DIAMEDIPORT

increasing elderly agency
by improving triage at home

8. APPENDICES

A8.1 MEETING WITH FLUENT

On January 16th 2019, a meeting was held with Gerard van Glabbeek (Diamediport), Agnes R. van 't Hof (Máxima Medical center), Colette de Vries (Precies!) and Geert de Kousemaeker (Fluent) and Matthijs Rebel (graduate student). This meeting's audio was recorded with permission of everyone present. This written summary is a transcription from relevant parts of the meeting.

The systems of Fluent are monitoring a thousand patients that are using eHealth and 2000 patients that are not using eHealth, to find out if there is a difference in the pattern of their disease, whether a reduction in hospital intake is observed. These patients are suffering from chronic heartfailure, COPD and diabetes. The goal is to reduce hospital intake.
For COPD, a reverse effect is observed. If the medical specialist at the hospital receives the measurement, an increase of hospital intake is found. If a call-center or a 'first-liner' (for instance a general practitioner) is included in the chain, a decrease in hospital intake is found. Geert de Kousemaeker concludes that adding a stimulus in the second line, increases hospital intake, but adding that same stimulus to a General Practitioner, decreases it.

Fluent can see differences and relations between regions. What do we financially contribute to the population 65+. There is one gap in their data: the general practitioners and the out-of-hours general practitioners.

Geert describes how Fluent observed another pattern at large cities, which they had not expected - here is where they observe the most admission stops. There is a capacity surplus, which is why hospitals aim to admit lucrative patients. In larger cities, social cohesion is low, also, if people need to move to an adapted house, they lose their informal caregivers, which in turn increases hospital take-in and therefore admission stops. They used the diagnosis at the emergency room and the followed treatment to categorize patients in these four groups:

1. Doctor has concluded there was no somatic problem, and no treatment was started. (social domain)
2. Light complaint, no clinical profile but there was a clinical intake, but no treatment was started. For instance, pain in the chest. Patient profiles include panic attacks, pneumonia (during the night, lying flat will cause fluid to move to the lungs).
3. Chronic diseased - exacerbation. This could have been prevented by earlier intervention, for instance a medicine.
4. Justified medical complaints. [39%]

Please note that all these patients present themselves with medical complaints.

Researcher memo: interview with the director of Erasmus MC general practice led me to believe there should be a third category between 'no medical necessity' and 'medical necessity': understandable necessity, or in Dutch, the decision was invoelbaar.
During the night, hospitals and general practitioner's out-of-hours offices tend to employ young medical personnel, and it can be socially undesirable to call in an experienced medical specialist. "The quantitative and qualitative peak of expertise in the hospital, and the peak of admission of elderly are mismatched"

It is easier for the Emergency Room to admit to the hospital than to arrange transport and [...]

Families of elderly people resist hospital release because they feel like the situation at home is no longer sustainable. The emergency room is being used to gain an urgent placement in assisted living housing, because hospitalized patients are prioritized.

A8.2 NOTES ON 'TABOES OP TAFEL'

Minister: Protocollen worden minder, maar ze zijn nog ingeregeld in de ICT.

Hans Buijing:
Er word veel gepland en gepraat, maar hij wil aan de slag.
Moet anders georganiseerd.
"Keten begint thuis" Zorgen dat de zorg de patiënt volgt.
Maatwerk is niet duurder omdat het zorg kan voorkomen.

We moeten echt de zorg radicaal veranderen. Het is erg belangrijk dat de mensen in de zorg, meer tijd aan de zorg kunnen besteden. Zorg gaat ook over welzijn. Hebt u comfort, hebt u geluk? Laatste levensfase?

Het systeem is onnodig ingewikkeld georganiseerd. Daar verdienen mensen heel veel geld zonder ooit een iemand te zien (verzorgen).

Er gaat meer fout sinds er taken bij de gemeente zijn gelegd. Gelijk opgegaan met een bezuiniging.

Minister:
1. Veel meer zorg rond de oudere organiseren
2. Zorg word niet door wetten gegeven, maar door mensen
3. Mantelzorgers meer laten doen
4. Nieuwe vormen van wonen en zorg
a. Soms gaat het niet

Elly (bejaarde):
1.Ondervoeding bij ouderen
2. Verpleeghuiszorg zouden een soort woningen moeten zijn.
3. Plek waar mensen die weinig hulp hebben, die geen kinderen hebben, die het niet meer kunnen, negentigers of jonger, die willen het niet meer. Ik wil nu gewoon verzorgd worden.

Toewerken naar nieuwe vormen van zorg. Terug naar vroeger is nooit een optie. Dat is "te one size fits all".

Mantelzorg is langdurige verpleging, verzorging of… van een naaste.
SCP: iedereen die voor een ander zorgt.
Groep mensen die langdurig en intensief, soms vele maanden, daarvan zijn er ruim 800.000 van.
"Het is mijn dochter, het is mijn vader"

In 2039 zijn er nog maar 6 potentiële mantelzorgers per oudere. (Nu 15)

Mantelzorgers aan het woord (31.00-
"wanneer is de grens bereikt?" 33:05
"ik heb tijd en ruimte [nodig] om me op te laden en ertegenaan te gaan, elk zorgmoment denk ik na of ik het kan blijven waarmaken"
"is er druk uit de omgeving?"
Overheid, ja. Beroep op naasten.

Minister: Er is geen plicht tot mantelzorg. Goed dat er wordt gevraagd naar de beschikbaarheid van een mantelzorger. Het moet wel passen. Als je een tijd van elkaar weg woont, dan is het veel moeilijker.

De zwaarte voor mantelzorgers is te hoog

"mensen zijn aan elkaar gegeven, ze zorgen graag voor elkaar" stukje visie vd CDA minister

Mantelzorgers kunnen er niets meer bij doen. Dat laat onderzoek zien. 43.00-44.00

Minister: "We hebben het allemaal ongelofelijk administratief dichtgeregeld"
"we moeten maat houden van wat we willen weten"
"regels zijn een vorm van gestold wantrouwen, we moeten toe naar gezond vertrouwen"
"je kan niet risico avers zijn"
"graag willen bewegen kan door domotica, dan neem je een risico als zorginstelling"

Mevrouw:
"mensen werken met mensen, daar gebeuren fouten" "het hoort bij het leven om meer dan je knie te schaven" "we verdragen het niet meer. We weigeren om er over te praten"
"gesprekken over risico's. Lopen --> wie neemt het risico"
"mantelzorgers moeten zorginstellingen dingen niet verwijten, alleen als er risico's bijkomen in zorginstellingen"

"afhankelijk zijn lijkt mij een verschrikking"
"geboren worden was niet mijn beslissing, waarom dan sterven ook niet?"

80+er kost 25200€ per jaar. (net hoorde ik een 100.000 per jaar per verzorgde in een verzorgingstehuis)

[[>> artsen
"dokter wil therapie, genezen. Veel artsen moeten kiezen namens de patiënt. Als zij de vraag niet stellen, hoor je het niet.
80.000€ per kwaliteitsjaar.
Als we het aantal 80+ers zien stijgen, dan kunnen we het niet betalen. De helft van alle overheidsuitgaven.
Geriater:De 170 miljard hoef je niet te bereiken als je passende zorg kunt leveren. Een hartklepvervanging is in 15% (of 50%) van de gevallen geen antwoord op de vraag.

A8.3 INTERVIEW DISTRICT NURSE

The recorder function of the smartphone that was used, failed after eight minutes. Also, the computer that was used for notes (which was the second option for recording) crashed during the interview.

Checklist:
1. Opname draait telefoon + pc.
2. Goede ruimte (stil, afgesloten)
3. Toestemming verbaal gegeven

Per subvraag:
Eerst algemeen beginnen, geef pas een voorbeeld als ze er zelf niet uitkomt
1. Kun je me meer vertellen over?
2. Op wat voor manier is dat zo gekomen?
3. Kun je daar misschien een voorbeeld bij geven?

Hallo Renske, zoals we gisteren hebben besproken mag ik vandaag meelopen. Ik heb er erg veel zin in en denk dat het heel nuttig gaat zijn voor mijn onderzoek en ontwerpproject! Graag stel ik je vooraf wat vragen voor mijn eigen voorbereiding

Onderzoeksvraag:
Hoe word er op de werkvloer, onder verpleegkundigen, gedacht over ouderen die worden opgenomen in het ziekenhuis?

Questions are omitted from appendix.

Hypothesis:
Verpleegkundigen zoals R zijn gefrustreerd met het systeem. Voelen zich nauwelijks gesteund.

Results:
Blood pressure gauges and glucose measurements are not available at all homes, but this is the first thing a general practitioner asks for.
"Sommige mensen hebben wel een bloeddrukmeter, maar dus niet allemaal. We hebben er hier wel eentje tot onze beschikking, maar die moet je dan wel ophalen, en dan moet je naar de cliënt toe. Soms dan ga je naar de cliënt toe en dan zie je dit gaat niet goed, en dan vraag je een collega. Die springt dan in, haalt een bloeddrukmeter, maar die heb je niet altijd standaard bij je nee. Dat is wel iets waar je aan moet wennen als je in de thuiszorg komt. Tenminste, voor mij persoonlijk."
[…]
"Je wil waardes kunnen doorgeven aan een huisarts. Dat wil je weten, want je belt een huisarts vervolgens op en die vraagt wat is de bloeddruk. Ja, die heb ik niet. Het eerste wat een huisarts komt doen is de bloeddruk opmeten.
MR Maar je bent wel geschikt om dat te doen, toch?
"Ja. Maar dat is het principe van een thuiszorg. Dat je niet standaard vraagt aan al die cliënten om in dat in huis te halen of dat mee te nemen."
Mr Vanuit het systeem, het is veel goedkoper als jullie dat in je koffer doen, want als die huisarts moet komen om dat te doen, weet je hoe duur dat is?
"Het gevaar daarvan is, dat je zelf diagnoses gaat stellen, wat je niet mag. Je mag alleen verpleegkundige diagnoses stellen en geen medische."
MR Ik hoop dan, dat een arts in staat gaat zijn om op afstand diagnose te stellen, geholpen door een verpleegkundige die daar speciaal voor opgeleid is om de handelingen uit te voeren. Want inderdaad, een arts moet de diagnose stellen. Iemand anders kan de metingen uitvoeren. Mijn ideaalbeeld is dat de specialist ouderengeneeskunde in de auto stapt. Dat degene met de meeste ervaring het echte werk doet. Maar ja, daar heb je er vijf van, hier
Dat zijn er niet veel nee.
MR Dat is het probleem. Jullie hebben het al zwaar, qua werkdruk, maar zij ook. Ik wil jullie samen toerusten zodat jij eigenlijk wel handelingen kan uitvoeren zodat de arts kan bepalen wat er aan de hand is.
Ja.
MR Maar goed dat is een oplossingsrichting die centraal is in de ontwikkeling van diamediport. Je gaat een soort differentiaaldiagnose doen – kan je zien of iemand zijn heup heeft gebroken?
Dat kun je zien, niet altijd, maar je KAN het zien.
MR En als iemand vage klachten heeft, wat doe je dan? Zegt ie "oeh ik voel me niet goed"
Dan ga je het uitvragen, vanuit allerlei vlakken om meer informatie te krijgen.
MR Wat voor vragen stel je dan?
Dat kan zijn over benauwdheid, over duizeligheidsklachten, wazig zien. Je kijkt ook een beetje naar wat al bekend is bij ons. Stel iemand is bekend met suiker, dan ga je eerst de suiker meten.
[…]
Mensen waarvan we weten dat ze suikerziekte hebben, daar ligt de apparatuur klaar, maar alle andere mensen die hebben gewoon een beetje pech
Ja.
Want ja, hoe duur is het wel niet om overal een bloeddrukmeter neer te leggen, en ik snap dat het niet helemaal past bij ons huidige idee van een verpleegkundige. Maar ik denk, men, de problemen, het water staat aan de lippen dus beter rusten we jullie goed toe, zodat jullie kunnen doen wat je moet doen. Maar, sorry ik moet niet teveel praten ik moet gewoon vragen.
Eehhh
Ik vind het ook wel leuk om te horen…
Ja, ehm. Je komt daar eigenlijk om, waarom?
Je komt daar om te kijken wat er aan de hand is. Wij mogen verpleegkundige diagnoses stellen, geen medische. Maar je voert een soort controles uit, [5:21,16 Renske 2]

A8.4 EXPERIENCES AS INFORMAL CAREGIVER

21-11-2019

Yesterday, I went to visit the extramural facility in the Hague. It was very helpful for my process. I talked with MvB – daughter of a 99 year old widower. Everything became so much more apparent when I was there and saw how frustrated she is with everything. This is a woman who has been trained as a doctor, she is very intelligent. She lives in Ede and is married, but her and her partner do not hold a paid job currently. Their lives are filled with caring for others and their community. However, she is no longer able to come to The Hague, where her father lives, because she is sick and should focus on her recovery. Being there, we had a conversation about everything that is on her plate. She calls herself the informal caregiver and feels like her brother and sister are not caring enough for their father.
So here I see happening what I suspected. This man of 99 years, is at risk of falling and it is obvious at some point an emergency moment will occur. It is the same thing I saw when doing the ethnography with the mobile night team of Zuidzorg. The elderly married couple where the man was caring for his wife, but I realize there is beauty and opportunity to be found in such a moment. In a way, one might even wish for such a moment, because it could bring change for a suffering elderly, but this would be uncommon. An idealized emergency moment is balanced: there is urgency that matches the urgent needs of the elderly, but without making rushed choices that come to hurt them in the end. The integral needs of the elderly should be supported by the medical system and the Dutch society, and this should be done by tuning or turning the situation around.
In 2020, a medical specialist can set the other players of the medical system in motion, and if he or she communicates it properly, they can also influence the Dutch system (if there is a medical necessity that causes a practical dependence or a psycho-social problem, it is easier to allocate funds from Wmo). In the moment of an emergency, people are caring about helping the elderly in need at that moment. They seem to experience more freedom and have more time for the elderly.
This reverses the trend of reducing the educational level of the people who do the work – who touch and care for the elderly – the nurses. In a way, for the past decade, the hands at the beds of the elderly, have been losing their heads. To reverse this trend completely, it would be recommended to allocate funds to educate the nurses, but this is not something that can be changed within a couple of years. What could be changed is offering nurses in emergency moments, meaningful connections to medical authority.

My handwritten notes reflect that the previous GP in her values a house visit so much. “huisbezoek geeft zoveel informatie”, “via de telefoon beperkt”.

21-11-2019

Just called the Technische Dienst (maintenance service) of the facility in The Hague where the 99 year old man rents his apartment. They put me on hold twice – and I was wanting to use my headphones to continue working, but I did not for some reason. I had to explain who I am, use my voice to gain some trust, and introduce myself as the grandson of the man I am helping. The first telephonist recognized the name, but only after asking for the birthdate of my grandfather, which I do not know or have available currently. But because he is using the alarm service, he knew where to connect the call to. Then I was put on hold again, and I was wondering if it would take a long time. A lady picked up, and I explained the situation and that I wanted to get in touch with the Technische Dienst. She then told me the huismeester is not available / at work right now, so she wanted to know whether it was something that had to be done today. I told them that there is no big leakage, the tap of the shower is just dripping water. I told her that my grandfather does not know there is a problem that has to be solved, but to me the problem is apparent. I did this because I do not trust that technical guy to properly solve the problem without me being there, because in the experience of the informal caregiver of the elderly man, his daughter, there was someone who had came to the apartment and asked how is it going, and then the elderly man said everything is great, so he left. I of course did not tell her this. She asked to have my mobile phone number and I gave it to her. The huismeester is going to call me back tomorrow. To be continued.
I am left with a relieved feeling because the call took 7 minutes of my time, but one has to be very clear on what has to be done, to get what you need. Since I am available to come on Wednesday afternoons, I might be more flexible than people with a fulltime job. But if that maintenance guy does not work on that day, we have a problem and I am probably forced to be flexible.
They were friendly on the phone. After the call, I imagined my aunt calling. I fear that she, with her female voice, could be easier perceived as stressful and therefore it could be harder for her and the people on the other side of the line to find a solution that fits both the needs of the informal caregiver, the facility and the elderly. And we are both from a well-educated, Dutch and explicit family, imagine how it would work for people with lower social capability or -status. For people who are illiterate, having a very tough job, this might be a very taxing thing already.
Reflecting, it would have been better to ask the lady if she thinks it is possible to make an appointment for Wednesday afternoon next week. And get a call tomorrow. This way, I prevent that I get screwed.

26-11-2019

This morning I realized Jeroen did not call me back. He called me and told me he would go by, but I did not hear from him after that.

I just heard the elderly man has had a ‘kind of TIA’. The triage

moment of Saturday 23 November 2019. The eldest daughter of the elderly man was with him, and called her sister. She told her, that their dad was trying to eat his soup with a fork and had trouble walking. The youngest daughter, a previous GP, called this 'aphasie' and 'apraxie'. She, at-distance, 'diagnosed' him with a small TIA (Transient Ischemic Attack), but he is already on heavy anti-clotting medication. So they decided to leave it like it is. They had been previously to 'SMASH' – an out of hours GP office. She told me so I would be warned.

9-12-2019

Saturday, I was called by the son of the elderly man of 99, my dad around 11AM. He told me that my granddad was not doing well. Being both a grandson and a researcher, I was instantly motivated to go to The Hague and to see what was going on. He told me he was called even though he is not the first responder, and that the 'thuiszorg' was only available to meet during the morning. So I had to get in touch with them from the train, to ask them to be present, open the door, and talk about the situation. My father + aunt tasked me with taking care that he would get dinner brought to him. They were concerned Florence would not do this independently. The nurse contacted them because the elderly man was getting sicker. They told them that he did not know where he was, and that he was confused. In the meantime, I tried to get in touch with my father for details on what happened, and when I arrived my granddad was in bed.

It was quite difficult to gauge how he was doing. He seemed both happy and tired. Also, he kept saying 'ok, I wish you the best', which is a way for him to say goodbye to people. I repeatedly asked him how he was doing, why he was still in bed, and other questions to provoke him to tell me what is going on with him, so I could understand. He gave different and conflicting answers. He also was talking with a 'double tongue' like he was drunk. I tried to get him to drink coffee but he did not even lift his hand, whereas last Wednesday he was not like this at all.

When the nurses arrived, I started asking them what had happened and started to get a better picture:
1. He was seen by the GP downstairs, and after testing his urine that he did not have a bladder infection (which would explain the confusion), but the flue. I was puzzled that he concluded that he had the flue, because how would he have indicated symptoms? To my knowledge, it could also be a TIA or pneumonia… But I am not a doctor.

2. I agreed with them that they would:
a. Upgrade the regular care-moments. They would take care for him to eat and drink properly, because earlier when he had flue, he quit drinking and eating, and if he would do that now, he would probably start to degrade very quickly.
b. If he would not improve, they would make sure the GP would visit him Monday (the day of writing). I am wondering what the GP will do, and am not sure whether the GP and nurses are cooperating sufficiently to get a picture of what is going on with this 99 year old elder man.
c. If his health would decrease, they would inform his children and the GP.

3. What I realized afterwards:
a. They told me a lot of things quickly that mattered more than I realized at that moment. For instance, when they came to him on Saturday morning, he was laying in bed wrong, but he did not use the alarm. His complaints of pain could be muscle soreness because of his bad posture during sleep.
b. According to nurses, he was not able anymore to use his alarm pendant.
c. The diagnosis 'flue' of the GP acted like a frame through which the nurses looked at him, and therefore me too. I started to realize during the conversation that this diagnosis was not set by anything conclusive. It was just a suspicion, and especially because the elderly man was not able to properly communicate his complaints, it was uncertain at best that it was in fact, flue.
d. He seemed to be not wanting to cough or swallow. Not sure what the medical significance is, but to me it seemed like he was becoming very weak. He had trouble sitting up, and after feeding him a small piece of bread he chewed on it for over five minutes. When he swallowed, I was afraid he would choke.
e. Before leaving, I was not sure if I would see him again. I prayed for him and read from Revelations.

I called my father, and he picked up. I told him what I had agreed with them. Told him I would not whatsapp in the big family group but leave it up to him to call his sisters. Later that day, I was called by my aunt, who realized that he could get up in panic in the night, and could fall and not know how to use the alarm pendant. She was afraid he would be left alone, and would be found in the morning in a bad way.

This was the first time I experienced the journey of an elderly, where I knew more about him then just from a triage moment alone. I had interviewed him for this project and his daughter, but of course as his family I know his history, personally and medically. Standing in the shoes of an informal caregiver, I start to realize the extent of the importance of details and how nurses and doctors act and communicate.

Also, it must be quite difficult for these nurses to completely transfer everything they heard from the GP. I am not sure whether they were present, but they told me that the GP had excluded a bladder infection. But my aunt, a previous GP, asked me for the temperature of my grandfather. Nurses, anyone actually, can take someone's temperature, and a fever is an important indicator. As is blood pressure.
I summarized it like this on the evening of yesterday:
"ok. Ik begreep gister dat de huisarts vrijdag het vermoeden van griep vaststelde na zijn urine gecontroleerd te hebben (en bepaalde dat er geen blaasontsteking was). Eigenlijk weten we niet wat hij onder de leden heeft, behalve dat hij ziek en moe is, kan hij niet goed zelf aangeven wat hem mankeert. Maar ziek en zwak is hij zeker... Zolang de thuiszorg en huisarts goed samenwerken en elkaar en jullie goed informeren, gaat het volgens voor nu voldoende. Maar er ligt dan wel veel verantwoordelijkheid bij de huisarts + thuiszorg om goed te blijven controleren of hij niet verder achteruitgaat - en zolang er geen 'positieve' diagnose is, kunnen we geen betrouwbare verwachting hebben."
-whatsapp with aunts + dad + spouses.
I end my message to them with 'we cannot have a trustworthy expectation'. In other words, his situation could deteriorate very quickly. After this encounter, I realize this can not lead me

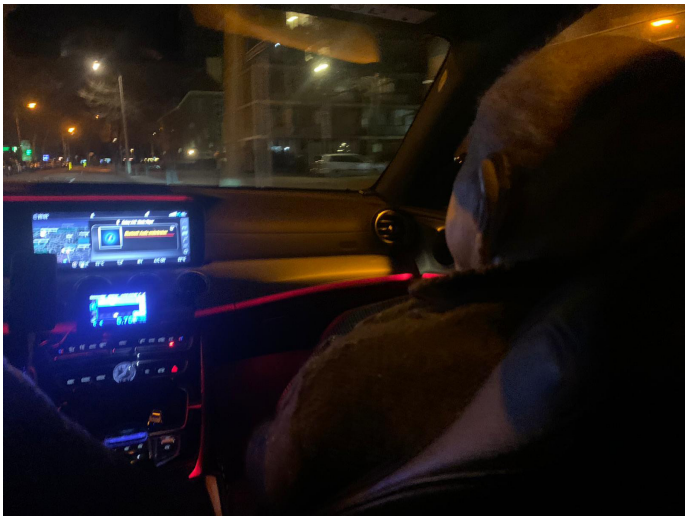
too much.
Reflections on research/design:
- Since I am recognizing things, is it safe to state I am reaching a state of saturation? I start to keep ending up at the same conclusions: working together for nurses and doctors is difficult when they encounter elderly triage moments. Overcoming these difficulties is possible with diagnosing elderly people where they are, and providing digital presence so a doctor can see the patient. You really have to see an elderly yourself to make a dependable decision on what their illness is.
-For nurses to ask informal caregivers to be present at a certain time results in sacrifices brought by these informal caregivers. Picking up a telephone could be a problem because of other obligations. Communicating amongst family can also be difficult. However, they are inclined to act on behalf of the elderly because it is needed.
-There is a digital patient environment where the children of the elderly man can log into. I am not sure what is exactly on it. As far as I know they did not even bother to check what information was uploaded and preferred to trust the communication through me and the nurses. In other words, the information flowed from elderly, to GP, to nurse, to me, to the informal caregivers. Every new set of eyes, including mine, have probably adapted the understanding of the situation.

23-2-2020

On this day, a special opportunity arose. The elderly man of 99 years old was in distress. The informal caregiver that is depicted on the picture on this page alerted the mobile night team (because it is a Sunday) and because the mobile night team respondee heard the elderly man say he had problems with his heart, the ambulance came. The design student rushed to his home, and arrived 5-10 minutes after the ambulance. When the ambulance personnel suggested to bring him to the hospital, it was unclear why they wanted to do so. After calling the informal caregiver, it was clear they wanted to check him up. The non-verbal interpretation of the elderly man (he was sitting very still and seemed distressed, but had conflicting verbal messages “I am very good” vs. “I am not feeling well”).

A total of fifteen audio recordings were made. Most notably from the body examination and differential diagnosis. The student mediated between the informal caregiver and the doctor, because the elderly man was not able to communicate what was wrong. It was very hard to clarify why he was brought to the hospital, but once he was there, a complete blood test was done and his longues were checked for fluid-built up.

Conclusion:
When the informal caregiver is not involved, for instance by not giving all the information, errors can be made. The ambulance nurses want to act in order to make sure nothing is going wrong. The concrete reason was to confirm heart failure by measuring Troponine and CRP.
The decision to bring the elderly man was made after the student called the informal caregiver, but when looking back, the decision was left to the elderly man and not the informal caregiver. It would have been better if the informal caregiver would have felt more freedom to make a choice.



A8.5 SCREENPLAYS

ARME ANNEKE - PART 1

HOSPITAL VISITS

Written by

Matthijs Rebel

FADE IN:

1 EXT. ANNEKE’S HOME - NIGHT 1

Moon peaks through clouds above quiet suburban neighbourhood. 2-story row home. Corner home lit upstairs.

2 INT. ANNEKE’S HOME - BEDROOM - NIGHT 2

ANNEKE (80s) frail, hair silver, one arm in cast, alarm pendant on another arm, wears bathrobe. Fidgety in bed. Feet crumble sheets. On nightstand: lamp, clock, pill box, glass of water. 12 PM clock face. Anneke props herself up against pillow. Cast arm knocks lamp onto floor.

ANNEKE
Stomme lamp!

Winces. Fumbles with pill box.

ANNEKE (CONT'D)
Nee!

Gulps 3 pills with cup of water.

ANNEKE (CONT'D)
Help!

Presses alarm pendant on uncast arm. Grimaces. Presses again. Eyes bulge out. Again. Screams.

3 EXT. ANNEKE’S HOME - NIGHT 3

Car with triage sign parks in front of Anneke’s home. NURSE (30s, female) wears pink suit, jumps out of car, rings Anneke’s doorbell.

4 INT. ANNEKE’S HOME - ENTRANCE - NIGHT 4

1 AM clock face at entrance's grandfather clock. Anneke's uncast arm grips onto a crutch. Cast arm fumbles with front door key. Drops crutch onto floor. Screams as door opens.

5 INT. ANNEKE’S HOME - BEDROOM - NIGHT 5

2 AM clock face on nightstand. Nurse stands by Anneke's bedside. Wraps blanket around Anneke.

ANNEKE
(to Nurse)
Doe toch iets!

Anneke wiggles her cast arm. Nurse dials # on phone.

NURSE
(to Hospital Admin)
Klopt, Anneke de Waal. U kunt haar gegegevens niet vinden? Niet in het systeem? Het verkeerde ziekenhuis?

6 EXT. ANNEKE'S HOME - ENTRANCE - NIGHT 6

PARAMEDIC (30s, male) wears red suit. Paramedic and Nurse rolls Anneke down her walkway in wheelchair.

NURSE
Procedure, mevrouwtje!

Paramedic stops wheelchair at yellow ambulance truck parked in front of Anneke's home. Knocks Anneke's head as she enters from back doors. Anneke's eyes bulge out.

ANNEKE
Idioot!

7 EXT. HOSPITAL - NIGHT 7

Moon above hospital. Ambulance breaks at hospital's entrance.

8 INT. HOSPITAL - RADIOLOGY ROOM - NIGHT 8

Inside sterile, white medical office, Anneke stands with crutch across RADIOLOGIST (40s, male) wearing white coat. Radiologist gestures black-white screen. X-ray of broken arm.

RADIOLOGIST
(to Anneke)
U moet opnieuw gegipst worden, maar uw behandelend arts is pas morgen om 8 uur aanwezig.

Anneke stomps her clutch 3x on the floor as if it's a staff.

ANNEKE
Wat een stelletje idioten!

Radiologist frowns. Casts his eyes away.

9 INT. ANNEKE'S HOME - BEDROOM - NIGHT 9

4 AM clock face on nightstand. Anneke lays in bed. Rubs her cast arm. Grimaces.

10 INT. HOSPITAL - SPECIALIST OFFICE - DAY 10

Inside sterile, white medical office, Anneke sits on hospital bed. At her bedside DOCTOR (50s, male), wearing blue coat and stethoscope, saws off her cast with laser cutter.

Anneke frowns as her cast is removed. 8 AM clock face on wall.

ANNEKE
Ziekenhuizen zijn gewoon dure doodskisten.

FADE OUT.

THE END.

ARME ANNEKE - PART 2

DIAMEDIPORT VISITS

Written by

Matthijs Rebel

FADE IN:

1 EXT. ANNEKE’S HOME - NIGHT **1**

Moon peaks through clouds above quiet suburban neighbourhood. 2-story row home. Corner home lit upstairs.

2 INT. ANNEKE’S HOME - BEDROOM - NIGHT **2**

ANNEKE (80s) frail, hair silver, one arm in cast, alarm pendant on other arm, wears bathrobe. Fidgety in bed. Feet crumble sheets. On nightstand: lamp, clock, pill box, glass of water. 12 PM clock face. Anneke props herself up against pillow. Cast arm knocks lamp onto floor.

ANNEKE
Stomme lamp!

Whimpers. Fumbles with pill box.

ANNEKE (CONT'D)
Nee!

Gulps 3 pills with cup of water.

ANNEKE (CONT'D)
Help!

Presses alarm pendant on uncast arm. Grimaces. Presses again. Eyes bulge out. Again. Screams.

3 EXT. ANNEKE’S HOME - NIGHT **3**

Car with triage sign parks in front of Anneke’s home. Diamediport NURSE (30s, female) wears pink coats, jumps out of car, rings Anneke’s doorbell.

4 INT. ANNEKE’S HOME - ENTRANCE- NIGHT **4**

1 AM clock face in entrance's grandfather clock. Anneke's cast arm fumbles with front door key. Uncast arm grips onto crutch. Drops crutch onto floor. Screams. Door opens.

5 INT. ANNEKE’S HOME - BEDROOM - NIGHT **5**

2 AM clock face on nightstand. Nurse sits at Anneke's bedside. Wraps blanket around Anneke.

ANNEKE
(to Nurse)
Doe toch iets!

Anneke wiggles her cast arm.

NURSE
Kunt u even uw arm omhooghouden, dan zal ik met deze scanner bekijken wat er precies mis is.

Nurse opens Mobiele Diagnose Box of Voorspoedzorg near Anneke's bed. Scans Anneke’s arm with ECHO device. Dials # on phone. Relays data on a monitor to on-screen DOCTOR via video call. DOCTOR (50s, male) wears white coat and stethoscope.

DOCTOR
(to Nurse via video call)
Helaas is de breuk niet goed genezen. Mevrouw de Waals arm moet opnieuw in het gips. Ik kom de oude verwijderen.

Anneke frowns. Her arm trembles.

ANNEKE
O nee!

DISSOLVE TO:

5 AM clock face on nightstand. Doctor saws off Anneke's cast with laser cutter. Her cast is removed. She smiles.

ANNEKE (CONT'D)
Diamediport is een Godsgeschenk.

FADE OUT.

THE END.

BLADDER BERT - PART 1

HOSPITAL VISITS

Written by

Matthijs Rebel

FADE IN:

1 EXT. BERT'S NURSING HOME - DAY 1

Raining cats and dogs. 8-story grey, concrete, featureless building.

2 INT. BERT'S NURSING HOME - LIVINGROOM - DAY 2

5 PM clock face on wall of communal living room. On coffee table: teapot, cups of tea. BERT (90) wears PJs, belly bulging. Slumps down into his rocking chair. CAREGIVER of Bert (40s) granddaughter and her SON (teens) sit on couch across Bert. His unsteady arm misses tea. Drinks flood table and splatter on Caregiver. She jumps, startled.

CAREGIVER
Gewoon een ongelukje, opa?

BERT
(frowning)
Het is de schuld van de overheid, dat je nu dichtbij moet komen, ehh. Voor corona, kon je tenminste vredig sterven. Ik deed alles toch alleen, ehh. Jij erft mijn gezondheid als ik dood ben, ehh.

SON
(snickering to Caregiver)
Opa zit hier al zo lang dat ie niet weet wat social distancing is. En is hij zijn geld niet verloren met gokken?

Sweat drips down Bert's yellow, bald head. Caregiver pats tissue on his moist forehead.

BERT
(to Caregiver)
3 meters! Veeg anders de kopjes eerst af.

Caregiver crosses her arms. Scolds.

3 INT. BERT'S NURSING HOME - NURSES' STATION - DAY 3

NURSE (30s, female) wears pink suit, shifts her gaze away from her desktop computer and glares at Caregiver.

CAREGIVER
Kent u Bert Bongers? Lastpak van het jaar!

NURSE
(smirking)
Niets nieuws onder de zon.

CAREGIVER
Hoe dan ook, dit lijkt serieus. Hij doet verward en lijkt koortsachtig. Meer vermoeid dan normal, en hij ijlt ook een beetje. Het zal toch geen corona zijn?

NURSE
Klinkt meer als dementie.

4 INT. BERT'S NURSING HOME - LIVINGROOM - DAY 4

5 PM clock face. Bert fidgets in his chair. Nurse deflates a blood pressure cuff around his arm.

NURSE
(to Caregiver)
Hmmm, 120 boven 180. Zijn bloeddruk is veel te hoog. Net als zijn temperatuur. Het bloedlab heeft geen tijd. Zijn huisarts is niet beschikbaar, het is te druk door corona helaas. Ik kan alleen een consult inplannen alszijn bloed - en urinetests er zijn. Misschien maandag?

NURSE (CONT'D)
(to Bert)
Kom, hup, tijd voor bed, meneer Bongers.

Bert rocks his shoulders. Nurses lifts him out of his chair. His legs are stiff. His steps are laboured. His catheter slips off its hook by his hip. He trips. Caregiver breaks his fall.

5 INT. BERT'S NURSING HOME - BEDROOM - NIGHT 5

Bert snores in his bed. Caregiver slips out of her lazy chair beside him. Groggy, knocks her foot at the corner of his nightstand. Clock face reads 2AM. Caregiver raises his arm. Pulls up an eyelid. Bert stiffens. His eyes pop open.

CAREGIVER
(mumbling)
Gelukkig is er één van ons wél alert.

DISSOLVE TO:

6 INT. HOSPITAL - PHARMACY - NIGHT 6

10AM clock face near pharmacy entrance. Caregiver wears face mask, shuffles in a queue. PHARMACIST (20s, male) wears purple shirt, lays down box of antibiotics on counter.

PHARMACIST
Geef meneer Bongers twee van deze pillen, twee maal per dag voor een week om zijn blaasinfectie te behandelen.

Caregiver shoves box of antibiotics in her purse.

CAREGIVER
(mumbling)
Dementie, corona, blaas-infectie...
Kom op mensen, maak een keuze!

FADE OUT.

THE END.

BERT BLADDER - PART 2

DIAMEDIPORT VISITS

Written by

Matthijs Rebel

FADE IN:

1 EXT. BERT'S NURSING HOME - DAY 1

Raining cats and dogs. 8-story grey, concrete, featureless building.

2 INT. BERT'S NURSING HOME - LIVINGROOM - DAY 2

5 PM clock face on wall of communal living room. On coffee table: teapot, cups of tea. BERT (90) wears PJs, belly bulging. Slumps down into his rocking chair. CAREGIVER of Bert (40s) granddaughter and her SON (teens) sit on couch across Bert. His unsteady arm misses tea. Drinks flood table and splatter on Caregiver. She jumps, startled.

CAREGIVER
Gewoon een ongelukje, opa?

BERT
(frowning)
Het is de schuld van de overheid, dat je nu dichtbij moet komen, ehh. Voor corona, kon je tenminste vredig sterven. Ik deed alles toch alleen, ehh. Jij erft mijn gezondheid als ik dood ben, ehh.

SON
(snickering to Caregiver)
Opa zit hier al zo lang dat ie niet weet wat social distancing is. En is hij zijn geld niet verloren met gokken?

Sweat drips down Bert's yellow, bald head. Caregiver pats tissue on his moist forehead.

BERT
(to Caregiver)
3 meters! Veeg anders de kopjes eerst af.

Caregiver crosses her arms. Scolds.

3 INT. BERT'S NURSING HOME - NURSES' STATION - DAY 3

NURSE 1 (20s, female) wears pink suit, shifts her gaze away from her desktop computer and glares at Caregiver.

CAREGIVER
Kent u Bert Bongers? Lastpak van het jaar!

NURSE 1
(smirking)
Niets nieuws onder de zon.

CAREGIVER
Hoe dan ook, dit lijkt serieus. Hij doet verward en lijkt koortsachtig. Meer vermoeid dan normal, en hij ijlt ook een beetje. Het zal toch geen corona zijn?

NURSE 1
Ik ga een bezoekje van Diamediport inplannen.

4 INT. BERT'S NURSING HOME - BEDROOM - DAY 4

5 PM clock face. Diamediport NURSE 2 (40s, male) wears hazmat suit. Enters Bert's room, Sits by his bedside. Opens Mobiele Diagnose Box of Voorspoedzorg.

Bert's eyes bulge out. Caregiver slides out of her lazy chair, stands near Bert. Waves at Bert frantically.

CAREGIVER
(to Bert)
Ontspan je, opa. Dit zijn nou eenmaal de corona-maatregelen.

Nurse 2 deflates a blood pressure cuff around Bert's arm. Relays data on a monitor to on-screen DOCTOR via video call. Doctor (50s, male) wears white coat and stethoscope.

NURSE 2
(to Doctor via video call)
120 boven 180. Te hoog, die bloeddruk. Hij heeft ook verhoging.

DOCTOR
(to Nurse 2 via video call)
Geef hem het antibioticum op infuus.

Nurse 2 punctures a hole in Bert's wrist then a cannula linked to a tube and IV bag held by a rod behind Bert. Feeds him antibiotics through IV bag.

NURSE 2
(to Caregiver)
Het antibioticum zal meneer Bongers er weer snel bovenop krijgen.
(MORE)

NURSE 2 (CONT'D)
Ik verwacht dat hij weer snel de oude is en kan hij weer rustig zijn gang gaan.

CAREGIVER
Kent u Bert Bongers? Lastpak van het jaar!

FADE OUT.

THE END.

HARTJE HATHAI - PART 1

HOSPITAL VISITS

Written by

Matthijs Rebel

FADE IN:

1 EXT. HATHAI'S RETIREMENT CONDO - DAY 1

Sun shines above upmarket, 20-story glass panel condo.

2 INT. HATHAI'S RETIREMENT CONDO - KITCHEN - NIGHT 2

Modern kitchen. 10 PM clock face on white wall. On counter-top: cheese platter, wine bottle. HATHAI (70s) athletic, wears yoga costume and smart WATCH. Prances to fast beat on radio. Pops cracker in her mouth.

HATHAI
Wooo... Ik voel me misselijk.

Hathai clasps her hands on her heart. Grimaces. Shoulders slump. CAREGIVER (50s, male) wears Hawaii shirt, sets Hathai on bar stool, massages her flat abs.

CAREGIVER
Je bent enthousiast over onze reis naar Curaçao. Waan je op een zandstrand. Relax. Focus op het hier en nu. Adem in, adem uit.

Smart watch alarm whales.

WATCH
Beeeep. Beeeep. Beeeep.

Hathai's breathing is short and rapid. She touches her forehead. Dramatic gesture. Caregiver fiddles with her smart watch on her wrist. Heart rate monitor displays 240 beats per minute.

CAREGIVER
Vreemd. Je ruststand is 60. Dat horloge zal wel kapot zijn. Ik bel toch voor de zekerheid een ambulance.

Caregiver envelopes Hathai as she crumbles into his arms.

3 EXT. HATHAI'S RETIREMENT CONDO - NIGHT 3

11 PM clock face on Hathai's smart watch. Caregiver wraps blanket over her trembling shoulders. Ambulance halts in front of condo.

PARAMEDIC (20s, male) wears white suit. Rolls a stretcher toward a yellow ambulance. On stretcher, lays a limp, reclining Hathai. Her cheeks are white, breathing rapid.

4 INT. AMBULANCE - NIGHT 4

Paramedic fits oxygen mask over Hathai's blue lips, cuts open her skin tight shirt, sticks suctions and wires on her pumping chest, links them to ECG machine. ECG monitor displays erratic waves.

PARAMEDIC
(to Caregiver)
Is dit de eerste keer dat je vriendin zo'n verhoogde hartslag heeft?

Caregiver panicking, eyes darting around.

CAREGIVER
(to Paramedic)
Ik geloof het wel. Geen geschiedenis van hartproblemen of hartfalen. Ook geen littekens.

Caregiver gestures at Hathai's rapidly rising and falling chest.

CAREGIVER (CONT'D)
Ze is zo fit als een viool, een yoga-instructeur. Wat kan dit veroorzaken? Heeft ze een paniekaanval?

PARAMEDIC
(to Caregiver)
Sorry. Ik ben niet getraind om een diagnose te stellen. Ik zal de informatie doorgeven aan onze spoedeisende hulp artsen.

Hathai rips off her oxygen mask.

HATHAI
(shouting at Caregiver and Paramedic)
Jullie praten mijn oren eraf. Doe je werk, meneer. Breng me naar de eerste hulp.

5 INT. HOSPITAL - EMERGENCY ROOM - CUBICLE - NIGHT 5

Crash cart, ventilator and ECG machine in emergency room. Close by, Hathai lays unresponsive on bed. Her stomach gurgles. DOCTOR (30s, male) wears white coat and stethoscope. NURSE (20s, female) wears pink suit, positions ECG machine between Doctor and herself. ECG screen displays erratic/ irregular waves and 240 bpm.

DOCTOR
(to Nurse)
Abnormale atrium en ventriculaire sinusritmes. Kan atriaal flutter of ventriculaire tachycardie zijn. Code blauw.

NURSE
(Shouting on intercom)
Alle hens aan dek.

CARDIOLOGIST and ELECTROPHYSIOLOGY (40s, males) wear blue robes. Rush inside emergency room. Pull curtain of cubicle, closing the space off for privacy. Doctor hovers behind Cardiologist and Electrophysiologist. Cardiologist massages Hathai's carotid artery throbbing down her neck.

CARDIOLOGIST
(to Electrophysiologist)
Geen verandering. Hartslag blijft onregelmatig. Een infuus met antiartimica zou kunnen werken.

Cardiologist punctures a hole in Hathai's wrist then a cannula linked to a tube and IV bag held by a rod behind Hathai. Electrophysiologist feeds her stimulant through IV bag.

CARDIOLOGIST (CONT'D)
(to Electrophysiologist)
Werkt niet. Ze reageert niet. De peddels zullen haar hart in een normaal ritme brengen. Peddels, nu!

Electrophysiologist leads procedure. Connects suctions and wires to electric shock/ defibrillator paddles. Presses paddles onto her rapidly moving chest. Her chest rises and falls. ECG monitor displays horizontal line and 0 bpm. Hathai's chest is flat.

HEART MONITOR
Beeeeep.

Electrophysiologist repeats paddling. Horizontal line and 0 bpm on ECG monitor. Hathai's chest stays flat.

HEART MONITOR (CONT'D)
Beeeeeeep.

Electrophysiologist paddles again. Horizontal line and 0 bpm on ECG monitor. Hathai's chest stays flat.

HEART MONITOR (CONT'D)
Beeeeeeeeeep.

ELECTROPHYSIOLOGIST
(shouting)
Dit kan niet. Haar hart is ermee gekapt. Helemaal niets meer.
(voice deflated)
Wat is de tijd, zuster.

NURSE
Tijdstip van overlijden: 12 uur.

Caregiver's eyes bulge out. Falls on top of her chest.

CAREGIVER
(crying to Doctor)
Het is nog niet haar tijd. Ik dacht dat we samen zouden wonen tot ze 100 werd.

FADE OUT.

THE END.

HARTJE HATHAI - PART 2

DIAMEDIPORT VISITS

Written by

Matthijs Rebel

FADE IN:

1 EXT. HATHAI'S RETIREMENT CONDO - DAY 1

Sun shines above upmarket, 20-story glass panel condo.

2 INT. HATHAI'S RETIREMENT CONDO - KITCHEN - NIGHT 2

Modern kitchen. 10 PM clock face on white wall. On counter-top: cheese platter, wine bottle. HATHAI (70s) athletic, wears yoga costume and smart WATCH. Prances to fast beat on radio. Pops cracker in her mouth.

HATHAI
Wooo... Ik voel me misselijk.

Hathai clasps her hands on her heart. Grimaces. Shoulders slump. CAREGIVER (50s, male) wears Hawaii shirt, sets Hathai on bar stool, massages her flat abs.

CAREGIVER
Je bent enthousiast over onze reis naar Curaçao. Waan je op een zandstrand. Relax. Focus op het hier en nu. Adem in, adem uit.

Smart watch alarm whales.

WATCH
Beeeep. Beeeep. Beeeep.

Hathai's breathing is short and rapid. She touches her forehead. Dramatic gesture. Caregiver fiddles with her smart watch on her wrist. Heart rate monitor displays 240 beats per minute.

CAREGIVER
Vreemd. Je ruststand is 60. Ik bel meteen Diamediport.

Caregiver envelopes Hathai as she crumbles into his arms.

3 EXT. HATHAI'S RETIREMENT CONDO - NIGHT 3

Diamediport NURSE (20s, female) wears pink suit. Carries along a Mobiele Diagnose Box Voorspoedzorg. Walks into the condo.

4 INT. HATHAI'S RETIREMENT CONDO - BEDROOM - NIGHT 4

11 PM clock face on Hathai's smart watch. Hathai lays on bed, limp. Caregiver wraps blanket over her trembling body. Her cheeks are white, breathing rapid.

Nurse opens Mobiele Diagnose Box. Fits oxygen mask over Hathia's blue lips, cuts open her skin tight shirt, sticks suctions and wires on her pumping chest, links them to ECG machine. ECG monitor displays erratic/irregular waves and 240 bpm.

NURSE
(to Caregiver)
Is dit de eerste keer dat je vriendin zo'n verhoogde hartslag heeft?

Caregiver panicking, eyes darting around.

CAREGIVER
(to Nurse)
Ik geloof het wel. Geen geschiedenis van hartproblemen of hartfalen. Ook geen littekens.

Caregiver gestures at Hathai's rapidly rising and falling chest.

CAREGIVER (CONT'D)
Ze is zo fit als een viool, een yoga-instructeur. Wat kan dit veroorzaken? Heeft ze een paniekaanval?

Hathai lays unresponsive on bed. Her stomach gurgles. Nurse dials # on phone. Relays ECG data on a monitor to on-screen CARDIOLOGIST on video call. Cardiologist (40s, male) wears white coat and stethscope.

CARDIOLOGIST
(to Nurse via video call)
Abnormale atrium en ventriculaire sinusritmes. Kan atriaal flutter of ventriculaire tachycardie zijn. Masseer de halsslagader.

Nurse massages Hathai's carotid artery throbbing down her neck.

NURSE
(to Cardiologist via video call)
Geen verandering. Hartslag blijft onregelmatig.

CARDIOLOGIST
(to Nurse via video call)
Geef heer an infuus met antiaritmica.

Nurse punctures a hole in Hathai's wrist then a cannula linked to a tube and IV bag held by a rod behind Hathai. Feeds her antiarrhythmic stimulant through IV bag.

NURSE
(to Cardiologist via video call)
Werkt niet. Ze reageert niet.

CARDIOLOGIST
(to Nurse via video call)
De peddels zullen haar hart in een normaal ritme brengen.
Peddels, nu!

Nurse connects suctions and wires to defibrillator/ electric shock paddles. Presses paddles onto Hathai's rapidly moving chest. Hathai's chest rises and falls. ECG monitor displays regular waves. 240bpm declines to 120bpm. Hathai sits up in bed, alert.

HATHAI
He, kijk nou. Ik leef nog.

CARDIOLOGIST
Inderdaad. Maar U heeft geluk.
Uw hart zou het geen uur langer vol gehouden hebben.

Hathai's chest is pumping slower. Her resting heart rate reads 60bpm on smart watch. Caregiver smiles. Hugs Hathai.

CAREGIVER
Dank je Diamediport. Dankjewel.
Op naar Curaçao!

FADE OUT.

THE END.

A8.6 BRAND POSITIONING

The tools that are explained in 5.2-5.4, could be used within a branding strategy. A branding could help to improve consistency and direct further development. Keller's Strategic Brand Management (Keller, 2011) is used as theoretical background on the creation and development of a brand for Diamediport. Although it uses consumer-based brand equity, and one could wonder whether elderly people should really be defined as consumers, it offers a helpful framework for setting up a brand positioning for the Diamediport service, namely with points-of-parity and points-of-difference. Having a clear position in the minds of people, improves the recognizability of what the purpose is of a specific service.

A triage service could both be positioned as a separate entity, like a separate general practice, or as an extension of an existing service, like an ambulance that rides from and to a hospital. In 2020, the Diamediport service should aim to be relevant at the regional level, as the service will become viable when multiple regions are successfully able to prove that it helps elderly, doctors and nurses. However, if the brand Diamediport is organized and positioned differently, in different provinces of the Netherlands, this can be difficult for people to understand. Also, if its positioning has to change after five or ten years, it is also hard for investors and doctors to trust the brand to deliver on its promises. Medical service innovation requires strategic positioning that does not have to change over time. Hospitals, general practitioners and nurses hold valid and clear positions, are easy to recognize, and people, sick or healthy, can know who to ask what, and which problems should be solved by which institute. The question that this chapter answers, is where to position.

The service is desirable for the elderly people and informal caregivers, because offering hospital-grade diagnostics to extramural homes can reduce unnecessary hospitalization. Also, it can provide quick and detailed insight in the (medical) situation of the elderly's body, his socio-psychological abilities and his home context. This home context holds information of a person that is normally only 'unlocked' by a general practitioner on a house visit – the clinical eye of a doctor plays an essential role in a differential diagnosis.

It is good to be cautious when implementing a service with the primary purpose to reduce hospital intake of elderly. For example, the implementation of alarm pendants has led (Pritchard & Brittain, 2015) to adverse effects, like dehumanization. Other effects are also possible, for instance Ritzer's 'irrationality of rationality' (Ritzer, 1992). If the purpose of Diamediport is to prevent unnecessary ambulance rides, it will also remove side-effects that are caused by the ambulance ride (this is the 'red flag'-effect from ch. 4.2.1).

The concept of Diamediport aims to provide digital solutions for a problem that is currently mainly solved off-line. Regarding the theory of disruptive innovation, and the healthcare industry, Jones (2013) poses that 'cost savings and user experience' are not the 'significant drivers they are in other markets', and he poses that 'designing a better user experience is not necessarily a sustainable advantage', and that the healthcare sector is different, since large initiatives have not lead to disruptive innovation. The key component in innovations that do end up disrupting markets, are started from doctor's observation, from practice (Jones, 2013) .

Elderly healthcare *market*, is ripe for digital disruption, but disrupting elderly people, their carers and doctors, should be prevented as much as possible. Otherwise, innovation causes instead of prevents the problem described in 4.1. Also, the introduction of alarm pendants has provided us with valuable insights, that should be included when positioning a new triage service.

POSITION STATEMENT

For elderly who receive extramural care, Diamediport prevents needless and repeated suffering, by offering a virtual house visit that includes the informal caregiver, providing medical assurance and authority so the elderly can retain his agency

8.6.1 POINTS OF PARITY AND DIFFERENCE

According to Keller, brand positioning is about establishing points-of-parity (POPs) and points-of-difference (PODs). Three services that target similar problems (compared to the problem statement of 4.1) are examined below to establish how people could relate Diamediport to its 'competitors' in triage services.

In this case, 'competitors' are identified in the field of elderly triage, from the perspective of elderly and their informal caregiver. How might an assertive elderly prefer to be served? Would he prefer to go to the hospital with all the hassle that that includes, or something else? A recognizable doctor is important according to the research of ch. 3.2.1, but a doctor can be part of a different 'healthcare player', like an ambulance or out-of-hours general practice. Since Diamediport offers both new functions (including medical expertise in the home of the elderly) and forms (the point-of-care technology and telepresence-screens have a different physicality than being present in the same room), it would be good to search for recognizable existing healthcare identities.

Points of parity
A visiting general practitioner values seeing a person in their own context. His clinical eye is essential for him, next to the body examination. Information on blood pressure and temperature can help him to diagnose someone at the spot, and he can opt to test a blood sample or urine sample. Diamediport positions itself as a service that brings more diagnostic information to the doctor, and that virtually brings the doctor to the elderly's home. Therefore, Diamediport is branded as a tele-house visit from the general practitioner.

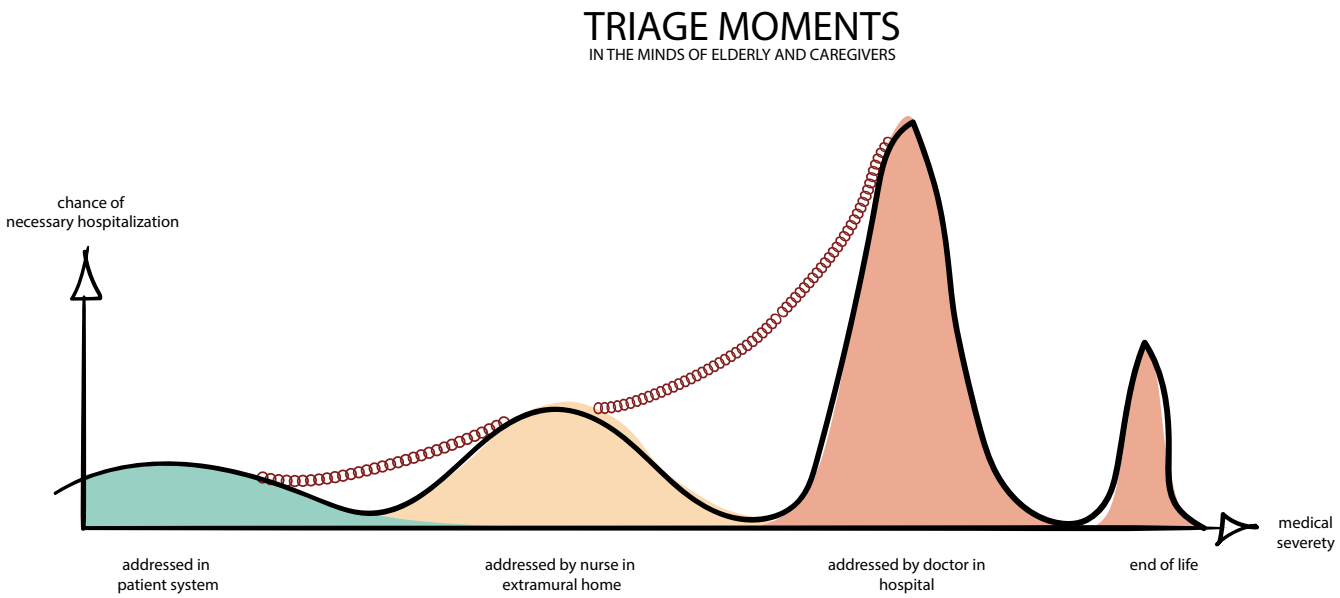
The *signal* that an ambulance offers to the social context of the elderly person, is something that Diamediport should pair with. An ambulance ride is a loud and clear sign that something is very wrong with the elderly and their context. Diamediport should prevent this signal to go away, because bringing real change to the situation of the elderly is sill necessary. If a doctor can see the elderly, and gets the information he needs about the elderly and their context, he can decide to set a treatment plan or request a change of the care context of the elderly in such a way, that continued suffering is prevented. This signal is reverted to a medical authority, instead to people who have no power in the medical institutions.

Points of difference
An ambulance is a transport vehicle for all kinds of patients. Being logistically and medically responsible, how an ambulance is designed, can still cause elderly people to suffer because an elderly is removed from their familiar context.

Unintended side effects like stress and hospital-induced risks for infection are associated with hospital readmission. Frail elderly are "o*ften under-triaged and insufficiently treated resulting in adverse health outcomes*", according to Rosted, Schultz, & Sanders (2016). Ambulances make elderly self-identify as sick patients without agency , but the medical system is benefited by elderly who are assertive. Elderly people who are not at risk of dying immediately, should not be treated as patients, but as elderly people with their agency in mind. In other words, one should not move an old tree.

8.6.2 Positioning statement

The Diamediport service chains the context of the hospital to the patient system, and therefore it catches elderly who would have otherwise fallen between the cracks. See figure 12 on the next page. The positioning as a chain, linking together different medical contexts, works because it becomes harder and harder for the medical industry to properly care for the increasing elderly population. Together with the increase in multimor-



Diamediport is able to act like a chain, connecting different kinds of triage that would currently happen in an elderly's home, or in the hospital. The largest effect is when an elderly should receive hospital-grade diagnostics, but it is preferred to stay home.

bidity and chronic diseases, a diminishing number of nurses is decreasingly able to build rapport with the elderly people they care for (meaning, elderly people do not remember their carers). These nurses, would they have been with enough and with enough medical understanding, could prevent elderly people from putting a disproportionate amount of pressure on the resources of the healthcare industry. Therefore, a virtual chain is built with experienced nurses.

Diamediport perceives elderly as in need for urgent and dependable triage. Not all elderly in extramural care, are frail but some of them are at risk, because there are cracks in the medical and societal systems. The medical system is not designed for multimorbid and chronically ill elderly, and the societal system is not able to allocate enough informal caregivers who can fight the system, nor is society supportive enough.

Triage moments can be beautiful opportunities for the warm nature health professionals have, and for informal caregivers. Diamediport aims to create beautiful and warm triage moments, filled with opportunity for sustainable change in the situation of the elderly. Technology and elderly can only be combined with nurses with an eye for the elderly, who allocate enough integral interpersonal warm and touching care, that are educated and well payed. These nurses are able to convey the visual and audio information they gather to a tele-doctor, so the doctor can offer his medical authority. If the potential of this moment is used, sustainable and consistent change in both cure and care of the elderly can be made. Hardly anyone wants to deny taking drastic actions on behalf of the elderly, but the system has become so complicated and hard to change, that only a medical authority can inspire change. If that actor (a nurse or a weak GP for instance) lacks medical authority, it will be a low-impact moment, and therefore harm the elderly.

In other words, emergency moments are perceived as caused by cracks in the underlying systems of the Dutch society and medical world. There is fragmentation in the medical world that does not fit the holistic, medical needs of elderly people. multimorbidity and polypharmacy () are prevalent: so only experienced nurses and doctors can properly deal with elderly in emergency.

Diamediport is a medical emergency and triage service for elderly people and their informal caregivers. The technology that is used, might also be used for other things medical, but the elderly, extramural care, market is the best point of first implementation. In order to determine the stakeholders that are included in the service, so for whom it should be designed, and in order to determine the stakeholders that are outside the service, so whom is paying, benefiting, or being informed about it, it has been positioned with points of parity and difference, and with a positioning statement. The next steps are to describe internal and external stakeholders, and what role they play in the new service.