorities of municipalities, or OZJT. Calamities are identified via neighbourhood coaches, the front office, contract managers, and other departments within the municipality [9][37].

2.4.4 Quality supervision and thematic supervision

Quality supervision focuses on the quality of a provider's care. The quality of providers checked with the traffic light from the barrièremodel. In an emergency, an investigation is conducted into the quality of a healthcare provider. Thematic supervision is not subject to structural supervision within the municipality of Enschede. However, there are themes described within the municipality where the supervisors of Enschede want to adjust. How these adjustments are tracked is not stated. The six spearheads of Enschede of the Wmo and youth care are as follows: Courage and punctuality, integrated support and cooperation, client (result) first, youth and family focus, (longer) independent living, and efficient use of general facilities [37].

Thus, a start has been made with risk-driven approaches, but only with contracted providers. While the literature indicates that data-driven and risk-driven supervision is beneficial, the next section discusses the method used in this research to determine what risks municipalities should use to implement data and risk-driven supervision.

3. Method

This chapter discusses how the research questions were answered. Successively, the research design, the research population, the procedure, and the data analysis are discussed.

3.1 Research design

A qualitatively study was conducted to determine the risks that must be included in risk-based supervision. A combination of literature research and field research was used. Literature from 2010 to 2021 about risks of inadequate quality and unlawfulness of care was collected. Subsequently, interviews were held with supervisors from the municipality of Enschede to gain insight in risk for inadequate quality and unlawfulness of care.

3.2 Data characteristics: Inclusion and exclusion criteria

The first step of the literature review was finding relevant studies in Scopus, Google scholar and PubMed. Search terms were related to: “risks Wmo”, “unlawfulness oh healthcare”, “youth care and Wmo” and “insufficient care in Wmo and youth care”. Articles published after 2010 have been included in the literature review. Both risks and indicators for these risks that are mentioned more often in the literature and that are only mentioned once are included. Because the information in literature about these risks is scarce and the premise is making the connection between literature and practice, it is irrelevant how often a risk is identified in literature. For judging when to stop reviewing, theoretical saturation was used. Meaning that there was stopped reviewing, when no additional outcome and risks were found after reviewing a great number of studies. In this way a list with relevant risks for inadequate quality and unlawfulness of care was created.

To determine the risks that supervisors encounter in supplier satisfaction, semi-structured interviews were held in Dutch with five officials between 20 to 60 years old in November 2020 via Microsoft Teams. Semi-structured interviews were used to obtain structured answers to the sub-questions and to allow interviewees to expand on their answers to gather more information. The Dutch interview schedule can be found in Appendix 1. The interviews lasted between 45 and 60 minutes. The interviewees were interviewed one by one. The audio of the interviews was also recorded in accordance with the interviewees to analyse the answers after the interviews were complete. All interviewees signed the consent form with which they give permission for the data to be used anonymously.

After determining which risks occurred both in the literature and in the interviews, indicators and limit values were determined. These indicators and limit values arose from both the literature and the interviews

3.3 Procedure/Research course

The intention was to interview five civil servants of the municipality of Enschede in November 2020. To gain better insights into the possibilities for improvement of risk-based supervision, the interviews were ultimately conducted with five officials. Because all interviews were conducted in full, they were included in the analysis. Notes were made during the interviews to register the answers. Four interviews were also audio recorded with the consent of the interviewees. One interviewee preferred not to have recorded audio.

3.4 Data analysis

First, the interviews were transcribed in Word. Started with open coding these codes indicate, per fragment, the main theme. After this step, axial coding was used. These codes were compared and merged within an umbrella code. A number of main categories emerged from this step, after which all found codes were placed within the categories, and on the basis of these categories, relationships and connections were made between the data. A distinction was made for risks between lawfulness of healthcare and risks for quality of healthcare. Subsequently, the results of the literature search and the interviews were combined. Next, binding indicators for the risks that occurred both in the literature and in the interviews were created. The combination was used because officers of the municipality were considered to ensure support for the model.

4. Results

The results of the literature review and interviews are presented in this chapter. This chapter starts with the results of the sub-questions. Results of risks from both literature and interviews are outlined and indicators and limit values are set for each risk.

4.1 Transition into the social domain

Since 2015, municipalities have been given a number of additional tasks in the field of care, participation and self-reliance, work, and youth assistance [3]. The most impactful change was that the fields of care, self-reliance and participation, work, and youth assistance shifted from being a national responsibility to being the responsibility of the local municipality [4]. As a result, municipalities have not only become responsible for the performance of care tasks but also for the quality and legality of care.

4.2 Types of supervision possible for municipalities

How municipalities organize supervision is decided per municipality; on the one hand, municipalities have set policies, and considerable freedom on the other hand. There are six types of supervision that a municipality can apply when conducting investigations and surveillance by providers: data-driven and risk supervision, calamities and signal-controlled supervision, quality supervision, and thematic supervision [19][24][25]. Often a combination of these forms is used. It is necessary to consider which forms best suit the purpose of the municipality, and the personnel available.

4.3 Problems municipalities in the Netherlands experience

Money and capacity both play an important role in the difficulties that supervisors within municipalities experience. In short to work with the resources available. Municipalities have difficulties with limited time and personnel, self-organization with little control, increased number of providers, long process and investigations, and more integrated work. The difference between small and large companies and different laws that apply to acts such as long-term care and Wmo means the requirements providers must adhere to are not known. Many problems have two sides; for example, too few providers is not desirable but so is too many. There are many choices municipalities must make. All these problems lead to the fact that, among other issues, the current supervision of providers is not optimally organized.

4.4 Investigation and surveillance in the municipality of Enschede

The literature indicates that the municipality of Enschede works together with 12 other municipalities in the region in the field of investigation and surveillance. In Enschede, the barrièremodel is used for risk-driven supervision. Enschede also uses calamity-driven supervision in the form of an email address where anyone can report failures or problems about the quality and legality of care providers. Data driven supervision has not yet been set up systematically as Enschede currently uses different databases.

The investigation and surveillance is now mainly organized in a proactive and reactive way: proactive by looking at the colours of the providers in the barrièremodel (green, orange, red), and reactive when an investigation is started after an calamity has occurred.

> "Most investigations start with notifications from the neighbourhood teams. It is also possible for a resident or a client to email a report. Sometimes reports come from other teams within the municipality, not most of them, but it is possible." (Interviewee 4) (supervision and enforcement, November, 2020)

The supervisors explained they split their investigation and surveillance operations into small and large investigations. For small investigations, the provider is often contacted for more information (e.g., an incident in which a neighbourhood coach asks whether there is sufficient personnel employed by a specific provider). A large investigation can result from the outcome of a small investigation.

> "There are about eight major investigations per year. We cannot do more within our team. And small investigations, there may be 80 to 100 per year, but they take little time. But what is

possible is that these small investigations can lead to larger investigations." (Interviewee 3) (supervision and enforcement, November, 2020)

The interviewees divide large investigations into five categories: organization, finances, personnel, client, and safety.

> "The organization must be good, so the documents must be in order. Good, qualified personnel must be employed. The care must be client-oriented – the client must get what he/she needs. And the physical environment must be safe and suitable to receive the care that the client needs." (Interviewee 3) (supervision and enforcement, November, 2020)

The interviewees addressed that an investigation is started after an incident is reported. What follows is desk research to determine whether a major investigation of the provider will be conducted. This investigation entails collecting internal data that is available within the municipality and public sources to clearly understand the provider. After the desk research, supervisors have a conversation with the provider. It is then determined whether the preliminary investigation and interview is sufficient or if more information is needed. If this is the case, more documents are demanded and the provider is given 14 days to provide the required documents. The investigation will only commence when all the required materials have been received.

> *"*When we received all the documents, we started the investigation. And that is quite intensive. We check hours and personnel, VOG, attendance lists, and care plans. We do some preparations – for example, appointment lists for care plans, but this is minimal. It is a difficult period. We wait for the documents, but when you start another investigation while waiting, you have two investigations right through each other." (Interviewee 2) (supervision and enforcement, November, 2020)

The time frame of investigations varies significantly for each case. If an investigation leads to a lawsuit, it can sometimes take from six months to a year.

> "What everyone underestimates is if an investigation is started and we really have the idea there are things wrong. Then we will be doing an investigation for at least three months. We really have to find out everything. And the burden of proof is on us, because the moment we get to the court everything has to be right." (Interviewee 2) (supervision and enforcement, November, 2020)

4.5 What risks lead to inadequate quality and unlawfulness of care?

This section explains the risks that lead to inadequate quality and unlawfulness of care within Wmo and youth care according to the literature and interviewees. The risks are divided into overarching headings. All risks are presented in tables 1 and 2 (pp. 22–23). Table 1 lists the risks for lawfulness based on the literature and interviews, while Table 2 outlines the risks for quality, also based on the literature and interviews. It is important to underline the difference between an indicator and a risk. An indicator is an early warning that measures possible changes in a risk. A strong indicator monitors changes in risk level and predicts unwanted events, revealing how quickly a risk changes and when it peaks or falls.

4.5.1 Lawfulness

Legislation is the actions involving healthcare funds in violation of laws and regulations. Unlawfulness is not necessarily fraud, although the word fraud is often used regarding. The definition of fraud is: "wrongful or criminal deception intended to result in financial or personal gain" [38]. Demonstrating intentional action and personal gain is difficult within Wmo and youth care. Thus, lawfulness examines whether an action is unlawful, whether it is purposeful or not. The risks that lead to unlawfulness in healthcare are categorized under two headings: money not spent on healthcare and transparency.

Money not spent on healthcare

The municipality is responsible for verifying whether the invoice and the agreed care provided at a provider are consistent [19]. The first risk that arises from this responsibility is that healthcare providers do not provide the correct amount of indicated care. This risk includes ghost care (care not provided but claimed), upcoding (where a care provider declares a more expensive treatment than was given), declaring violation (different treatments were claimed than those performed), and double funding (care provided is doubly claimed), as well as providers deliberately declaring an amount higher than the agreed rate [21]. For example, in non-reimbursed care, declarations are submitted that are not reimbursed or only reimbursed under special conditions. The interviewees also indicated that ghost care is a risk. An indicator for this risk can be the redemption rate of providers. The redemption percentage is the extent to which the expected costs for care, based on an indication, have actually been realized [39]. The redemption percentage for municipalities' ZIN varies between 50% and 70% [39]. There are a number of possible causes for all care not being used by clients. For example, it takes time to start care after it has been granted, less care is used during holiday periods or due to illness, and clients sometimes do not fully use their indication for other reasons [40]. As it is unlikely that agreements will always take place, a high redemption rate can therefore indicate unlawfulness of care.

> "We therefore look at the declarations when everything is fully declared. We also want to see this reflected in attendance lists, proof that the client has also been at the daytime activities." (Interviewee 2) (supervision and enforcement, November, 2020)

Money not spent on healthcare due to the organization's shape is also an issue. First, unclear private company structure and collaboration between subcontractors for the sake of personal gain is a risk for unlawfulness in healthcare provision [11][41]. Healthcare providers can transfer money from one company to another without it being immediately noticeable on the annual reports. The interviewees mentioned a risk when there are a lot of private companies intertwined. The interviewees call this a Christmas tree structure, where different companies are connected like the lights on the tree.

> "The structure of the private company is certainly important to consider, especially with a Christmas tree structure when many private companies are intertwined." (Interviewee 4) (supervision and enforcement, November, 2020)

In addition to these risks, money not spent on agreed care is a recurring theme in many literature sources. Reasons for this problem include high winnings and high profit distribution [42]**.** A normal healthcare provider can provide Wmo services and youth care at about 10% profit [43]. When higher, something may be wrong because rates and healthcare costs are under pressure, so delivering the agreed care is only just possible [37]. In response to reports of excessive profits in healthcare, the Ministry of Health, Welfare and Sport investigated whether it could impose additional conditions on healthcare providers' dividend payments. This investigation indicated it is possible to set preconditions for the financial health of a healthcare provider before they may distribute profits as remuneration for the contribution of capital and to set a standard for one socially acceptable profit distribution [42]. A profit of more than 10% is worrisome and should be investigated as a risk. Interviewees indicated that high profit percentages are one of the risks that can give rise to an investigation, the aim of which is to determine whether a healthcare provider meets the requirements with regard to the correct registration and declaration of care.

> "At Samen14 we have not yet described anything about what we think of profit percentages – how high it can be. But it is a good indication when it is not in proportion to the care that is provided." (Interviewee 5) (supervision and enforcement, November, 2020)

Furthermore, risk occurs if proper personnel are not deployed and are replaced with cheaper personnel such as interns to achieve a higher profit; therefore, claiming for the care provided with insufficiently qualified personnel [41]. Interviewees also addressed this risk and suggested that an indicator for this

risk is when personnel cost does not match the turnover. The barrièremodel uses an value limit of 20% wat is acceptable to minimal spend on personnel.

> "What can also be a signal for us if a lot of volunteers work at a provider, is whether they still have enough personnel for the care they have to provide." (Interviewee 2) (supervision and enforcement, November, 2020)

Transparency

There is transparency between the provider and the municipality regarding, among other items, financial data and care plans. Furthermore, there is transparency occurring between the provider and the client and the municipality and the client, including the kind of care expected and what providers are entitled to deliver. Municipalities should know the number of clients they are responsible for, the turnaround times, the workload, and the results and costs of policy. These data are used to determine whether the implemented policy is working and is properly monitored [33]. The interviewees stated that they see rapid growth of an organization as an indicator for the risk of employing the right personnel. One of the reasons they consider rapid growth as a risk is because personnel is scarce.

> "I also see the growth of a provider as a risk. If an organization has two clients at the beginning of the year and 15 at the end of the year, for example. Personnel is very scarce, so how does that provider do that?" (Interviewee 2) (supervision and enforcement, November, 2020)

The interviewees indicated that when providers offer other services in addition to the Wmo and/or youth care, they consider this provider to be risky because the more services offered, the more specialized personnel must be employed. The risk also occurs when providers switch from ZIN to PGB or the long-term care act (Dutch: wet langdurige zorg [Wlz]) because the control is less strict.

Lack of data is a heading under transparency. The annual digital data accounts for all healthcare, youth care and safe at home institutions are held at the Central Information Point for Healthcare Professions, part of the Ministry of Health, Welfare and Sport. Large, medium and small companies are differentiated [44]. More financial data is available for large and medium-sized companies than for small companies because they are obliged to provide more information. A provider may submit a simplified annual account if it meets at least two of the following criteria in two consecutive years: a net turnover of less than 700,000 euros; less than an average of 10 employees; and assets not exceeding 350,000 euros (according to the balance sheet with explanatory notes). When this is the case, a business is considered small [44]. The annual figures often do not contain information about the providers' results. The literature indicates that small providers often make a lot of profit, and data is missing precisely because providers are allowed to send a simplified version of the annual report [14]. Healthcare provider subcontractors' annual reports contain little financial data. They often provide incomplete or misrepresented information, or false information about the billed care [14]. Therefore, limited financial key figures are an indicator for the risk of unlawfulness of care and can be summarized as lack of ethical behaviour on the part of healthcare provider directors. Interviewees also suggested that the lack of data also depends on whether providers only provide Wmo and youth care or, for example, also the Wlz. The Wlz has other rules that Wmo and youth care providers must comply with.

> "For example, if providers also offer other services outside of the Wmo, if all of that is also included in the package with one care provider, then I think by myself, how are you going to do all that?" (Interviewee 5) (supervision and enforcement, November, 2020)

A care plan has vaguely defined goals written by the care provider is a risk described by the VNG. It must be possible to demonstrate that the care has been provided, which indicates transparency. If the goals are not specifically defined, there is no possibility to check if the care provided gave the desired results. Interviewees also stated that providers need to keep track of when and what care was provided to each client.

> "That is the part of lawfulness that we check. Can they show us that they have provided the care they claim." (Interviewee 1) (supervision and enforcement, November, 2020)

Relationships between healthcare provider and client are also covered under transparency. The VNG provides guidance for municipalities for ZIN. Risks include the client's representative is also the healthcare provider, and the care provider provides more answers than the client during the kitchen table discussion [20]. The risk here is that a client has already been informed or instructed by the representative to choose a particular provider and there is no more freedom of choice. The more complex the service and the less measurable the result, the greater the risk of unlawfulness, errors, or inappropriate use. In particular, the service guidance as an independent service or as part of protected living requires attention because, as the literature suggests, it is not always clear to customers what they can expect from guidance. This concerns a client who is disadvantaged because they no longer have a choice, but it is also possible the other way around (i.e., that the client understands very well what they are entitled to). The risk is not adapting care to changing situations and not scaling up or down in time [45].

When a situation worsens (e.g., the illness becomes more serious or a caregiver drops out), it is likely that the client will report this change. When a situation improves (e.g., the illness becomes less serious or the customer has a new relationship), it is less likely that the client will report the change. The large-scale re-assessment currently conducted by municipalities offers opportunities to analyse, both in improvement and deterioration, whether the indicated care still matches the care needs [7]. In the event of collusion, the care organization and the client make agreements to declare care in such a way that they both retain something from it (e.g., when a report states that more hours were delivered). The clients agreed with this because due to the declared excess, their personal contribution can be completely "free" and the care organization was paid significantly more than what it was entitled to [46]. If clients and providers have a relationship, this can be an indicator of the two abovementioned risks of unlawful care.

4.5.2 Quality

As described in Section 2.3, quality broadly includes providing safe, effective, efficient and client-oriented care. The risks found in the literature and reported by the interviewees are therefore divided into four headings.

Safe care

First, safety is guaranteed by matters established by law, such as the use of an existing quality tool [10][25]. Providers with a quality mark go through various internal and external audits. In addition, municipalities can use the award criteria for quality instruments and make the use mandatory. Providers themselves also have a range of options to measure quality and customer experiences. Instruments such as MANSA, participation ladder and the ROPI are used to gain insight into the quality of their own offer and quality [25]. When providers do not make use of any quality tool, this can be a risk for the quality of care provided. In addition to these tools, the law also stipulates that providers must immediately report any incident that has occurred when care is provided to the supervisory official. There is case of a risk when an incident occurs more than once at a provider [10]. The interviewees also mentioned this as a risk to the quality of care:

> "An incident, or multiple incidents, is priority one to start an investigation. If an incident occurs often, the provider is often no good." (Interviewee 1) (supervision and enforcement, November, 2020)

Finally, in addition to what is described in the law about quality requirements, there are also other institutions that inspect quality. The IGJ examines the quality of youth care and uses assessment frameworks in safety supervision. A number of risks that are examined can also be applied to the Wmo's quality control. The IGJ assessment framework consists of five themes: aid implementation, safety, living climate, client position, and administrative organization. Each theme is detailed in a number of

criteria and expectations [26]. The risks from safety and living climate come under the heading of safe care. In terms of safety, the IGJ focuses on whether professionals ensure the safety of young people and systematically estimate the safety risks [44]. If these are not right, risks can arise. Specific risks are not described. However, the living climate theme describes a specific risk, namely when the location is not intended for care or the physical living environment is not of high quality. Permits are required for locations where healthcare is provided. Not having these permits can therefore be an indicator that these properties are not suitable for providing health care. Interviewees also mentioned that having a permit is an indicator for checking whether the location meets the quality requirements.

> "We now have a client who lives at a location offered by the healthcare provider, where there is no permit to live at all." (Interviewee 3) (supervision and enforcement, November, 2020)

Effective care

Effective care involves producing a result that is wanted. The reason clients are not subject to the Long-Term Care Act but the Wmo and Youth care is that clients at the Wmo and youth care improve, meaning this improvement should also be visible. A treatment plan is created for every client who receives Wmo or youth care. The care plan indicates the results the municipal administration wishes to achieve in the period covered by the plan. Criteria are used to measure how these results should be achieved and the performance indicators used for providers [10]. The care plan is also used to monitor the implementation of care. When there is no improvement over time, this can be harmful to the patient because there is a risk that the quality of health care is not sufficient. There is also support within the Wmo where this does not apply (e.g., help in the household). A risk that is linked to this is that the provider's working method is not result-oriented (intentional or not) [46].

An indicator can be when the care plan has not been properly drafted or tracked. The care plan is mandatory and has a contract function that allows the client to check whether the care offered is being realized. Another indicator is the client's lead time, which indicates that health is not improving over time, since people stay longer and do not improve, as has been agreed. The interviewees indicated that if clients do not see the results described in a care plan, this could be a risk for the quality of care. In addition to tracking and following a care plan, there are other indicators that may indicate that no effective care is provided, such as large distances or a long travel distance between the healthcare provider and client. This can indicate a risk when providers indicate they provide 24-hour care. If the distance is too great, there is a risk that the provider cannot deliver the care on time or not at the agreed time or speed. As a result, the quality of care will not be sufficient [19].

When care is provided from several legal domains, providers who offer other services in addition to the Wmo, such as Wlz, can be also a risk. If many different types of care are provided, the provider also needs personnel for this. Guiding specific target groups requires different skills. As mentioned earlier, there are not always enough employees to be able to properly answer the care or assistance request. This is a risk to the continuity and quality of care [46].

> "What we sometimes see is that providers accept everyone. I do wonder whether the personnel is trained in such a way that they can manage clients with all those different problems. So, their workforce compared to their client base." (Interviewee 2) (supervision and enforcement, November, 2020)

As mentioned in the interviews, the data that can be used for this compares the personnel hours with the care hours.

Client-oriented care

A risk of not providing client-oriented care is limited knowledge and significant vulnerability of part of the client group. Vulnerable clients within Wmo can be clients who do not speak the Dutch language, people with mental health and psychiatric disabilities, or frail elderly [25]. The vulnerability can be caused by, among other things, clients not always fully understanding what they are entitled to in terms

of care. Providers with a lack of integrity handle vulnerable clients relatively easily, increasing indications and providing less care than the clients are entitled to. An indicator of lack of client-oriented care is that the providers have many or only vulnerable clients.

> "If I have to name one risk where I think a lot goes wrong, it is when the client does not speak the Dutch language. They start knitting and watching TV and sign every week because the client is happy. In the meantime, the provider fills his pockets." (Interviewee 2) (supervision and enforcement, November, 2020)

The risk profiles of clients, particularly elderly people and people who do not speak the Dutch language, are thus indicators of the quality of healthcare. At the request of the House of Representatives, clients' risk profiles were examined [41]. Several sources indicate that different clients pose different risks. Mapping the most vulnerable and risky groups within the municipality can form a starting point for (proactive) supervision. Based on this analysis, the most vulnerable groups (i.e., those at highest risk) are given priority. Vulnerable groups, therefore, have a greater risk of poor-quality care. The risk indicators used target group vulnerability. In addition, complexity of care or support is a risk. The GGD Gelderland Zuid conducted a study into the vulnerability of different groups and found: mentally limited, psychiatric, and addiction clients scored 3 points; financial situations scored 2 points; and elderly (over 70), somatic and under 70, and the physically limited scored 1 point. The risk indicators used, such as vulnerability of the target group, complexity of the care/support, and the use of existing quality instruments were combined with several other GGDs in the country. This is the first exercise in creating risk profiles. In practice, Wmo supervision will have to demonstrate whether this method of classification is satisfactory and exhaustive.

> "Risks associated with the care provided have the most impact on clients because of the composition. For example, if there are many young people I think that is a fairly high risk. Or are there many elderly people, how does this take place and where?" (Interviewee 3 (supervision and enforcement, November, 2020)

Efficient care

Efficient care is capable of producing desired results without wasting materials, time, or energy. The IGJ established signals from which risky situations arose, including: a scheduled employee would have to provide an amount of care that exceeds the capacity of a person and the care providers would later provide care by insufficiently qualified employees [46].

The law states that it is required that the provider has a statement of conduct within ten weeks for each professional [10]. According to the law and regulations, it is also a risk if personnel who do not meet these requirements are employed. Personnel need to provide a statement of conduct and some need to be SKJ or BIG registered prior to employment (Foundation Quality Register for Youth). All interviewees indicated that having personnel working without these requirements posed a risk to the quality of care.

> "Be sharper than the number of clients. What you actually want is how many hours of care should be provide. For the daytime activities for 19 clients, you need two people. But if you have ten times two hours of daytime activities, 0.5 FTE is enough." (Interviewee 2) (supervision and enforcement, November, 2020)

The data required for this is, as described in the quote, the number of hours of care that must be delivered compared to the personnel hours.

All these risks affect the legality or quality of health care. Many risks are also intertwined and affect both quality and legality, such as not having the personnel to provide the required care. It is therefore important to consider the risks that are outlined in the literature and the interviews in terms of both quality and legitimacy.

Table 1. Lawfulness risks from the literature and interviews

	Literature	Interview
Healthcare money not spent on healthcare		
Healthcare providers do not provide the correct amount of indicated care		
Ghost care	X	X
Upcoding	X	
Declaring violation	X	
Using double funding	X	
Claiming non-reimbursed care	X	
Overtreating	X	
Money is not spent on healthcare due to the organization's shape		
Unclear private company structure and collaboration between subcontractors	X	X
Lack of ethical behaviour on the part of directors of healthcare providers	X	
High profit	X	X
High dividend pay-out	X	
Proper personnel not employed	X	X
High costs not in keeping with the nature of the healthcare company (expensive cars/equipment)	X	
Owner without a healthcare background		X
Transparency		
Multiple services		
Providers who switch from PGB to ZIN		X
Providers who also provide other services in addition to Wmo and/or youth care		X
Lack of data		
Incomplete annual accounts	X	
The annual reports contain limited financial data	X	
A care plan with vaguely defined goals	X	
Not keeping track of the hours of care provided		X
Policy rules described too broadly and not in line with the claims as formulated in the services	X	
Relationship between healthcare provider and client		
The client's representative is also the healthcare provider	X	
The care provider provides more answers than the client during the kitchen table discussion	X	
There is an unwanted dependency relationship between the provider and client	X	
The provider requests extra money from clients	X	
Provider and customer know each other personally		X

Table 2. Quality risks from the literature and interviews

	Literature	Interview
Safe care		
"Bad" publications and publicity/negative publicity and/or media	X	
The results of an IGZ report	X	
Multiple incidents are reported	X	X
Not using an existing or strong quality assessment tool	X	
The provider not performing systematic quality management	X	
The location is not intended for the provision of care	X	X
Effective care		
Failure to provide the agreed care	X	
A care plan with vaguely defined goals created by the care provider	X	
The provider's work method is not result-oriented	X	
Long travel distance between care provider and client	X	
No improvement by clients over time	X	X
Overtreatment of client	X	
Care is provided from several legal domains		X
Client-oriented care		
Vulnerability of clients	X	
Professionals without respectful attitudes toward clients	X	
The client does not speak the Dutch language		X
Relationship between healthcare provider and client	X	X
Client mix		
Clients with diverse needs at one provider		X
Care not specific to a client's needs	X	
Limited knowledge and significant vulnerability of the average client	X	X
Large variation in the composition of clients (i.e., mix of clients in terms of services)		X
Large variation in the composition of clients (i.e., mix of clients in terms of age)	X	X
Many clients with a high demand for care		X
Efficient care		
The right personnel not employed		
Unqualified personnel employed	X	X
Too few personnel employed for the number of hours of care that the providers have to deliver/should provide	X	X

Table 3 examined which risks have been mentioned in both the literature and the interviews.

Table 3. Lawfulness and quality risks from the literature and interview

Risks	Indicator
Lawfulness	
Ghost care	The redemption rate of providers, limit value between 50% and 70%
Unclear private company structure and collaboration between subcontractors	Collaboration between subcontractors or intertwined private companies
High profit	Profit, limit value 10%
Proper personnel not employed	Personnel costs not matching the turnover, limit value 20% Rapid growth or decline of clients
Quality	
Multiple incidents are reported	Number of incidents that occurred at provider
The location is not intended for the provision of care	Having a permit for the location
No improvement by clients over time	The care plan not being properly drafted or tracked The clients' lead time
Relationship between healthcare provider and client	Many vulnerable clients; elderly people and people who do not speak the Dutch language
Limited knowledge and great vulnerability of the average client	Provider registered for all or a lot of different tenders
Large variation in the composition of clients, on mix of clients in age	Number of different clients
Proper personnel not employed	Personnel without the correct papers The number of hours of care that must be delivered set to the hours of staff employed

4.6 Ranking

It is important to determine at what point an indicator is considered to present a risk, such as when the indicator entails a high profit. In these cases, the 10% cut-off value that is described in the literature can be used. Cut-off points for when an indicator is considered a risk are used in the barrièremodel. However, the interviewees stated that this method does not work optimally in all cases.

> "Because a cut-off point is used, some providers are sometimes on the red, while for a few questions they are only a few percent below the desired level. This gives a distorted picture." (Interviewee 5) (supervision and enforcement, November, 2020)

A ranking system can be used as an option to avoid this distorted picture. The greatest strength of ranking is its simplicity. The problem currently experienced by regulators is that there is no difference between a small and a large deviation; both deviations lead to a red colour on the traffic light model. By using a ranking system, this problem is solved as regulators can interpret when something is "wrong". Ranking also suits the problem of having little time, so supervisors can set their own priorities based on where a provider is ranked instead of focusing on all the red providers. An estimate of the risk should than be made by the supervisors themselves. All providers contracted by the municipality will receive a ranking for the risks to which ranking applies. For the 11 risks described in Table 3, ranking can be applied to seven. For lawfulness ; ghost care (ranking of the percentage of the redemption rate); high profit (ranking of the percentage of the profit) and proper personnel not employed (ranking of the percentage of personnel costs and percentage of growth or decline of clients). And for quality; multiple incidents are reported (ranking the number of incidents); no improvement by clients over time (ranking of the clients' lead time); large variation in the composition of clients (ranking on number of clients in specific age groups and ranking of different types of clients); and proper personnel not employed (ranking of the percentage of hours of care that must be delivered compared to the hours personnel are employed).

For the four risks where ranking cannot be implemented, a binary result of yes and no, a number or a list will be sufficient. Thus, this sufficient for: unclear private company structure and collaboration between subcontractors (binary: yes or no), the location is not intended for the provision of care (binary: yes or no), relationship between healthcare provider and client (number of elderly clients, number of clients who do not speak the Dutch language) and limited knowledge and vulnerability of the average client (number and list of tenders registered for).

Risk-driven supervision will require a notification when a risk occurs, a point count should be added (e.g., how often a provider is in the top 1–50, 50–100, 100–150). In this way, providers who score, on average, higher than other providers for multiple risks become visible. The traffic light model or a certain cut-off value can also be implemented if the municipality decides to attach certain weights to the various risks and wants certain risks to be more heavily weighted.

Figure 1 illustrates a possible dashboard layout. There is a separate page for each provider where the general information about this provider can be found. The headings "quality" and "lawfulness" are placed beneath it. Under lawfulness, the four risks are described with the indicator and ranking of the provider on these four risks (including the optimal values if these were described in the literature). If the provider is in the top 50 of the ranking of a risk, it will turn red. This can also be seen in the provider's general information, which has a 1 in red behind the word lawfulness. In this way, how many risks the specific provider falls into a risk category for can be seen at a glance.

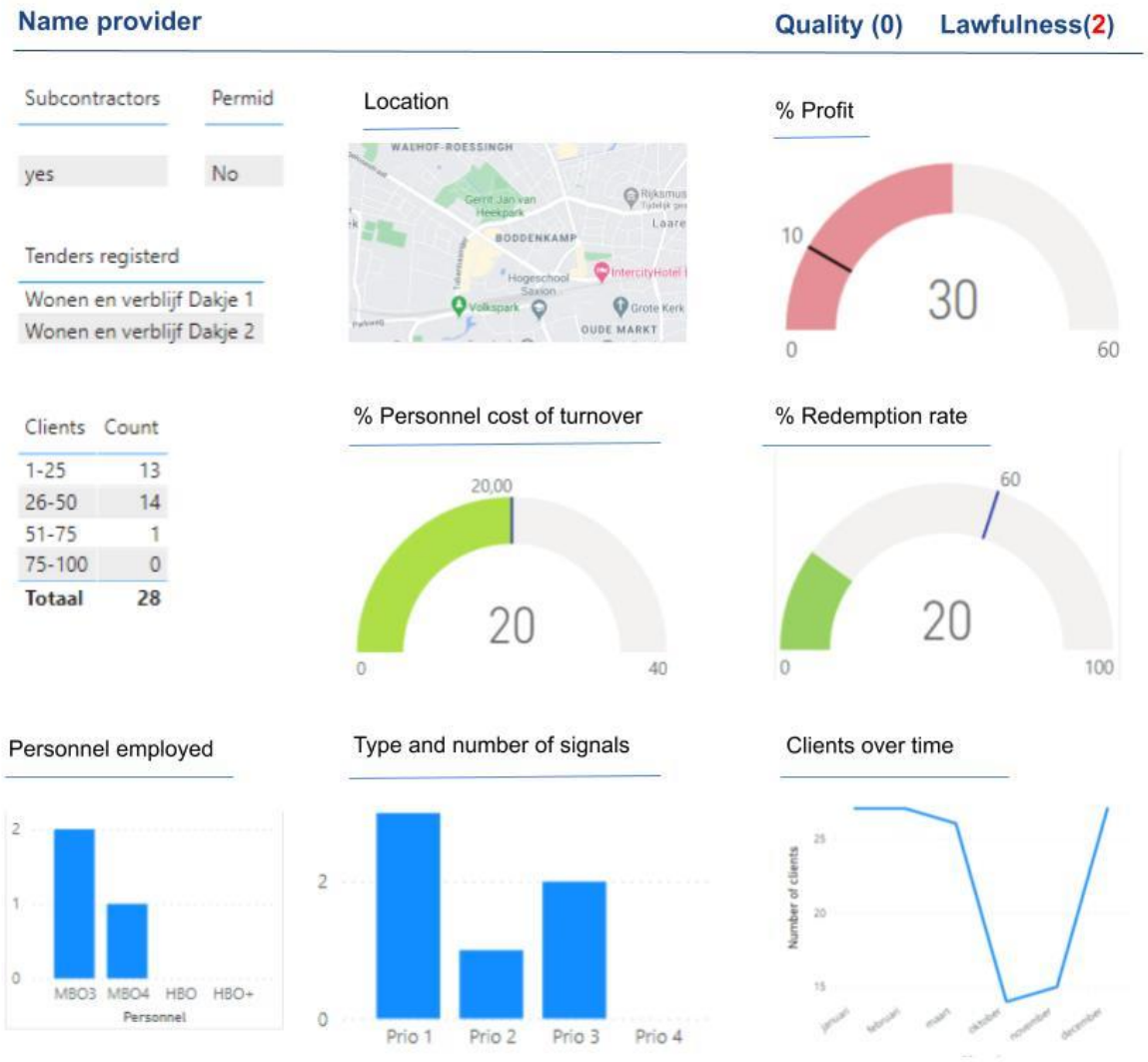

Figure 1. Example dashboard, risks and indicators of quality and lawfulness of the provider

5. Discussion and Conclusion

In this section, the main results and conclusion of this study are presented. Afterward, the results are discussed, and the strengths and limitations of the study are described. Finally, recommendations for further research are given.

5.1 Conclusion

This study aimed to answer the following research question:

Which risks and which tool should municipalities in the Netherlands consider in risk-based supervision of the quality and lawfulness of care to reduce inadequate quality and unlawfulness of healthcare providers in the context of the Wmo and youth care?

For this study, a literature review was completed and interviews were conducted with supervisors of the Wmo and youth care to identify the risks of inadequate quality and unlawfulness of care. The results were then used to determine risks, indicators and limit values that can be used in risk-based supervision. Risks with the greatest impact on unlawfulness and poor quality of healthcare were, among others, ghost care, high profits, and proper personnel not being employed. The impact was considered great when the risks were mentioned both in the literature and interviews. This was the case for 11 risks, which can be found in Table 3. The results from this study indicate that the overarching themes that appeared in both the literature and the interviews were the issues of money not being spent on healthcare and a lack of transparency regarding lawfulness and the importance of efficient, effective, safe, and client-oriented care regarding quality. Table 3 also lists indicators of these 11 risks. For three of the risks, two indicators can be used. For a total of three risks, a limit value was found in the literature. The redemption rate should be between 50% and 70%, 10% profit is the maximum and personnel costs should not be higher than 20%. To implement these risks into risk-based supervision, a dashboard needs to be made presenting them. For the risks where no limit value was found in the literature, the use of a ranking system is advised. By ranking a provider in comparison to the other contracted providers in the municipality, supervisors of quality and lawfulness can themselves determine the size and impact of the indicator of the risk to lawfulness and quality of care. The answer to the main question, therefore, is to create a dashboard whereby the values and ranking scores of the 11 risks per provider are visible. In this way, a more risk-based supervision can be carried out.

5.2 Discussion of results

Prior to the interviews, expectations were that the risks discussed in the literature would be comprehensive. This would mean that no new risks would be presented in the interviews. Surprisingly, there were eight risks that are mentioned in the interviews but not in the literature. One explanation for this could be that Enschede is at the forefront of development regarding supervision of the Wmo and youth care, as shown through its collaboration with Samen14 and the barrièremodel that was developed. The interviewees also mentioned this, saying,

> "The advantage is that if court they see that it is an investigation from Enschede, we are re in the lead 1 to 0, because it has turned out that our investigations have been done properly and carefully." (According to interviewee 2) (supervision and enforcement, November, 2020)

Consequently, this study presents new risks that have not been previously discussed in the literature.

Second, the problems municipalities experience that have been found in this study can be linked to the risks of inadequate quality and unlawfulness. The problems that have arisen with the new regulations are mainly due to limited time and personnel, which resulted in municipalities not being able to handle the increased number of providers and having to do self-organization with little control. Which requires time, agreement and personnel. Because municipalities are still busy with figuring out how to incorporate the new policies, there is not always time to extensively check each new or already contracted provider. Due to a lack of time, regulators are first focusing on the red providers from the

barrièremodel and the new providers, leaving no time for more preventive investigations. But now, after the changed policy, more focus is also being placed on risks and signals and as a result more risks are being discovered.

Third, what is striking about the risks to quality and lawfulness is that there are a lot of risks that are caused by scarce personnel at the provider. Many risks are related to or can be derived from this scarcity. At least five of the 11 risks can be linked to personnel scarcity. For example, high profits can come from working with cheap, unqualified personnel, and calamities occur because the right personnel are not employed. Because many risks and indicators are interwoven, it is difficult to pin the precise risk on a provider. However, on the other hand, if all the risks are examined simultaneously, it can immediately be seen when there is a connection to the personnel and when it is something else that causes the risk. There are a number of data points that are required to estimate risks, like the size of the company. This refers to whether it is a large, medium or small company. There are a number of factors that determine which data providers must provide, and these also influence the risks. These data requirements should be clear for every provider. These requirements can currently be found in various places within the municipality, which is confusing and takes a lot of time, and as discussed, supervisors have too little time.

The ultimate answer is to use these risks to create a dashboard, but due to limited time and the development of policy, it is recommended to use the dashboard in the first instance as a reference so that providers can be quickly assessed on the basis of these risks by the supervisors. This also provides signals that can be interpreted, but this is not the only goal of the dashboard.

5.3 Strengths and limitations

First, a limitation was that the 11 risks were not verified with retrospective research on investigations that have taken place in Enschede over the past five years. What could have been interesting was how much time the average investigation took, and also the reasons why investigations were started. This information could have been verified to see whether it was one of the 11 risks. This was tried, but the information was so limited that no results or comparisons could be obtained from it. However, a start has been made by researching the basis in the literature, identifying how big the problem is and determining where the solution fits within the problems that municipalities are now experiencing.

As for the interviews, interviews become more valid if the same structure and the questions are used for different interviews within a study. By using a structured interview with pre-formulated questions, the influence of other elements on the results was reduced. However, a limitation may have been that only supervisors or Enschede were interviewed. It could be the case that other municipalities required another set of indicators than those found in this study. This study only interviewed the supervisors of Enschede. When interpreting the results of this study, care should be taken in generalizing the results to another context. In other municipalities, they may not have an e-mail address or some other form of disaster reporting, which may cause more or less risk to come to light. However, in the literature study, documents with risks from other municipalities were used.

Third, the generalizability of the results was limited by the method of interviewing only five people from the municipality of Enschede due to a limited set of supervisors. Interviewing supervisors from other municipalities within Samen14 and elsewhere in the Netherlands about the risks they experience would be beneficial additional research. By interviewing only five supervisors, this study got a picture that was less broad picture than that which would have been derived by interviewing 50 people. However, given that there was used a lot of literature from other municipalities, it was sufficient that five supervisors were interviewed.

By only looking at legality and not specifically at fraud, no distinction can be made in interpreting risk signals. However, the municipality may want to give a higher priority to investigating wrongdoing if it turns out that there is intent. It is therefore a limitation that the risks and dashboard can't filter this out.

In the literature review, certain studies, indicators, risks and limit value measures could have been missed. But through the use of theoretical saturation this was kept to a minimum. Nevertheless, it may be the case that a risk that was mentioned in the interviews may also have been mentioned in the literature and has therefore not been included.

In comparable studies, a source from 2012 mentioned some risks that still apply today. Much of the literature focuses on mapping things out and describing possible risks. Other works present step-by-step plans on how to tackle the problem globally. This research specifically contributed in that it showed what specific information is needed and how one can subsequently monitor risks. Other researchers have drawn up spearheads, but the real implementation is missing. This research takes a step further in that. Clear guidelines are provided on what to focus on and why, but also on how the municipality can achieve this. These results build on existing evidence of risks that are seen in municipalities throughout the Netherlands. This research contributed to existing literature on risks in the context of the Wmo and youth care. Previous studies did not provide a comparison of the differences and similarities between the literature and practice.

5.4 Advice and future research recommendations

Further research should determine whether the results of this study can be generalized to other municipalities. It should try to identify additional risks that could have been overlooked in the situation of Enschede and that have not been mentioned in the literature. Repeating this research method in another context could contribute to creating a more generalizable set of risks instead of looking solely at one specific context, namely, Enschede. The various risks found in the limited literature that has focused specifically on the severity of both quality and lawfulness risks have not yet been weighted. In the literature, this can be done by looking at how often risks are mentioned to determine weighting. For the risks mentioned only in the interviews, monitoring how often these risks occur is recommended, as well as looking at the data retrospectively. Currently not included in the dashboard are the risks mentioned only in the interviews, but it would also be interesting to collect data for these risks precisely because they are not mentioned in the literature.

It is recommended to do more research on how often the various risks actually occur and how large is the problem is now in percentage terms. There are mainly studies on how much money fraudsters have misappropriated. Further research should be conducted into how to get more out of legislation from fraud in order to better target providers. It is also interesting to express the magnitude of the problem not only in monetary terms but also in the number of clients duped or inadequate quality it causes. Second, during the study, it appeared that there was little to be found in the literature about cut-off points and value limits that would determine when an indicator has a value that can be classified as high- or low risk. More extensive research will be required to assess the cut-off points of various risks. The solution to this is in this study the use of ranking, but ideally, all risks should have a value or a guideline by which to steer.

Although (inadequate) quality and (un) lawfulness often show correlation, this connection is by no means always established in supervisory practice [19]. Therefore, the advice is to look at a model where quality and legality are not viewed separately, but at the same time. This can be done, for example, by dividing investigations into the five parts that are now used to divide research: organization, finances, personnel, clients, and safety, instead of quality and legality. The advantage is that quality and lawfulness are not viewed separately – the risks are considered in their entirety. This way, one avoids possible duplications of work and has an idea more quickly of the risks involved and associated with one provider. In practice, in the municipality of Enschede, considerable data are available on the quality and legality of healthcare providers. These data are stored in many different places. The difference between small and large companies and different laws for Wlz and Wmo and so on means that one does not know the requirements for providers. A coherent dashboard including these requirements as well as their scores on the presented indicators can show at one glance which laws and regulations a provider

must comply with. Moreover, if a provider ranks high with multiple risks, a specific ‘high risk’ section of this dashboard should clearly point this out to civil servants. It should also be possible to look at rankings comparing care providers with similar client bases instead of comparing each provider.

For a number of indicators, it must be further determined how exactly this data should be entered in the dashboard. For example, this is the case for the indicators of the number of hours of care that must be provided or the number of staff that must be employed. The choice must be made regarding whether this is divided into hours, minutes or half-days. It seems obvious that everything would be converted to minutes, but for half-days, it must be taken into account that there may be several clients at the same time and that more staff is needed. This also applies to supervisors having to wait two weeks for the requested documented person to be able to view the personnel employed. This involves an interaction. The provider needs clients to hire staff, but also staff to be able to hire clients. This makes it difficult, but with already-contracted providers who have clients, this should not be a problem. These will need to be linked only for providers who have no staff and no clients.

6. References

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7. Appendixes

7.1 Appendix 1: Interview scheme

Titel onderzoek: Gemeente Enschede: risico gestuurd toezicht

Onderzoeker: Universiteit Twente

In te vullen door de deelnemer: Ik verklaar op een voor mij duidelijke wijze te zijn ingelicht over de aard, methode en doel van het onderzoek. Ik weet dat de gegevens en resultaten van het onderzoek anoniem en vertrouwelijk behandeld zullen worden. Ik begrijp dat geluidsmateriaal of bewerking daarvan uitsluitend voor analyse en/of wetenschappelijke presentaties zal worden gebruikt. Ik stem geheel vrijwillig in met deelname aan dit onderzoek. Ik behoud me daarbij het recht voor om op elk moment zonder opgaaf van redenen mijn deelname aan dit onderzoek te beëindigen.

Naam deelnemer: ……..

Datum: ……

Handtekening deelnemer: …..…….

Contactgegevens onderzoeker: m.s.willems@student.utwente.nl / madelon.willems@enschede.nl

Interviewschema

Inleiding: Bedankt dat je wilt meewerken aan dit onderzoek. Om jullie te kunnen helpen bij het beantwoorden van de vraag “Hoe kunnen we binnen de Gemeente Enschede risico gestuurd toezicht realiseren”, heb ik een aantal vragen over risico’s en indicatoren die daar aan gekoppeld zijn. Voorafgaand aan dit interview wil ik je vragen of je een toestemmingsformulier wilt ondertekenen. Door dit formulier te ondertekenen, geeft je toestemming om alles wat binnen dit interview ter sprake komt te gebruiken voor mijn onderzoek. Daarnaast geeft jij mij ook toestemming om dit gesprek op te nemen. De opname van dit gesprek zal uitsluitend gebruikt worden voor mijn onderzoek en zal niet verspreid worden. “Na het tekenen van het toestemmingsverklaringformulier. “Als voor jou alles duidelijk is kunnen we beginnen met het interview. Indien er nog iets onduidelijk is of als er nog vragen zijn, kunt je dat aangeven.

Doel van het onderzoek: Inzicht krijgen in risico’s die belangrijk zijn voor risico gestuurd toezicht en inzicht krijgen in de indicators die deze risico’s goed aangeven. Vooral inzicht krijgen in wat in de ‘werkelijkheid’ / op de werkvloer het meeste gezien wordt.

Doel van het interview: Inzicht krijgen in de wensen van verschillende afdelingen / collega’s voor risico gestuurd toezicht. En waarom deze collega’s deze wensen hebben.

Thema 1; Algemeen

We zullen beginnen met een aantal vragen over de inhoud van uw werkzaamheden.
Vraag 1: Zou jij jouw werkzaamheden kort kunnen omschrijven?
Vraag 2 : Hoelang werk je al in deze functie
Vraag 3: Met welke andere teams heb je allemaal te maken / werk je nauw mee samen.
Vraag 4 : Zijn er teams waarmee je nauwer mee samen zou willen werken? Zo ja waarom wel of niet?

Thema 2 : Wat valt op

Vraag 3: Welke soort meldingen lijden het meeste tot onderzoeken?
Vraag 4: Welke risico’s hebben het meeste impact of de geleverde zorg volgens jou?
Vraag 5: Kijk je naar dezelfde risico’s als in het barrièremodel?
Vraag 6: Hoe helpt het barrièremodel in jouw werkzaamheden?
Vraag 7: Als ik je deze risicolijst laat zien welke 5 vind jij dan uit eigen ervaring het belangrijkste voor de geleverde zorg?

Thema 3: Data

Vraag 8: Is de data die je nodig hebt voor toezicht makkelijk te vinden?
Vraag 9 : Zo nee waar lopen jullie nu tegen aan?

Thema 4: Risico gestuurd toezicht wat hoop je er mee te bereiken?

Vraag 10: Zou u wat kunnen vertellen over de ontwikkelingen op risico gestuurd toezicht die op dit moment al behaald zijn?
Vraag 11: Wat wil je dat risico gestuurd toezicht gaat toevoegen in jouw functie?
Vraag 12: Zou een dashboard jou kunnen helpen in risico gestuurd toezicht?
Vraag 13: Welke risico’s zou je willen zien in een dashboard?

Afsluiting
Wil je nog dingen kwijt die nog niet ter sprake zijn gekomen in dit gesprek? Dit waren alle vragen voor mijn onderzoek. Ik wil je graag bedanken voor je medewerking.