Deliverable D 5.2:

Report on Learning Session I on stakeholder management and change management

WP 5: Stakeholder and change management

ACT@Scale

Advancing Care Coordination and Telehealth @ Scale

This publication arises from the ACT@Scale (Advancing Care Coordination and Telehealth deployment at Scale) Programme which has received funding from the European Union, in the framework of the Health Programme under grant agreement 709770.
The ACT@Scale programme is fully aligned with the European Innovation Partnership in Active and Healthy Ageing objectives to deploy integrated care for chronically ill patients.

Document Information

PROJECT ACRONYM:	ACT@Scale
CONTRACT NUMBER:	709770
DISSEMINATION LEVEL:	Public
NATURE OF DOCUMENT:	Report

TITLE OF DOCUMENT:	Deliverable 5.2
REFERENCE NUMBER:	D5.2
WORKPACKAGE:	WP5
VERSION:	V1.0
EXPECTED DELIVERY DATE:	M7
DATE:	19 Dec 2016
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EDITOR:	AQuAS

Short description of the Deliverable:

The work package 5 (WP5) of the Advancing Care Coordination and Telehealth deployment at Scale (ACT@Scale) project, which strives for obtaining commitment and support from interest groups related to care coordination and telehealth, intends also to apply a collaborative methodology (PDSA – Plan, Do, Study, Act) to improve performance of four key drivers of change (Stakeholder and Change Management, Service selection, Sustainability and business models, and Citizen empowerment).
This deliverable presents the results of the first learning session from the programmes that have selected Stakeholder and Change Management as one of their improvement areas.

REVISION HISTORY			
REVISION	DATE	COMMENTS	AUTHOR (NAME AND ORGANISATION)
V0.1	21/10/2016	First version including Basque Country	AQuAS
V0.2	14/11/2016	Second version including Northern Netherlands	AQuAS
V1.0	15/11/2016	Final version including executive summary	AQuAS

Executive Summary

ACT@Scale will work jointly with the programs on the implementation of improvement projects based on a collaborative methodology.

For this purpose, the PDSA methodology (Plan – Do – Study – Act) has been selected. PDSA is a cycle based methodology for improvement, which provides a framework framework for iterative assessment of changes.

Figure 1 depicts the framework of the methodology proposed for ACT@Scale:

after a **Baseline** phase to agree the methods and indicators across regions and programmes, there will be two improvement cycles. In each, the regions will deploy PDSA cycles. Results can be discussed locally, and then in transferability sessions.

The **Learning Cycle** will consist of a learning session with local stakeholders (regional meeting) to depict the PDSA cycle of the Action Period 1 (Regional implementation 1: 1 year). The WP leader will implement the specific topic, always guided by the WP3 leader (Evaluation).

The **Coaching Cycle** will have a similar timeframe, and consider the lessons learned. At the end of the project, specific activities on dissemination and transferability will be performed.

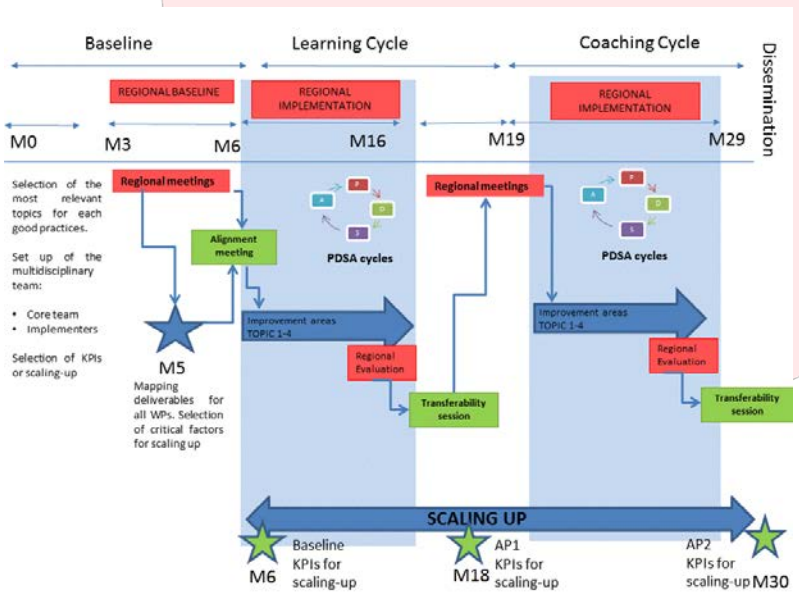

Figure 1 ACT@Scale adapted collaborative methodology

According to this, each of the programmes included within ACT@Scale has initiated its own improvement project and have completed the **Baseline** phase, in which they have carried out the following activities:

1. Discuss what drivers can promote a greater scaling-up of each good practice.
2. Look for scientific evidence to support the selection of drivers in each good practice.
3. Select the drivers to work in, at least two for each good practice:
    a. Stakeholder management and change management
    b. Optimization of recruitment, service selection and service dynamic adaptation
    c. Sustainability and business case
    d. Citizen empowerment
4. Define the interventions to be carried out within each driver.
    a. Develop specific ideas for changes that lead to scaling-up within the selected drivers in each good practice.
    b. Agree on the interventions to be implemented. Those interventions will be run in the Learning cycles.
    c. Document the interventions in "change package".
5. Define the key performance indicators

This document includes the programs which have selected 'Stakeholders and Change Management' as a driver for scaling up.

Each program has identified improvement areas, interventions with their goals, and key performance indicators.

Content

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Introduction

This document presents the report on Learning session I of each programme which has chosen "Stakeholders and Change Management" as a driver to facilitate the up-scaling process. The reports describes the tasks performed during the baseline phase, mainly the distinct steps defined for the route maps: topic selection, creation of multidisciplinary team, identification of improvement areas, set up of objectives, definition of change interventions and building of the evaluation framework.
The programmes that have selected " Stakeholders and Change Management" driver are:

1. Integrated care pathway for multimorbid patients (Basque Country)
2. Telemonitoring in CHF (Basque Country)
3. Asthma COPD Telehealth service (Northern Netherlands)
4. Effective cardio, telemonitoring for heart failure patients (Northern Netherlands)
5. Embrace, an integrated elderly care model (Northern Netherlands)

Collaborative Methodology: Baseline Regional Report (Basque country) - Integrated care pathway for multimorbid patients

The first phase of the collaborative methodology in ACT@Scale project is the baseline phase. The below template documents the information collected during the session.

1. Topic selection

The drivers to facilitate the scaling-up of the "Integrated care for multimorbid patients" program chosen are:

A. Stakeholder management and change management
B. Optimization of recruitment, service selection and service dynamic adaptation
C. Citizen empowerment

2. Multidisciplinary team (number and profile)

The multidisciplinary team is composed by different members, the functions and roles are:

- *Organizer:* three members of the methodological staff with skills in leading team dynamics
- *Experts:* six internists with extended experience in service managing and implementing new organizational models, and two implementation experts
- *Decision makers:* twelve members of distinct managerial team, one representative of the Healthcare Directorate of Osakidetza
- *Project Manager/Representatives of organizations:* one project manager with the general overview of the project and nine representatives of fourteen organizations

- *Implementers/Representatives of organizations:* nine representatives of fourteen organizations
- *Total participants:* 27

* Some participants have multiple roles and are counted in different categories.

3. Improvement areas

The multidisciplinary working team has defined several improvement areas that include resistance to change, labor instability, lack of time of professionals, weak training of professionals, lack of leadership, low participation of patients and caregivers etc.

The improvement areas in which the efforts will be put on during the PDSA cycles are:

A. Stakeholder management and change management
- Not all relevant stakeholders are included in the definition and implementation of care pathways and unbalanced involvement of the stakeholders exists
- Not uniform clinical knowledge among healthcare professionals
- Blurred definition of the functions of nursing roles
- Poor use of technological tools to support the provision of care
- Insufficient and ineffective coordination, information sharing, result dissemination and communication between healthcare professionals of distinct care levels
- Misalignment of professionals´ and managers´ objectives
- Lack of incentives and acknowledgement for professionals

4. Objectives

Agree and describe the progress you want to achieve on each improvement area.

A. Stakeholder management and change management
- ➢ Promote the creation of multidisciplinary teams involving all stakeholders (patient, informal caregiver, professionals and managers of healthcare including out-patient care and mental health, and social sector) to create and deploy the integrated care pathway focused of frail elderly patients

- Increase awareness among professionals of the importance of changing the provision of care to multimorbid patients to increase their engagement
- Increase the clinical knowledge of the healthcare professionals of all care levels on how to better treat multimorbid patients
- Focus the care provision on patient´s perspective and avoid inequalities in the service provision
- Recognize healthcare professionals´ commitment to the program and increase their motivation
- Assess the performance of the program in terms of cost-effectiveness
- Facilitate the communication and the coordination between stakeholders providing an unified language, access to relevant information, user-friendly ICT tools and specific procedures

5. Change package (interventions)

The interventions that will be carried out are summarized below. They will be further refined once the first PDSA cycle starts.

A. Stakeholder management and change management

1. Create a multidisciplinary team representing all stakeholders and all integrated care organizations to work collaboratively on the design of the integrated care pathway for frail elderly patients
2. Analyze data on cost-effectiveness of the program (pilot basis) and share evidence-based results among all stakeholders
3. Develop, set up and implement a peer-to-peer training program for healthcare professionals focused on increasing clinical knowledge in the management of multimorbid patients
4. Develop, validate and deploy an unified and sustainable patient-centered integrated care pathway for multimorbid patients for all organizations (who, what, when, where, how)
5. Define and implement a corporative framework for incentives and acknowledgement for the healthcare professionals
6. Collaboratively agree (between clinical and managerial teams) the indicators to measure the cost-effectiveness and sustainability of the program, create a scorecard to allow monitoring, collect data and analyze the performance in each organization
7. Include the relevant information related to the management of multimorbid patients in the Electronic Health Record and the online Health School to facilitate knowledge sharing and coordination among professionals

8. Adapt and enrich (add questionnaires) the Personal Health Folder to monitor patient´s health status and enable communication between professionals and patients/caregivers

6. Key Performance Indicators

The programme will use WP4 indicators in the PDSA cycles: Up-scaling, cluster and process indicators.

UP-SCALING INDICATORS

Data input	Topic	Type	Measure	Target for surveys
Scaling-up: Experience of Care	Healthcare Consumer Assessment	**NPS** question		Patients
	Psycho-social factors	**PAM** included in **MAY** survey		Patients
Scaling-up: Health of a population	Coverage	Databases **Population**	Population size Stratified population Target population Population served Population diagnosed	-
	Coverage	Databases **Individual**	Diagnosis Status in the program Reasons for out	-
	Disease burden:	Databases **Population**	Incidence Prevalence	-
Scaling-up: Per capita costs	Total cost	Databases **Population**		-
	- Utilisation - Unit cost	Databases **Individual**		-

CLUSTER SPECIFIC INDICATORS

Cluster	TYPE	Measure	Note
Multimorbid	ADJ	Charlson Comorbidity Index	CCI score
	ADJ	Comorbidity Polypharmacy Index	CPS score
	HOM	Total cholesterol	mmol/l
	HOM	LDL cholesterol	mmol/l
	COM	PC: home visit	Cost + utilization
	COM	PC: GP visit	Cost + utilization
	COM	PC: nurse visit	Cost + utilization
	COM	SC: ED visit	Cost + utilization
	COM	SC: specialist visit	Cost + utilization
	COM	SC: admissions	Cost + utilization

	COM	SC: readmissions (30)	Cost + utilization
	COM	SC: hospitalization	Cost + utilization
	COM	SC: outpatient visit	Cost + utilization
	COM	CC: community care referrals	Cost + utilization
	COM	CC: home visit	Cost + utilization

PROCESS INDICATORS

Questionnaires by WP5 (Stakeholders and Change Management) will be used as process indicators.

Appendix 1 includes the complete list of these indicators.

Collaborative Methodology: Baseline Regional Report (Basque country) -Telemonitoring in CHF

The first phase of the collaborative methodology in ACT@Scale project is the baseline phase. The below template documents the information collected during the session.

1. Topic selection

The drivers to facilitate the scale-up chosen by the "telemonitoring in congestive heart failure" progam are:

A. Stakeholder management and change management
B. Optimization of recruitment, service selection and service dynamic adaptation
C. Citizen empowerment

2. Multidisciplinary team (number and profile)

The multidisciplinary team is composed by different members, the functions and roles are:

- *Organizer:* two members of the methodological staff with skills in leading team dynamics
- *Experts:* one cardiologist with extended experience in service managing and different monitoring initiatives (telemonitoring, phone-based follow-up), and one implementation expert
- *Decision makers:* three representatives of the Healthcare Directorate of Osakidetza
- *Project Manager/Representatives of organizations:* one project manager with the general overview of the project and two representatives of distinct organizations (integrated care organization and eHealth Centre)
- *Implementers/Representatives of organizations:* two representatives of distinct organizations (one integrated care organization and eHealth Centre)
- *Total participants:* 6 participants

* Some participants have multiple roles and are counted in different categories.

3. Improvement areas

The multidisciplinary working team has defined several improvement areas that include weak communication between professionals, lack of leadership, poor capacity to redefine care pathways, low particpation of patients and caregivers etc.

The improvement areas in which the efforts will be put on during the PDSA cycles are:

A. Stakeholder management and change management
- Not all the required stakeholders are involved in the telemonitoring service, out-patient care (Continuous Care Units, emergency rooms, eHealth Centre), patients and informal caregivers are not represented
- Healthcare professional do not have appropriate technological tools to monitor patients´ health status
- Lack of evidence of the effectiveness of the telemonitoring service
- Ineffective communication and dissemination of the telemonitoring program and its results to all stakeholders of distinct care levels

4. Objectives

A. Stakeholder management and change management
- Share the information of the telemonitored patients among all stakeholders of different care levels
- Provide all congestive heart failure patients with an equivalent telemonitoring service irrespective of the healthcare organization
- Define a clear implementation strategy
- Assess the effectiveness of the telemonitoring program

5. Change package (interventions)

The interventions that will be carried out are summarized below. They will be further refined once the first PDSA cycle starts.

B. Stakeholder management and change management

1. Integrate all patient´s information in the Electronic Health Record (including telemonitoring data) and make it easily accessible to his/her clinicians.
2. Define and implement the corporative integrated care pathway supported by the telemonitoring service for patients with congestive heart failure by all stakeholders of different care levels (primary care and hospital) and sectors (health, social and mental health) which can be slightly tailored to each specific context.
3. Define, validate, share and execute a corporative deployment plan among all stakeholders (healthcare professionals, managers, social workers) that includes: objectives, requirements, actions, risks, contingency plans and timelines.
4. Define and apply an evaluation framework to monitor the cost-effectiveness of the telemonitoring service and set up a methodology and protocol for continuous improvement

6. Key Performance Indicators

List the scaling-up, program and process (drivers) indicators that will be used in the PDSA cycles. Used WP4 indicators as a reference.

UP-SCALING INDICATORS

Data input	Topic	Type	Measure	Target for surveys
Scaling-up: Experience of Care	Healthcare Consumer Assessment	**NPS** question		Patients
	Psycho-social factors	**PAM** included in **MAY** survey		Patients
Scaling-up: Health of a population	Coverage	Databases **Population**	Population size Stratified population Target population	-

			Population served Population diagnosed	
	Coverage	Databases **Individual**	Diagnosis Status in the program Reasons for out	-
	Disease burden:	Databases **Population**	Incidence Prevalence	-
Scaling-up: Per capita costs	Total cost	Databases **Population**		-
	- Utilisation - Unit cost	Databases **Individual**		-

CLUSTER SPECIFIC INDICATORS

Cluster	TYPE	Measure	Note
Multimorbid	ADJ	Charlson Comorbidity Index	CCI score
	ADJ	Comorbidity Polypharmacy Index	CPS score
	HOM	Total cholesterol	mmol/l
	HOM	LDL cholesterol	mmol/l
	COM	PC: home visit	Cost + utilization
	COM	PC: GP visit	Cost + utilization
	COM	PC: nurse visit	Cost + utilization
	COM	SC: ED visit	Cost + utilization
	COM	SC: specialist visit	Cost + utilization
	COM	SC: admissions	Cost + utilization
	COM	SC: readmissions (30)	Cost + utilization
	COM	SC: hospitalization	Cost + utilization
	COM	SC: outpatient visit	Cost + utilization
	COM	CC: community care referrals	Cost + utilization
	COM	CC: home visit	Cost + utilization

PROCESS INDICATORS

Questionnaires by WP5 (Stakeholders and Change Management) will be used as process indicators.

Appendix 1 includes the complete list of these indicators.

Collaborative Methodology: Baseline Regional Report (Northern Netherlands) – Asthma COPD Telehealth service

The first phase of the collaborative methodology in ACT@Scale project is the baseline phase. The below template documents the information collected during the session.

1. Topic selection

The drivers to facilitate the scaling-up of Embrace program are:

A. Stakeholder management

D. Sustainability and business models

2. Multidisciplinary team (number and profile)

The multidisciplinary team is composed by different members, the functions and roles are:

Certe and other large laboratories providing the initial assessment of patients referred from the GP offices.

Primary care offices screening potential asthma and COPD patients.

Secondary care professionals performing online assessment of the results collected at the laboratories.

Educational institutes participating to develop education and training modules for professionals working in the program.

University Medical Center Groningen, department of General Practice for(scientific) evaluation of the program.

3. Improvement areas

The different organisations collaborating in the program have defined improvement areas that include convincing stakeholders to adopt the AC service and develop sustainable reimbursement models. The improvement areas in which the efforts will be put on during the PDSA cycles are:

Stakeholder management

- Reluctance of large laboratories and GP offices to adopt the asthma COPD telehealth service within their normal routine.
- Support from laboratory nurses and clinicians in working with the service.
- Motivation/ behavioral change of caregivers in supporting patients in the follow-up phase.
- Lack of automated support based decision tree implementation.

4. Objectives

The following objectives on each improvement area have been identified by the group as those they wish to progress through the PDSA learning cycles.

Stakeholder management

- Create awareness among large laboratories, GP offices and insurance companies in the region and beyond on the way of working and results obtained by the AC service.
- Reach consensus on ways to develop and implement the AC service in different regions.
- Collect information on other initiatives sharing the aims and goals of the AC service scale up ambitions.
- Gather and reflect on the lessons learned and best practices by organising meeting and discussion group sessions.

5. Change package (interventions)

The following proposed interventions will be carried out and will be further refined once the first PDSA cycle starts.

Stakeholder management

1. Installation of both working and discussion groups on the aims and delivery of diagnosis and care according to basic principles of the AC service.
2. To perform a literature study on disease burden measurement scales to be included in the AC service.
3. Carry out proposed changes in current processes and evaluate outcomes.
4. Develop education and training modules for caregivers to work with the new system including disease burden measurement aspects.
5. Participation in agreed methodologies (surveys) to measure stakeholder involvement.

6. Key Performance Indicators

Questionnaires by WP5 (Stakeholders and Change Management) will be used as process indicators.

Appendix 1 includes the complete list of these indicators.

Collaborative Methodology: Baseline Regional Report (Northern Netherlands) – Effective cardio, telemonitoring for heart failure patients.

The first phase of the collaborative methodology in ACT@Scale project is the baseline phase. The below template documents the information collected during the session.

1. Topic selection

The drivers to facilitate the scaling-up of Embrace program are:

A. Sustainability and business models
B. Stakeholder management

2. Multidisciplinary team (number and profile)

The multidisciplinary team is composed by different members, the functions and roles are:

Treant hospital group, location Scheper Emmen, department of cardiology responsible for initiating and monitoring patients enrolled in the program.

Insurance companies proving financial support for implementation of the program.

Philips Home Healthcare providing the telemonitoring system and devices for selfmanagement, as also financial support for implementation.

3. Improvement areas

The organisations working together within the program have defined several improvement areas that include development of sustainable financial models to ensure future implementation and scaling up as well as stakeholder involvement including cultural change in primary care organisations. The improvement areas in which the efforts will be put on during the PDSA cycles are:

Stakeholder management

- Implementation of telemonitoring services in current care pathways.
- Cooperation with primary care organisations and implementation into existing care pathways.
- Training and education programs for professionals to work with the system.
- Sharing best practices between caregiver for care pathway optimisation.
- Investigate work load of care professionals.

4. Objectives

The following objectives on each improvement area have been identified by the group as those they wish to progress through the PDSA learning cycles.

Stakeholder management

- Discuss cooperation and implementation of services to primary care organizations.
- Transfer knowledge on effective pathway set-up with the telemonitoring system between care professionals.
- Collect and disseminate best practices and lessons learned by holding stakeholder meeting sessions.
- Evaluate the possibilities and conditions for scaling up services.
- Collect feedback from stakeholders and develop an implementation plan on how to tackle barriers and achieve scaling up of the program.
- Study the effects of implementation of the program on the work load of primary and secondary care professionals.

5. Change package (interventions)

The following proposed interventions will be carried out and will be further refined once the first PDSA cycle starts.

Stakeholder management

6. Plan meetings with primary, secondary care and home care organisation on cooperation within the program.
7. Evaluate planned meeting and design an action plan on how to overcome hurdles and improve implementation.
8. Evaluate implementation plans and provide best practices for dissemination purposes.
9. Develop and implement training and coaching modules for both primary and secondary care professionals.
10. Collect agreed upon methodologies (surveys, questionnaires) to measure stakeholder involvement.

6. Key Performance Indicators

Questionnaires by WP5 (Stakeholders and Change Management) will be used as process indicators.

Appendix 1 includes the complete list of these indicators.

Collaborative Methodology: Baseline Regional Report (Northern Netherlands) – Embrace, an integrated elderly care model

The first phase of the collaborative methodology in ACT@Scale project is the baseline phase. The below template documents the information collected during the session.

1. Topic selection

The drivers to facilitate the scaling-up of Embrace program are:

A. Sustainability and business models
B. Stakeholder management

2. Multidisciplinary team (number and profile)

The multidisciplinary team is composed by different members, the functions and roles are:

Healthcare insurance companies and municipalities providing funding for the program and who are collaborating in developing structural financial models.

The elderly care teams (including the case manager) of the Embrace program offering care in the participating regions.

Home care organisations responsible for delivering care at home as part of the program.

Educational institutes participating to develop education and training modules for professionals working in the Embrace elderly care model.

University Medical Center Groningen, department of Health Sciences for (scientific) evaluation of the Embrace program.

3. Improvement areas

The organisations working together within the program have defined several improvement areas that include misalignment of financial models to ensure a sustainable care model and hesitation of stakeholder towards cultural change. The improvement areas in which the efforts will be put on during the PDSA cycles are:

Stakeholder management

- Hesitation towards cultural change in thinking about innovative, more sustainable elderly care models.
- Uncertainty on which elements of the program can or may be financed out of government budgets.
- Lack of interoperability of IT systems to implement an elderly owned electronic elderly dossier.

4. Objectives

The following objectives on each improvement area have been identified by the group as those they wish to progress through the PDSA learning cycles.

Stakeholder management

- Include all stakeholders in the decision making process.
- Evaluate and reflect on possibilities of agreeing on decisions with all stakeholders involved.
- Assess positive and negative responses and develop an action plan on how to tackle issues and improve implementation.
- Consolidate lessons learned and best practices by dissemination and stakeholder meeting sessions.

5. Change package (interventions)

The following proposed interventions will be carried out and will be further refined once the first PDSA cycle starts.

Stakeholder management

11. Organize and evaluate stakeholder meeting to identify barriers and areas of improvement.
12. Agree on, plan, and implement changes suggested by stakeholders.
13. Agree on and collect methodologies (surveys) to measure stakeholder involvement.
14. Develop and plan education and training sessions for professionals working in integrated care models for elderly care.

6. Key Performance Indicators

Questionnaires by WP5 (Stakeholders and Change Management) will be used as process indicators.

Appendix 1 includes the complete list of these indicators.

Region of South Denmark

During the first six months of ACT@Scale, RSD has experienced certain challenges in the involvement of the identified telepsychiatric service and professionals. These challenges have emerged as the identified service is more mature than what was intended for ACT@Scale. Furthermore, the organisational set up required to participate in ACT@Scale does not exist in the current telepsychiatric service as the service has already moved beyond this stage. The challenges have resulted in a delay in the planned project activities, primarily the Collaborative Methodology.

Currently, RSD is working to engage a different telepsychiatric service and a new set of professionals to be part of ACT@Scale. The new service focuses on the use of telemedicine in diagnosing, treating and monitoring citizens suffering from depression. The involvement of this service will ensure a more coherent contribution to ACT@Scale. However, the schedule for the data collection and the collaborative methodology will be delayed as the new constellation and engagement have to be properly established. If the engagement of the new service is secured, the activities are expected to be initiated in January 2017 and the aim is to be in line with the rest of the consortium by March 2017.

Appendix 1. WP5 Questionnaires on stakeholder and change management

Background

The specific objective of Workpackage 5 (WP5) is to achieve an appropriate level of support and commitment from the stakeholders to innovative health services, specifically care coordination and telehealth.

The main target will be to gather baseline information of staff engaged within the ACT@Scale programme, to know stakeholder engagement through knowing the overall staff engagement across programmes and finally validate the change management through the maturity map of the EIP-AHA B3.

The specific objectives of WP5 are:

1. To identify stakeholders and analyse their contribution and commitment to the project, as well as issues related to organisational or technological change.
2. To develop and deploy a tool to provide a baseline for stakeholder engagement.
3. To design an action plan aimed to increase stakeholder contributions to the project.

This questionnaire is intended to be addressed to the programme managers of each of the ACT@Scale programmes involved in the project to collect the map of current situation in the area of stakeholder management and change management.

Mapping: description of structural items

Stakeholder Management

1. In the strategic plan of your programme, is there any specific strategy of identification and selection of stakeholders of your programme?
   - Yes
   - No

2. Is there an implementation plan available for the identification and selection of stakeholders in your programme?
   - Yes
   - No

3. Could you please describe what the process you usually follow to identify is, select and prioritize stakeholders (**identification:** listing of relevant groups, organizations; **analyzing:** understanding stakeholder perspectives and interests; **mapping:** visualising relationships and other stakeholders; **prioritizing:** ranking stakeholder relevance and identifying issues.

4. Please describe which stakeholders are involved in your progamme? (please select all that apply)

- Patient/users
- Health professionals – primary care
- Health professionals – secondary care
- Health administrators
- Payers
- Politicians
- Private health providers
- Other stakeholder (please specify)

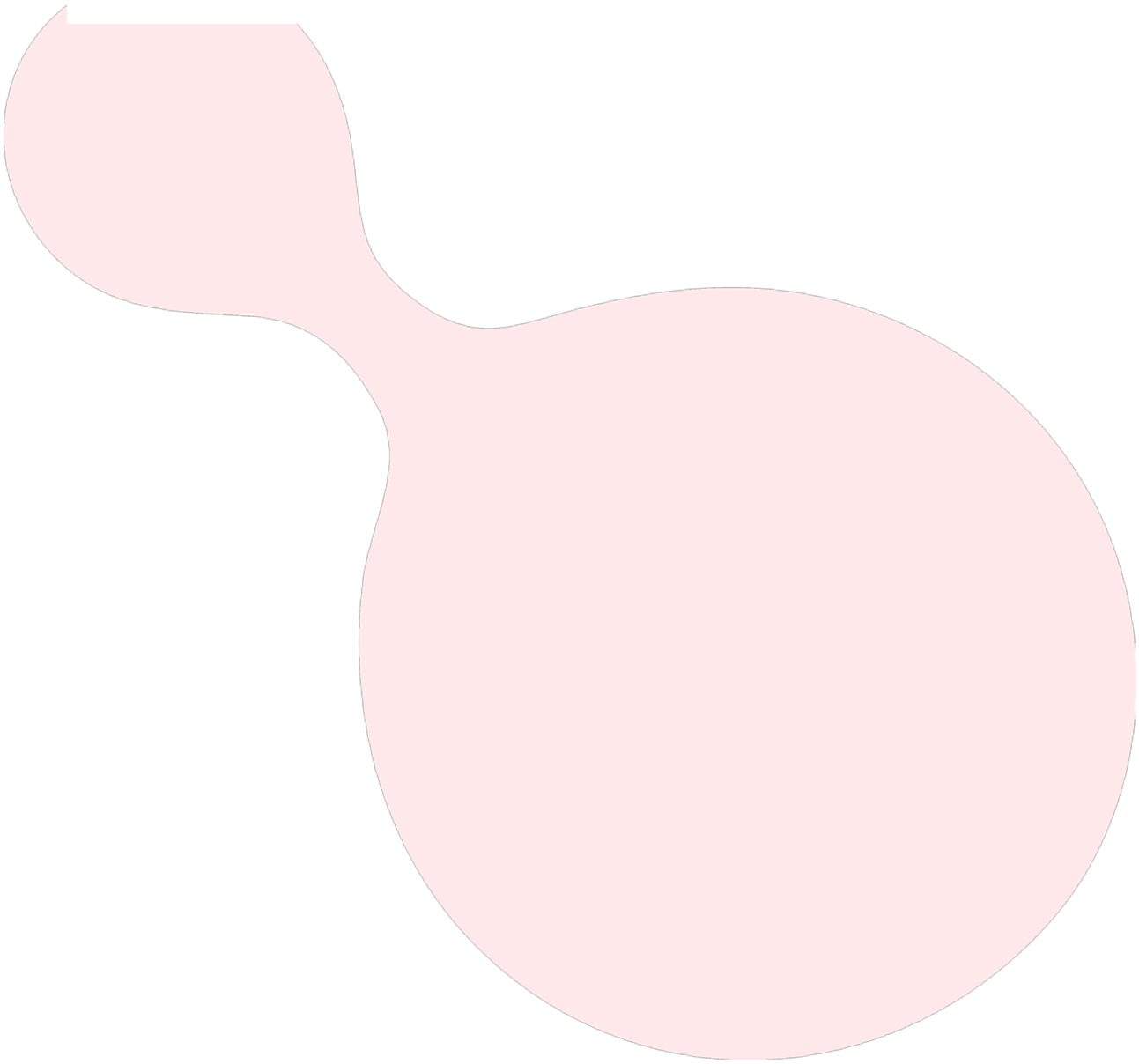
Considering:

Phase 1: Planning of change, is the designing phase of the program. The case for change is built, all aspects for the program are defined (intervention, scope, timeframe, resources, etc.), and support for the program needs to be gathered

Phase 2: Adaptation phase, in which the program is tested in a pilot implementation

Phase 3: Full scale implementation phase, final implementation of the program

Phase 4: Continuous improvement after deployment, once the program is implemented, outcomes are assessed and adaptations of the program may occur in order to improve their performance



5. How did you involve stakeholders in your programme? **(please select all that apply)**				
	Phase 1: Planning of change	Phase 2: Adaptation phase	Phase 3: Full scale implementation phase	Phase 4: Continuous improvement after deployment
Patients/Users	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder
Health professionals – primary care	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder
Health professionals – secondary care	1 – inform (give info) 2 – consult (ask for info)	1 – inform (give info) 2 – consult (ask for info)	1 – inform (give info) 2 – consult (ask for info)	1 – inform (give info) 2 – consult (ask for info)

	3 – collaborate (work with) 4 –Give responsibility to stakeholder	3 – collaborate (work with) 4 –Give responsibility to stakeholder	3 – collaborate (work with) 4 –Give responsibility to stakeholder	3 – collaborate (work with) 4 –Give responsibility to stakeholder
Health administrators	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder
Payers	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder
Politicians	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with)	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with)	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with)	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with)

	4 –Give responsibility to stakeholder	4 –Give responsibility to stakeholder	4 –Give responsibility to stakeholder	4 –Give responsibility to stakeholder
Private health providers	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder
ICT Industry	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder
Academy	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder

Other stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder	1 – inform (give info) 2 – consult (ask for info) 3 – collaborate (work with) 4 –Give responsibility to stakeholder

6. Has the programme performed a stakeholder commitment assessment prior to the beginning of the programme?
   - Yes
   - No

7. Have risk related to stakeholders commitment been analysed?
   - Yes
   - No
8. Have mitigating measures been adopted?
   - Yes
   - No

9. Has the programme an action plan oriented to maintain and increase stakeholders commitment?
   - Yes
   - No

10. Does the programme perform periodic assessments on the stakeholders management process?
    - Yes
    - No

Change Management

The survey is in three main sections. Section 1 collects the usual process and key elements you follow for change management in your programme. Section 2 collects in which areas and phases of change management is your programme at the moment. Finally, section 3 collects the main barriers faced for change management.

Section 1. CHANGE MANAGEMENT PROCESS AND KEY ELEMENTS FOR ADDRESSING IT

1. If any, which methodology for change management are you applying in your programme? Please give a short explanation.

1. Which elements of change management are you addressing? (select all that apply)

1. Culture. Analysis of the readiness to change and innovation culture.
2. Strategy/re-organization. Towards chronic care management and integrated care and implementation plans.
3. Leadership and guidance. Selection of leaders, type of leadership and sponsors of the changes.
4. Communications. Dissemination of the new strategy in the organization. Possibility of top-down and bottom-up initiatives.
5. Capabilities. Analysis of the new roles and capabilities required. Processing of old-role models.
6. Alignment. Availability of political, legal and organisational support/endorsement towards integrated care.

7. Financing and Incentives. Mechanisms to promote the change and overcome resistance

8. Monitoring. Availability of performance indicators related to integrated care in primary, secondary levels and programs.
9. Availability of public data.

3. Please describe how are you addressing the previously selected elements

Culture. Analysis of the readiness to change and innovation culture.

Strategy/re-organization. Towards chronic care management and integrated care and implementation plans.

Leadership and guidance. Selection of leaders, type of leadership and sponsors of the changes.

Communications. Dissemination of the new strategy in the organization. Possibility of top-down and bottom-up initiatives.

Capabilities. Analysis of the new roles and capabilities required. Processing of old-role models.

Alignment. Availability of political, legal and organisational support/endorsement towards integrated care? At which level?

Financing and Incentives. Mechanisms to promote the change and overcome resistance

Monitoring. Availability of performance indicators related to integrated care in primary, secondary levels and programs. Availability of public data.

Section 2. CHANGE MANAGEMENT AREAS AND PHASES

4. In which step are you in the process within the following integrated care areas? (select all that apply)

	Phase 1: Planning of change	Phase 2: Adaptation phase	Phase 3: Full scale implementation phase	Phase 4: Continuous improvement after deployment
a. Organisational models			X	
b. Workforce development			X	
c. Development of population stratification tools				
d. Integrated care pathways			X	
e. User involvement/Patient engagement			X	
f. Support of technology for the new care model			X	

Phase 1: Planning of change, is the designing phase of the program. The case for change is built, all aspects for the program are defined (intervention, scope, timeframe, resources, etc.), and support for the program needs to be gathered

Phase 2: Adaptation phase, in which the program is tested in a pilot implementation

Phase 3: Full scale implementation phase, final implementation of the program

Phase 4: Continuous improvement after deployment, once the program is implemented, outcomes are assessed and adaptations of the program may occur in order to improve their performance

Section 3: CHANGE MANAGEMENT BARRIERS AND MAIN TOOLS TO OVERCOME THEM

5. Please indicate barriers you have faced for change management (Please tick the appropriate box)

(Please rate the following aspects, where 10 means that it can block change and 0 is irrelevant or not applicable)

	Phase 1: Planning of change	Phase 2: Adaptation phase	Phase 3: Full scale implementation phase	Phase 4: Continuous improvement after deployment
a. Lack of time	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable
b. Pressure for short term results	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1

	0 – irrelevant /not applicable	0 – irrelevant /not applicable	0 – irrelevant /not applicable	0 – irrelevant /not applicable
c. Stakeholder resistance (specific stakeholder).	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable
d. Unstructured approach to change management	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable
e. Lack of recognition of need for change	10- essential (potentially can block change) 9	10- essential (potentially can block change) 9	10- essential (potentially can block change) 9 8	10- essential (potentially can block change) 9 8

	8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	7 6 5 4 3 2 1 0 – irrelevant /not applicable	7 6 5 4 3 2 1 0 – irrelevant /not applicable
f. Lack of leadership	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable
g. Lack of vision	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1

	0 – irrelevant /not applicable	0 – irrelevant /not applicable	0 – irrelevant /not applicable	0 – irrelevant /not applicable
h. Inadequate skills	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable
i. Inflexible Information technology	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable
j. Lack of funding	10- essential (potentially can block change) 9	10- essential (potentially can block change) 9	10- essential (potentially can block change) 9 8	10- essential (potentially can block change) 9 8

	8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	7 6 5 4 3 2 1 0 – irrelevant /not applicable	7 6 5 4 3 2 1 0 – irrelevant /not applicable
k. Lack of adequate incentive schemes for change	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable	10- essential (potentially can block change) 9 8 7 6 5 4 3 2 1 0 – irrelevant /not applicable

6. Strategies/tools that you are using/have used with success to overcome the above indicated barriers. Please explain why there were successful.

a. Lack of time

b. Pressure for short term results

c. Stakeholder resistance (specific stakeholder).

d. Unstructured approach to change management

e. Lack of recognition of need for change

f. Lack of leadership

g. Lack of vision

h. Inadequate skills

i. Inflexible Information technology

j. Lack of funding

k. Lack of adequate incentive schemes for change