

Comprehensive Framework for Care Vision

Implementation: Optimizing Organizational Scale and Collaborative Strategy

Published: April 20, 2026 | Index ID: #129

In the contemporary healthcare landscape, the conceptualization of a **Zorgvisie**(Care Vision) transcends mere mission statements; it serves as the foundational architectural blueprint for clinical excellence, organizational efficiency, and patient-centered outcomes. As healthcare systems evolve toward more integrated and specialized models, the interplay between strategic vision, organizational scale, and collaborative frameworks becomes paramount. This technical analysis explores the multifaceted dimensions of developing a robust care vision, with a specific focus on the optimal sizing of care units, the 'Triangle' model of engagement, and the integration of diagnostic-treatment frameworks within multidisciplinary networks.

1. Theoretical Foundations of a Strategic Care Vision

A **Zorgvisie** is not a static document but a dynamic strategic framework that aligns an organization's mission with its operational execution. It acts as a bridge between high-level institutional goals and the day-to-day interactions between care providers and clients. According to technical documentation regarding the **Stichting Exploitatie Hilversum (STEH)** and the **STEM** methodology, an effective care vision must address six core spearheads: clinical quality, patient autonomy, staff competency, resource allocation, collaborative synergy, and educational equity.

1.1. The Cyclic Communication Model

To realize a care vision, organizations must adopt a cyclic communication strategy. This involves a continuous feedback loop where the mission informs the strategy, the strategy dictates the operational plan, and the results of the operational execution are fed back into the visioning process. This ensures that the **zorgvisie** remains responsive to the changing needs of the patient population and the healthcare market. The integration of various documents—ranging from function profiles for support specialists to organizational charts—creates a cohesive ecosystem that prevents strategic drift.

2. The Mathematics of Scale: Optimizing Care Unit Size

One of the most critical technical challenges in healthcare management is determining the **optimal size of care units**(Grootte van zorgeenheden). If a unit is too large, patient individualization is lost, and staff burnout increases due to bureaucratic overhead. Conversely, if a unit is too small, it may lack the financial viability and clinical diversity necessary for comprehensive care.

2.1. Span of Control and Span of Support

In analyzing the optimal size, we must consider the **Span of Control** (the number of subordinates a supervisor can effectively manage) and the **Span of Support**(the number of patients a care team can effectively treat). Technical research suggests that for high-intensity specialized care, such as that provided by STEH, smaller, decentralized units often outperform large, centralized wards in terms of patient satisfaction and recovery speed.

Unit Scale	Typical Patient Count	Clinical Advantages	Operational Challenges
Micro-Unit	5 - 8	High personalization, deep relationship building, agile decision-making.	Higher cost per patient, limited specialized equipment access.
Meso-Unit	12 - 20	Balanced resource allocation, peer support for staff, moderate scalability.	Requires robust middle management, potential for communication gaps.
Macro-Unit	40+	Economies of scale, 24/7 specialized onsite coverage.	Risk of institutionalization, high staff turnover, complex hierarchy.

2.2. Mathematical Modeling for Unit Efficiency

The efficiency (E) of a care unit can be modeled as a function of Patient Complexity (C), Staff Competency (S), and Resource Availability (R), divided by the Administrative Load (A): $E = (C * S * R) / A$. As the unit size increases, the Administrative Load (A) tends to grow exponentially rather than linearly, often leading to a point of diminishing returns where the quality of care drops despite increased resources.

3. The 'Triangle' Model: Integrating Parents, Clients, and Professionals

A recurring theme in modern care visions, particularly within the **STEM** and **Kempler Institute** frameworks, is the concept of '**Working in the Triangle**' (Werken in de driehoek). This model posits that the most effective care occurs when there is a balanced, collaborative relationship between the client, the professional caregiver, and the client's social network (usually parents or legal guardians).

3.1. Dynamics of the Triangle

- The Client-Professional Axis: Focused on clinical intervention, goal setting, and therapeutic progress.
- The Client-Parent Axis: Focused on emotional support, long-term history, and cultural identity.
- The Professional-Parent Axis: Focused on education, transparency, and the transfer of care techniques to the home environment.

When one side of this triangle is weak—for example, if the professional ignores the parents' input—the stability of the care plan is compromised. The care vision must explicitly define the roles and responsibilities within this triangle to ensure clinical alignment.

4. Implementing the Dings and Van Dijk Framework

For specialized diagnostic and treatment environments, the **Dings and Van Dijk** schema provides a technical workflow for integrating play-diagnostics with systemic treatment. This approach is particularly effective in pediatric and neurodevelopmental care settings where traditional verbal communication may be limited.

4.1. Technical Workflow for Play Diagnostics

1. Initial Observation: Unstructured play to identify baseline behavioral patterns.
2. Structured Intervention: Introduction of specific stimuli to test cognitive and emotional responses.
3. Network Synthesis: Bringing the findings from the diagnostic phase into the 'Triangle' to develop a unified treatment plan.
4. Continuous Evaluation: Using the cyclic communication model to adjust the treatment based on real-time

feedback from the netwerk (network).

5. Collaborative Models Between Healthcare Organizations

The 2020 revision of care visions, as seen in the partnership between **Lister** and **STEH**, highlights the necessity of inter-organizational collaboration (Samenwerken tussen zorgorganisaties). In a complex healthcare economy, no single organization can provide the full spectrum of care required by high-needs individuals.

5.1. Integration Levels

Collaboration can be categorized into three distinct technical levels:

- Level 1: Information Exchange: Organizations share best practices and clinical data while maintaining separate operations.
- Level 2: Resource Sharing: Joint use of facilities, specialized staff, or diagnostic equipment (e.g., the STEH functional profile for shared support specialists).
- Level 3: Full Integration: A unified care vision where multiple organizations operate as a single virtual entity for the patient's benefit.

5.2. Case Study: STEH and Lister Revision (May 2020)

The May 2020 revision of the STEH care vision demonstrated how a legacy organization can integrate the modern recovery-oriented vision of a partner like Lister. This involved re-evaluating the **functieprofiel begeleider** (support specialist profile) to emphasize rehabilitation over maintenance. The result was a shift in organizational culture from "doing for" the patient to "doing with" the patient, a hallmark of modern **zorgvisie** evolution.

6. Operationalizing the Vision: The Plan van Aanplak

The **Plan van Aanplak**(Implementation Plan) serves as the technical manual for converting the care vision into reality. It outlines the specific steps, timelines, and Key Performance Indicators (KPIs) required for success.

6.1. Key Components of a Function Profile

For a care vision to be effective, it must be reflected in the hiring and training criteria for staff. A technical **functieprofiel begeleider** (support specialist profile) should include:

- Competency in Systemic Thinking: Ability to navigate the 'Triangle' model effectively.
- Diagnostic Literacy: Understanding of schemas like Dings and Van Dijk to implement treatment plans accurately.
- Adaptive Communication: The skill to translate clinical jargon into accessible information for parents and clients.
- Operational Agility: The ability to work within the specific constraints of the unit size (e.g., being a generalist in a micro-unit).

7. Educational Equality and Care Integration

A sophisticated care vision also addresses **gelijke onderwijskansen**(equal educational opportunities). For organizations serving children and adolescents, the care vision must integrate with the educational vision. This ensures that therapeutic interventions do not impede academic progress but rather support it. The goal is to provide a "backpack" (boekentas) tailored to the child's own pace and measurements, as mentioned in the JSON data. This requires a seamless interface between teachers, care providers, and diagnostic specialists.

7.2. Metrics for Success in Educational-Care Integration

Metric Category	Technical Indicator	Target Outcome
Developmental Velocity	Rate of milestone achievement vs. peer baseline.	Closing the opportunity gap for high-needs students.
Inclusion Rate	Percentage of time spent in mainstream educational settings.	Maximizing social integration while providing specialized support.
Support Efficiency	Hours of specialized care required to achieve educational goals.	Optimization of the 'Triangle' in the school environment.

8. Troubleshooting and Mitigating Operational Failure Modes

Even the most robust care vision can fail during implementation. Identifying potential failure modes early is essential for technical writers and strategists.

8.1. Common Failure Modes

- **Vision-Practice Decoupling:** When the zorgvisie exists only on paper and is not reflected in daily clinical routines. Solution: Regular auditing and staff training based on the Plan van Aanpak.
- **Siloed Communication:** When the different points of the 'Triangle' (parents, professionals, clients) do not share information. Solution: Implementation of shared digital health records and mandatory joint review meetings.
- **Scaling Paradox:** Expanding the size of a zorgseenheid to save costs while inadvertently destroying the quality of care. Solution: Use the mathematical models mentioned in Section 2 to maintain the 'Goldilocks' unit size.

8.2. Checklist for a Resilient Care Vision

1. Is the vision aligned with the latest clinical evidence (e.g., STEM, Dings & Van Dijk)?
2. Does the organizational structure support the vision (e.g., optimal unit sizes)?
3. Are the function profiles of staff specifically mapped to the vision's goals?
4. Is there a clear mechanism for collaboration with external partners?
5. Are there tangible metrics to measure educational and clinical outcomes?

9. Synthesis: The Future of Integrated Care Environments

The development and maintenance of a **zorgvisie** represent a continuous journey toward organizational maturity. By balancing the mathematical realities of unit scale with the human complexities of the 'Triangle' model, healthcare organizations can create environments that are both efficient and deeply compassionate. The technical integration of diagnostic frameworks, such as those by Dings and Van Dijk, with operational strategies like those implemented by STEH and Lister, provides a clear roadmap for the future.

Ultimately, the success of a care vision is measured by its ability to empower the client. Whether it is through providing equal educational opportunities or through the precise calibration of care unit sizes, every technical decision must serve the overarching goal of improving the quality of life for the individuals within the system. As we move toward more data-driven and collaborative healthcare models, the principles of clear communication, strategic alignment, and systemic integration will remain the cornerstones of effective care delivery. The appendices and schemas discussed throughout this analysis serve as the vital infrastructure supporting the delicate balance between clinical science and human care.

