JADE CARE

Joint action on implementation of digitally enabled integrated person-centred care

D3.3 FINAL EVALUATION REPORT

Aristotle University of Thessaloniki (AUTH)

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1.0	17/09/2023	Christina Plomariti, AUTH	First complete draft

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Table of abbreviations

Acronym	Description
AE	Affiliated Entity
AUTH	Aristotle University of Thessaloniki
CA	Competent Authority
CF	Core Feature
CFIR	Consolidated Framework for Implementation Research
DEIPCC	Digitally Enabled Integrated Person-Centred Care
EC	European Commission
EU	European Union
GA	Grant Agreement
GDPR	General Data Protection Regulation
ICT	Information and Communications Technology
JA	Joint Action
JADECARE	Joint Action on Digitally Enabled Integrated Person-Centred Care
KG	Kronikgune
KPI	Key Performance Indicator
LAP	Local Action Plan
LCF	Local Core Feature
LGP	Local Good Practice
NA	Next Adopter
NAWG	Next Adopters Working Group

NGO	Non-governmental organization
oGP	original Good Practice
PDSA	Plan-Do-Study-Act
QH	Quadruple Helix
RE-AIM	Reach Effectiveness Adoption Implementation Maintenance
SC	Steering Committee
SMART	Specific, Measurable, Attainable/Achievable, Realistic and Time Bound
SQUIRE 2.0	Revised Standards for Quality Improvement Reporting Excellence
tWP	transfer Work Package
WP	Work Package

1 Executive summary

The main aim of the JADECARE JA was to reinforce the capacity of health authorities to successfully address important aspects of health system transformation, in particular the transition to digitally enabled, integrated, person-centred care and support the best practice transfer from the systems of the "Early Adopters" to the ones of the "Next Adopters". The implementation of this Joint Action involved the transfer and adoption of four original Good Practices (oGP) to 21 Next Adopters (NA) accompanied by an internal evaluation of the final results, which are being presented in this report.

Based on a previous work of selection by the European Commission, four oGPs were selected to be transferred to other European Union countries concerning integration, chronic conditions, multimorbidities, frail people and patients with complex needs, self-care, prevention and population health, disease management and case management. JADECARE is focusing on the transfer and adoption of four oGPs: Basque Health strategy in ageing and chronicity: integrated care (Basque Country, Spain), Catalan open innovation hub on ICT-supported integrated care services for chronic patients (Catalonia, Spain), the OptiMedis Model-Population-based integrated care (Germany) and Digital roadmap towards an integrated health care sector (Southern Denmark Region). JADECARE involves partners from 16 countries all around Europe, providing a complete scenario of the idiosyncrasy and differences that can be found. The local context, maturity of integrated care models, legal frameworks, culture/values and relevant leaders are going to be considered for each of the 21 NAs.

The Final Report evaluates the last 18 months of JADECARE (from April 2022 to September 2023). The rest of the evaluation results are included in D3.2 Interim Evaluation Report, submitted in March 2022. The final evaluation findings, conclusions and recommendations are presented below. Work Package (WP) 3 prepared a methodological framework tailored for facilitating data collection included in D3.2. Here, a brief description of it is included (Section 2: JADECARE evaluation approach). The report is structured based on the adopted evaluation

framework. It first includes the overall process indicators and those indicators for evaluating the activities of the WPs during the period covered for the assessment (section 3: Project progress monitoring). Then, the document includes the systematic appraisal of the quality of the transfer and implementation process, evaluating and reporting the experience of NAs in adopting oGPs as well as the capacity of health authorities to organize and deliver digitally enabled, integrated, person centred care (section 4: Quality assurance of implementation). Later, it is assessed whether the project objectives have been achieved with regard to the delivery of outputs, to what extent the planned outcomes of JADECARE meet the needs of the project's target group and the process used to ensure that the project activities are implemented as intended (section 5: Impact Assessment).

The collection of the data analysed in this report lasted 18 months (M18-M36). A variety of data collection methods was used, and input was requested from all WP leaders. The overall participation of the consortium members was satisfactory, and the produced results reflect the high-quality work that was carried out in JADECARE.

2 Introduction

The ageing population, with the growing burden of chronic conditions and multimorbidity, is constantly increasing the demand for more efficient care and the delivery of smarter personalized care based on innovative solutions and health outcomes. Health systems seek to deliver digitally enabled integrated services that are person-centred, based on the needs of citizens. Within this context, JADECARE will contribute to innovative, efficient, and sustainable health systems through providing expertise and sharing good practices' solutions of Digitally Enabled Integrated Person-Centred Care (DEIPCC).

In general terms, JADECARE has two main objectives:

- To reinforce the capacity of health authorities to address all the important aspects of health system transformation successfully, in particular the transition to digitally enabled, integrated, person-centred care, and
- To support the best practice transfer from the systems of the "Early Adopters" to the "Next Adopters".

Specifically, JADECARE pretends to reinforce the capacity of care authorities to: support the change management and re-organization and pathways of care models, embed digital technologies and tools in the care services, rethink health workforce roles and skills with digital technologies, empower citizens and communities in active participation in healthcare, design new payment models and performance assessment methods.

In this context, the WP3 Evaluation aims to:

- Assess the quality and compliance of the project process and stakeholders' views inclusion and satisfaction.

- Perform a systematic appraisal of the quality of the transfer and implementation process, understanding, evaluating and reporting the experience of adopting oGPs in heterogeneous NA sites.
- Provide a methodological framework for assessing the different features of the oGPs adopted to cover the requirements and expectations.
- Evaluate the reinforcement of the capacity of health authorities to organise and deliver digitally enabled, integrated, person-centred care.
- Evaluate the transfer of the good practices (or their significant elements) from the oGPs to the NAs in terms of performance, acceptance, satisfaction and sustainability.

Three tasks will enable the achievement of the aforementioned objectives: T3.1 Project progress monitoring (to conduct a systematic assessment of the quality and compliance of the project progress and stakeholders' views on inclusion and satisfaction); T3.2 Quality assurance of implementation (to perform a systematic appraisal of the quality of the transfer and implementation process, adaptable to the different needs and maturity of the next adopters); and T3.3 Impact assessment (to measure the impact of the project). The Deliverable D3.1 Impact Assessment Plan mainly presents the description of the methodology to be used in each task, including a set of preliminary indicators. The D3.2 Interim Evaluation Report, based on the rationale of the previous deliverable, evolves and depicts the evaluation approach, and documents the project progress, implementation process and impact evaluation for the first half of the project. The D3.3 Final Evaluation Report includes the assessment of the whole project in terms of progress, quality and impact.

3 JADECARE evaluation approach

The JADECARE evaluation approach, based on the rationale presented in the *D3.1 Impact Assessment Plan*, provides a comprehensive and structured overview of the areas studied in the JA. This evaluation approach: (1) aligns the measurement of the JADECARE objectives according to the indicators defined in the WP3 tasks, avoiding redundancies and overlapping; (2) associates indicators with specific assessment level (Joint Action or Next Adopter level) and ensures all JADECARE dimensions are analysed in a robust and systematic way.

The JADECARE objectives have been translated into evaluation dimensions and are classified according to the application level:

At Joint Action level: Eight dimensions are defined to address several areas.

1. Digitally enabled integrated person-centred care
2. Capacity to deliver integrated person-centred care
3. Stakeholder network
4. Digital transformation of Next Adopters' regions
5. Sustainability of the practices
6. Quality of the transfer and implementation process
7. Knowledge and skills of transfer
8. Quality, compliance and usefulness

At Next Adopter level: Two general dimensions are defined with a set of sub-dimensions.

1. Transfer and Adoption process
    - Scope and degree of adoption of oGPs
    - Specific process, pathway reorganization and change management
    - Involvement and commitment of key stakeholders
    - Implementation experience
2. Digital transformation
    - Digital health system infrastructure
    - Risk stratification and data analytics
    - Use of technologies
    - Citizen empowerment and use of patient reported data
    - Innovation initiatives on integrated care reorganization of care pathways, workforce roles and skills
    - Training and research programs

The operationalizing of the evaluation framework consists in allocating indicators (process, output or outcome indicators) to each of the dimensions defined and according to the WP3 tasks. Overall, a total of 79 indicators have been constructed (re-defined from the preliminary proposal included in *D3.1 Impact Assessment Plan* or newly designed). As depicted in Figure 1, 24 out of 79 indicators are related to T3.1. "Project progress monitoring", 24 indicators to T3.2. "Quality assurance of implementation" and 34 to T3.3. "Impact assessment".

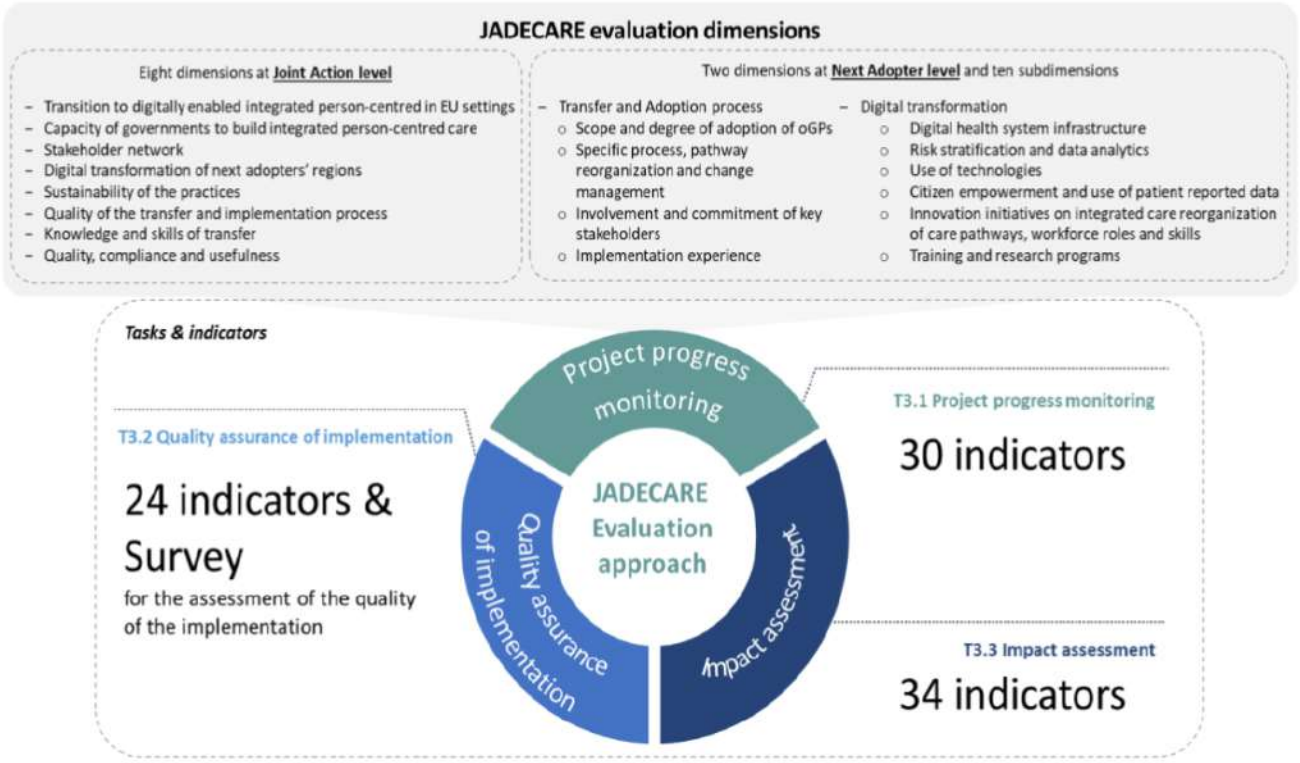


Figure 1: The JADECARE Evaluation approach

4 Project progress monitoring

4.1 Project Progress monitoring framework

The project progress monitoring of JADECARE provides a systematic assessment of the quality and compliance of the project process as well as stakeholders' views on inclusion and satisfaction through Task 3.1. This task oversees the establishment of the monitoring and internal evaluation plan, which is responsible for assessing the progress of the project. The main objectives of this task are: a) to verify the planned implementation of the project and the achievement of the objectives using a comprehensive approach with quantitative and qualitative methods and b) to provide key information to beneficiaries to correct the limitations detected and boost the strengths in the development of activities, helping to produce the most valuable outputs and outcomes.

The information in this chapter is organised in four sections. The first section explains the methodology designed for assessing the project progress monitoring. The second section presents the project progress monitoring indicators. The third part describes how the indicators were collected, mainly through conducting surveys and consulting documents or reports. Finally, in the fifth section, the results of the indicators are presented, analysed, and discussed.

4.2 Methodology

AQuAS designed a project progress monitoring framework to accomplish the objectives of Task 3.1, and more precisely, to evaluate:

- The achievement of the general objectives of the project, established in the Grant Agreement
- The evaluation of the objectives and individual actions of the Work Packages
- The accomplishment of the 33 milestones of the JA
- The submission of the 16 official deliverables of JADECARE
- The monitoring of the relevant meetings of the JA that include the annual meetings of the JA: Consortium Meeting, Stakeholder Forum, and Policy Board and the recurrent WP meetings.

The methodology used has taken into account the following considerations:

- Development or definition of Project Progress Monitoring indicators. Some of the project progress indicators were based on the Grant Agreement of JADECARE. For others, the Joint Action Chrodis Plus methodology has inspired their development, due to similarities between the two projects. During the process, AQuAS discussed proposed indicators with the coordinator of the JA, Kronikgune.
- Apart from the indicators, AQuAS compiled a list of specific objectives of the JA, milestones, and deliverables based on the Grant Agreement of November 2021, for their monitoring and assessment.
- Additionally, in February 2022, AQuAS decided to modify some indicators to avoid confusion and overlapping with other pieces of information collected in Task 3.3. Impact Assessment.

- For the definition of the completeness and acceptance criteria of the indicators, AQuAS agreed them with the leaders of each Work Package, considering the commitments of the Grant Agreement and being realistic with the development of the Project itself.
- WP3 is in charge of defining the evaluation criteria and compiling the indicators. The WPs are responsible for data collection and providing it to WP3, when asked so.
- The methodology used by AQuAS for collecting the indicators includes surveys (Consortium Meeting Satisfaction; project progress perception), input from reports, and information communicated by WP leaders.
- The WP3 is responsible for data analysis, sharing the results with the coordinator and WP leaders.

The complete list and information of project progress monitoring indicators is included in Annex 1 using the information included in ***¡Error! No se encuentra el origen de la referencia.*** presented in the previous *JADECARE evaluation approach.)*

AQuAS built all the indicators following the SMART-RACER methodological basis. These principles mean that they must follow SMART monitoring objectives and describe them in a RACER manner. In detail, that means the related goals are:

SMART

- Specific-Strategic: it is directed to a task or activity with a scientific interest and improvement of the Project,
- Measurable: the objective is quantifiable or can be described qualitatively in a way that can be acceptably predefined
- Assignable: the person in charge is clearly established,
- Realistic: results can be realistically achieved given the available resources
- Time-related: results are expected to be achieved in a specific time frame

and that the indicators are:

RACER

- Relevant: closely linked to the objectives to be achieved
- Acceptable: by those responsible for each indicator (general work package or task leaders), by the European Commission, and by the report's users. Indeed, they must be comprehensive for citizens and professionals.
- Credible: unequivocal, transparent, repeatable, and easy to interpret.
- Easy: data collection must be possible at a reasonable cost (available, feasible)
- Robust: attempts to avoid manipulation considering aspects such as sensitivity, quality, consistency, comparability.

In the case of objectives, milestones, and deliverables, the following information has been compiled for each of them:

[NAME of Objective/Deliverable/Milestone]		Due	[Month XX]	Achieved	[Y/N]
% Achieved	Means of verification	Deviations (if any)	Reasons for deviation	Corrective actions	
[X%]					
Main barriers:					
Main facilitators:					

Table 1: Description of objectives, milestones and deliverables

4.3 Project progress monitoring indicators

Following the JADECARE Evaluation approach, all the project progress monitoring indicators address aspects at the Joint Action level, not at the Next Adopter level.

4.3.1 Join Action level indicators

Table 2: Project progress monitoring indicators at Joint Action level

WP	Indicator		Dimension	Responsible	Data collection
1	M1.1	Perception of WP leader of Coordinator's support	Quality, compliance and usefulness	WP3	M24, M36
	M1.2	Ratio of milestones achieved on time	Quality, compliance and usefulness	WP1	M18, M36
	M1.3	Ratio of deliverables submitted to the EC on time	Quality, compliance and usefulness	WP1	M18, M36
	M1.4	Availability of a project handbook in the first year of the project	Quality, compliance and usefulness	WP1	M12/M18
	M1.5	HaDEA's participation in annual meetings	Capacity of governments to build integrated person-centred care	WP1	M12, M24, M36
	M1.6	Number of Steering Committee meetings celebrated per year	Quality, compliance and usefulness	WP1	M12, M24, M36

2	M2.1	Number of documents published on the website	Stakeholder network	WP2	M18, M36
	M2.2	Number of presentations at scientific and policy discussion events	Stakeholder network	WP2	M36
3	M3.1	Availability of an assessment methodology	Quality of the transfer and implementation process	WP3	M18 (completed by M12)
	M3.2	Degree of satisfaction of partners with the project progress	Quality, compliance and usefulness	WP3	M12, M24, M36
4	M4.1	Number of study visits	Knowledge and skills of transfer	WP4	M18
	M4.2	Number of thematic workshops	Knowledge and skills of transfer	WP4	M24
	M4.3	Number of workshops on implementation key learnings	Knowledge and skills of transfer	WP4	M34
	M4.4	Number of professionals participating in knowledge exchange actions	Knowledge and skills of transfer	WP4	M36
	M4.5	Satisfaction with knowledge exchange actions	Knowledge and skills of transfer	WP3	M36
	M4.6	Number of Local Action Plans including elements of sustainability	Sustainability of the practices	WP4	M36
	M4.7	Establishment of local/regional/national networks at Next Adopter level including key stakeholders to ensure sustainability	Sustainability of the practices	WP4	M36
	M4.8	Number of sustainability strategies at Next Adopter level	Sustainability of the practices	WP4	M36
5-8	M5.1 M6.1 M7.1 M8.1	Completed scope definition, situation analysis and PDSA cycle performed on schedule	Quality of the transfer and implementation process	WP5-8 Next Adopters	M12, M28

	M5.2 M6.2 M7.2 M8.2	Number of Next Adopters Good Practices and Action Plans	Quality of the transfer and implementation process	WP5-8 Next Adopters	M15
	M5.3 M6.3 M7.3 M8.3	Specific objectives regarding digital transformation are set in Next Adopters Action Plans	Digital transformation of next adopters' regions	WP3	M18

4.4 Collection of Indicators

This section briefly addresses the primary data sources and the instruments used to collect the indicators.

Regarding the information sources, the following ones have mainly been used:

1) The entity responsible for data collection. This information is available in the indicator chart and comes from the Grant Agreement.
2) All the project documents such as reports, deliverables, minutes, and other documents mainly available on JADECARE's Sharepoint.
3) Grant Agreement consultations to clarify doubts and responsibilities to collect the information.
4) Communication with the JA Coordinator (Kronikgune) and the WP3 leader (AUTH).

Information instruments are:

1) Online surveys aimed at both the general public (participants in the Consortium Meeting, for example) and other surveys aimed at more specific groups (for example, next adopters).
2) Consultations, interviews, and meetings with the WP leaders to collect data and internal documentation in the project's Sharepoint.
3) Focus group (this technique allowed to discuss and reach a consensus on the acceptance and completeness criteria by the WP5-8).
4) Participant observation in meetings and own notes.

4.5 Results of project progress monitoring assessment

4.5.1 Assessment of specific objectives of the project

The Grant Agreement outlines 36 specific objectives aimed at assessing project progress. In the interim evaluation report (Section 3.2), data for six indicators were collected by the end of month 18. By month 36, an additional 10 indicators were collected, while the remaining 20 specific indicators pertain to the impact assessment phase. In terms of satisfaction with the project's progress, the output received a rating of 4.3 out of 5 points, equivalent to 86%.

GA Specific Objective	GA Specific Indicator	Target value	Real output
2.JADECARE is useful for governments´ commitment to support for further building the capacity to deliver integrated person-centered care	Number of DG Sante and HaDEA representatives	2	2
3.To create a community of stakeholders that includes caregivers, healthcare experts, academia, industry, policy makers and /or general public	Number of presentations at scientific and policy discussion events	>40	55
4.To improve next adopters´ digital transformation	Establishment of specific objectives regarding digital transformation are set in next adopters Action Plans	23	23 (100%)
5.To support next adopters in facilitating the sustainability of the practice with plans for actions at local/regional/national level plans	Sustainability strategy and action plan of next adopters' practices	23	20/20 (100%)
5.To support next adopters in facilitating the sustainability of the practice with plans for actions at local/regional/national level	Elements of sustainability are addressed in all individual implementation action plans	23	17/21 (81%)
7.To improve knowledge and skills of transfer methodologies and tools	Satisfaction with knowledge exchange actions	80%	4,47/5 (89%)
7.To improve knowledge and skills of transfer methodologies and tools	Number of professionals participating in different knowledge exchange actions	200	Study visits (646); Thematic workshops (438); implementation key learning workshops (94)
7.To improve knowledge and skills of transfer methodologies and tools	Number of study visits	4	4
8.Quality, compliance and usefulness	% surveys completed (acceptance rate & perceived usefulness)	80%	Not applicable (NA)
8.Quality, compliance and usefulness	Satisfaction with the project progress	80%	86%

Table 3: GA Specific Indicators collected by month 36

4.5.2 Assessment of Project progress monitoring indicators

All the Project progress monitoring indicators for month 18 were collected and successfully achieved, meaning that they have reached at least the acceptance criteria (See Annex 1: Implementation process analysis) For complete detail about these indicator see deliverable D3.2 *Interim Evaluation Report*.

As for the monitoring indicators of WP1, all the indicators have achieved the defined completeness criteria.

WP	Indicator		Outcome	Achieved	Unachieved
1	M1.1	Perception of WP leader of Coordinator's support	4,6	•	
	M1.2	Ratio of milestones achieved on time (until M34)	100%	•	
	M1.3	Ratio of Deliverables submitted to the EC on time (until M34)	100%	•	
	M1.5	HaDEA's participation in annual meetings	100%	•	
	M1.6	Number of Steering Committee meetings celebrated per year	50	•	

Table 4: Progress indicators of WP1

Concerning the monitoring indicators of WP2, the indicator M2.1 has achieved the maximum level based on the completion criteria.

WP	Indicator		Outcome	Achieved	Unachieved
2	M2.1	Number of the documents published at website	7	•	
	M2.2	Number of presentations at scientific and policy discussion events	55	•	

Table 5: Progress indicators of WP2

Regarding WP3 indicators, the indicators M3.1 and M3.2 have achieved completion criteria.

WP	Indicator		Outcome	Achieved	Unachieved
3	M3.2	Degree of satisfaction of partners with the project progress	4,3/ 5	•	

Table 6: Progress indicators of WP3

With WP4 indicators, the M4.1 indicator has achieved the completion criteria. The other indicators will be collected and analysed for the final evaluation report (M36).

WP	Indicator		Outcome	Achieved	Unachieved
4	M4.2	Number of Number Thematic workshops	10	•	
	M4.3	Number of workshops on implementation key learnings	4	•	
	M4.4	Number of participants taking part in knowledge exchange actions[1]	1.178		
		Thematic Workshops	438[2]		
		Final Workshops	94		
		Study visits	646		
	M4.5	Satisfaction with knowledge exchange actions	4,47		
		Thematic Workshops	4,53/5		
		Final Workshops	4,9/5		
		Study visits	4/5		
	M4.6	Ratio of local action plans including elements of sustainability	17/21		•
	M4.7	Establishment of local/regional/national networks at Next Adopter level including key stakeholders to ensure sustainability	19[3]		•
	M4.8	Ratio of sustainability strategies at Next Adopter level	20/20[4]		•

Table 7: Progress indicators of WP4

WP	Indicator		Outcome	Achieved	Unachieved
5	M5.1	Completed Scope definition, situation analysis and PDSA cycle performed on schedule	100%	•	

[1] Cumulate result from all the study visits.
[2] WP4 - TASK 4.2 Report on thematic workshops pp. 16 of 162.
[3] Number of countries represented.
[4] Considering 20 active NAs during the complete implementation process. (MoHRS was not active in the project after December 2022)

6	M6.1	Completed Scope definition, situation analysis and PDSA cycle performed on schedule	72%	•	
7	M7.1	Completed Scope definition, situation analysis and PDSA cycle performed on schedule	100%	•	
8	M8.1	Completed Scope definition, situation analysis and PDSA cycle performed on schedule	100%	•	

Table 8: Progress indicators of WP5-WP8

4.5.3 Assessment of project milestones

From the total of 33 milestones defined in the GA, 4 had their deadline between month 18 and 36 and are gathered below. All the milestones defined in the Grant Agreement have been accomplished.

4.5.3.1 WP1

MI2 Periodic technical and financial report			**Due**	M18 – Mar 22	**Achieved**	31/03/2022
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100%	Periodic technical and financial report	Submitted on time, no deviations	None		Not necessary	
Main barriers:	The unresponsiveness of some Consortium partners.					
Main facilitators:	The cooperation of most of the Consortium partners to compile the information needed, and their responsiveness to respond to enquiries.					

MI3 Final technical and financial report			**Due**	M36 – Sept 23	**Achieved**	Ongoing
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100%	Final technical and financial report	Submitted on time, no deviations	None		Not necessary	
Main barriers:						
Main facilitators:						

Table 9: Milestones of WP1

4.5.3.2 WP2

MI7 Mid-term report on dissemination			**Due**	M18 – March 23	**Achieved**	Ongoing
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100%	Mid-term report on dissemination	None	None		Not necessary	
Main barriers:						
Main facilitators:						

MI8 Final Conference			**Due**	M36 – Sept 23	**Achieved**	Ongoing
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100%	Final conference of the project	None	None		Not necessary	
Main barriers:	The main barrier was the price to perform the Final conference during the European Health Forum Gastein, but this could be solved					
Main facilitators:	The high visibility and ongoing support of the JADECARE project also with politically relevant Stakeholders					

Table 10: Milestones of WP2

4.5.3.3 WP4

MI17 Summary report from meetings of Policy Board			**Due**	M36 – Sept 23	**Achieved**	Ongoing
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100%	Summary report from meetings of policy board	None	None		Not necessary	
Main barriers:						

Main facilitators:	

Table 11: Milestones of WP4

4.5.4 Assessment of project Deliverables

Regarding the deliverables, nine deliverables had to be submitted between month 18 and month 36. 100% of the deliverables were submitted on time.

4.5.4.1 WP2

D2.4 Final Report on dissemination			**Due**	M36-Sept 23	**Achieved**	**Ongoing**
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**		
100%	Report	None	None	Not necessary		
Main barriers:	At the end of the 3-years-project the WP2 has to fulfill many tasks in parallel.					
Main facilitators:	The dedicated work of the whole WP2 Team to gather all information into one consecutive document on time.					

D2.5 Layman of the Final Report			**Due**	M36-Sept 23	**Achieved**	**Ongoing**
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**		
100%	Report	None	None	Not necessary		
Main barriers:	Time constraints for accumulation of the events in the last period.					
Main facilitators:	Great dedication of the WP2 members.					

Table 12: Deliverables of WP2

4.5.4.2 WP3

D3.3 Final Evaluation Report			**Due**	M36-Sept 23	**Achieved**	**Ongoing**
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100%	Report	None	None		Not necessary	
Main barriers:	Low participation in surveys. Need to send reminders to partners all the time.					
Main facilitators:	WP3 team members, cooperation through preparatory work to define frameworks and indicators.					

Table 13: Deliverables of WP3

4.5.4.3 WP4

D4.2 Blueprint on learning from Good Practices			**Due**	M35 – Aug 23	**Achieved**	30/08/2023
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**		
100%	Report	Submitted on time, no deviations	None	None		
Main barriers:						
Main facilitators:						

D4.3 Characteristics of JADECARE practices, leading to sustainability and integration in national policies		**Due**	M36 – Sept 23	**Achieved**	Sept 23
Means of verification	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**		
100%	-	-	-		
Main barriers:					
Main facilitators:					

Table 14: Deliverables of WP4

4.5.4.4 WP5

D5.1 The Basque integrated care approach original Good Practice and transfer process			**Due**	M30 – March 23	**Achieved**	March 23
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**		
100 %	Available report	The information of all NAs was perfectly completed. Only one Next Adopter's documentation for a phase is missing in the Annex document.	The Next Adopters of Serbia (MoHRS) lost contact with the project in	Continuous attempts of contact from KG with MoHRS from December 2022 to September 2023; HaDEA properly informed		

			November 2022	
Main barriers:	loss of contact with the NAs of MoHRS			
Main facilitators:	engagement of NAs to complete all templates and send all reports to WP leaders			

Table 15: Deliverables of WP5

4.5.4.5 WP6

D6.1 The Catalan Innovation Hub original Good Practice and transfer process		**Due**	M30 – March 23	**Achieved**	March 23
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**	
100 %	Available report We shaped the verification plan according to the characteristics of each site. In summary, the bilateral meetings, the reporting and the visits during the Thematic Workshops, also the visits of some NA to Barcelona were an adequate way to verify the progress.	Deviations have been reported in detail in the revised version of D6.1 and also in the summary report of WP6 delivered to WP4. In summary: Estonia and Marche did not show deviations, Hungary did an excellent progress throughout the project. The site has high potential for generating a success story, but did not reach a scalable implementation during JADECARE lifetime. The strategy for the future has been formulated and it is feasible. Napoli reported substantial work but they did not show a collaborative approach and the quality of	- Hungary: They showed a reasonably good learning process to the extent that a scalable implementation strategy was formulated in Summer 2022 requiring a reformulation of the Next Adopter Working Group (NAWG) involving additional stakeholders. The process can be completed during 2023. A future hands on visit to Barcelona has	Hungary: Action has been taken and future plans seem to be in place. As indicated on the left Napoli: No corrective actions planned	

		achievements was not verifiable.	been considered Napoli Nord – Language limitations and busy agenda of the NAWG limited the interactions within WP6	
Main barriers:				
Main facilitators:				

Table 16: Deliverables of WP6

4.5.4.6 WP7

D7.1 The Optimedis Model original Good Practice and transfer process		**Due**	M30 – March 23	**Achieved**	March 23
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**	**Corrective actions**	
100 %	Available report	Implementation in some NA projects is slow/some NAs could not complete it within the implementation phase.	Coronavirus / Very ambitious programme	No particular measures planned. Different paths: Some NAs decided to do it as parts of the sustainability initiatives or of a larger initiative that continues after the implementation.	
Main barriers:	In general Corona impacted on everyone and original local collaboration structures did partly not materialize. For most partners, the implementation period was considered too short. Some NAs did maintain what was planned from PDSA1 to PDSA2, others adapted their plans according to their situation (EUSTRAS, Belgium).				

Main facilitators:	Some NAs did maintain what was planned from PDSA1 to PDSA2, others adapted their plans according to their situation (EUSTRAS, Belgium).

Table 17: Deliverables of WP7

4.5.4.7 WP8

D8.1 The Danish roadmap towards Integrated Care original Good Practice and transfer process			**Due**	M30 – March 23	**Achieved**	March 23
% Achieved	**Means of verification**	**Deviations (if any)**	**Reasons for deviation**		**Corrective actions**	
100 %	Available report	Implementation in some NA projects is slow/some NAs could not complet it within the implementation phase.	Coronavirus, very ambitious programme, bottlenecks in local IT department, recruitment problems		Different measures for different problems. Carryover of tasks from PSDA 1 to PSDA 2 and into the sustainability part of JADECARE.	
Main barriers:	In general, Corona influenced working methods, workflow and also the recruitment of HCPs and other key personnel to participate in the project and pilot. For most partners, the implementation period was considered too short, with not enough time in between the PSDA 1, PSDA 2 and the Sustainability report. Many of the projects experienced external bottlenecks with wait time, which stopped momentum and delayed some of the projects.					
Main facilitators:	Structured framework and JA, which facilitated relevant knowledge sharing across countries. Enthusiastic NAs who were willing to be flexible and think about solutions on the fly. The willingness to adapt was a key facilitator.					

Table 18: Deliverables of WP8

4.5.5 Meetings Indicators

Meetings are a crucial part of project development and management, and their monitoring can provide valuable information about the project's performance.

The following information was collected by the WP leader.

- Frequency of meetings (number of meetings)
- Attendance
- Duration of the session
- Minutes of the session delivered

When collecting the data related to the leading WPs, the analysis generally shows the WPs meet regularly: once or twice a month. The meetings last for at least 30 minutes and the participation is higher than 70%. As points for improvement, it might be a good idea that WP6 and WP8 organize and take notes more systematically and constantly on the data related to the meetings.

4.5.5.1 WP1

Consortium Meeting	**Freq.**	Annually First meeting: 26 and 27th October 2021
Attendance	Second Consortium Meeting • Day 1, 26th October 2022: 94 participants: 49 onsite + 45 online • Day 2, 27th October 2022: 77 participants: 48 onsite + 29 online Total: 99 total participants (Attendees + Panellists) as a sum of Day 1 and Day 2 Third Consortium Meeting • 26th September 2023: 65 participants	
Report of the session delivered?	Yes	
Satisfaction from participants	• Overall satisfaction: **4,5 out of 5** • The appropriateness of the agenda (time slots, content, etc): **4,4 out of 5** • Facilitation 4,4 • Networking time 4,42 • Time for questions 4,47 • Schedule (timing of sessions...) 4,5 • Take home resources 4,3 • Shared presentations 4,41 • Aspects that worked the best: **Organization and management of the event** • Aspects that may improve: **Microphone (for better audio)**	

Steering Committee Meetings	**Freq.**	Biweekly (55 meetings)
Attendance	% of WP leaders that attended. Average = 89,6 % of the attendance • WP1 = 100% • WP2 = 70% • WP3= 90% • WP4= 97% • WP5= 100% • WP6 = 10%%	

	• WP7= 87% • WP8 = 74%
Duration of the session	Between 60 and 90 minutes
Minutes of the session delivered?	Yes

WP1 regular meetings		**Freq.**	Weekly (75 meetings)
Attendance	100% of WP leaders attended		
Duration of the session	60 minutes/meeting		
Minutes of the session delivered?	No		

Table 19: WP1 organised meetings

4.5.5.2 WP2

Stakeholder Forum	**Freq.**	Annually Second meeting: 23rd November 2022
Attendance[5]	• 75 people • 60 organizations	
Duration of the session	1 day	
Minutes of the session delivered?	Yes	

WP2 regular meetings	**Freq.**	Biweekly (17 meetings) Other task related meetings when it is needed
Attendance	100% of WP leaders attended	
Duration of the session	60-75 minutes/ meeting	
Minutes of the session delivered?	Yes, every following week of the meeting	

Table 20: WP2 organised meetings

4.5.5.3 WP3

WP3 regular meetings	**Freq.**	Bi-weekly
Attendance	100% of WP leaders attended	

[5] Minutes of 2nd JADECARE Stakeholder Forum.

Duration of the session	30 minutes
Minutes of the session delivered?	Yes, kept by AUTH

Table 21: WP3 organised meetings

4.5.5.4 WP4

Policy Board		**Date**	Annually Second meeting: 17th November 2022
Attendance	47 people attended the second meeting		
Duration of the session	1 day		
Minutes of the session delivered?	Yes		

WP4 regular meetings		**Freq.**	Biweekly (32 meetings)
Attendance	100% of WP leaders attended		
Duration of the session	45 minutes/ meeting		
Minutes of the session delivered?	Yes, every following week of the meeting		

Table 22: WP4 organised meetings

4.5.5.5 WP5

WP5 regular meetings		**Freq.**	Monthly (12 meetings)
Attendance	• 100% of WP leaders attended • 79,98% of NAs attendance (without considering the NAs that withdrew WP5 at different moments of the project		
Duration of the session	60 minutes/ meeting		
Minutes of the session delivered?	Yes, every following week of the meeting		

Table 23: WP5 organised meetings

4.5.5.6 WP6

WP6 regular meetings		**Freq.**	On demand
Attendance	All agreed meetings had good attendance. As indicated, Napoli had some problems in terms of scheduling meetings		

Duration of the session	On average one hour duration for each meeting, except for specific events (Study visits, Thematic workshops, Key learning workshops)
Minutes of the session delivered?	Yes

Table 24: WP6 organised meetings

4.5.5.7 WP7

WP7 regular meetings		**Freq.**	Monthly
Attendance	• 90% of WP leaders attended • 75% of NAs attended		
Duration of the session	60 minutes/ meeting		
Minutes of the session delivered?	Yes, but 6 out of 21 minutes available. But 17 meetings recorded.		

Table 25: WP7 organised meetings

4.5.5.8 WP8

Table 26: WP8 organised meetings

WP8 regular meetings		**Freq.**	On demand (26 meetings since 01/06/2022)
Attendance	26 meetings with 8 NAs		
Duration of the session	60 minutes/ meeting		
Minutes of the session delivered?	No		

5 Quality assurance of implementation

The quality assurance of implementation is one of the three pillars of the JADECARE evaluation approach. It consists of the development and application of an implementation strategy presented in *D3.1 Impact Assessment Plan*, and the evaluation of the quality of the implementation.

The three-phase **JADECARE implementation strategy** includes a series of methods and techniques, concrete procedures and recommendations. It was designed to enhance the probability of the adoption and sustainability of JADECARE Local Good Practices, considering the particular needs, interest, possibilities and expectations of NAs by providing specific support, documentation, tools and guidance.

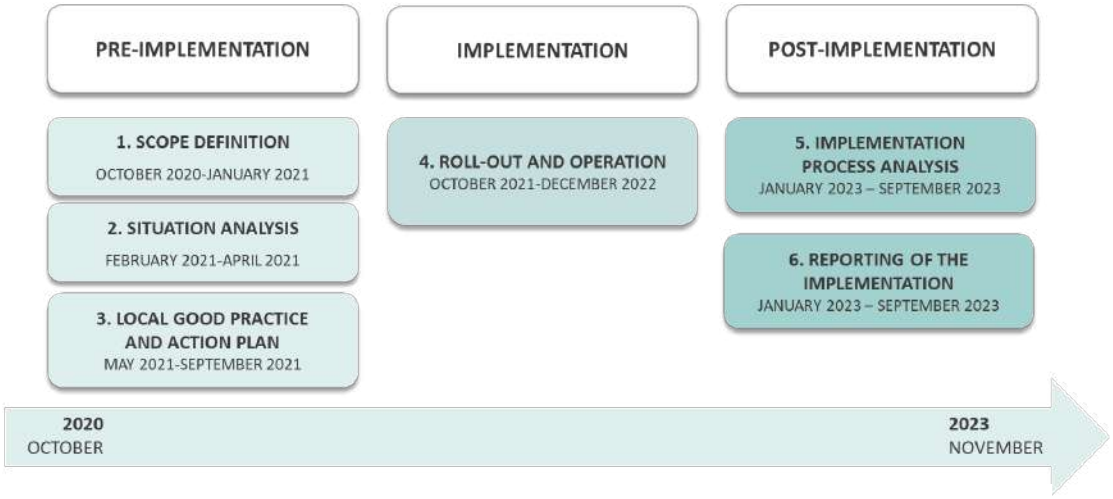


Figure 2: JADECARE Implementation strategy

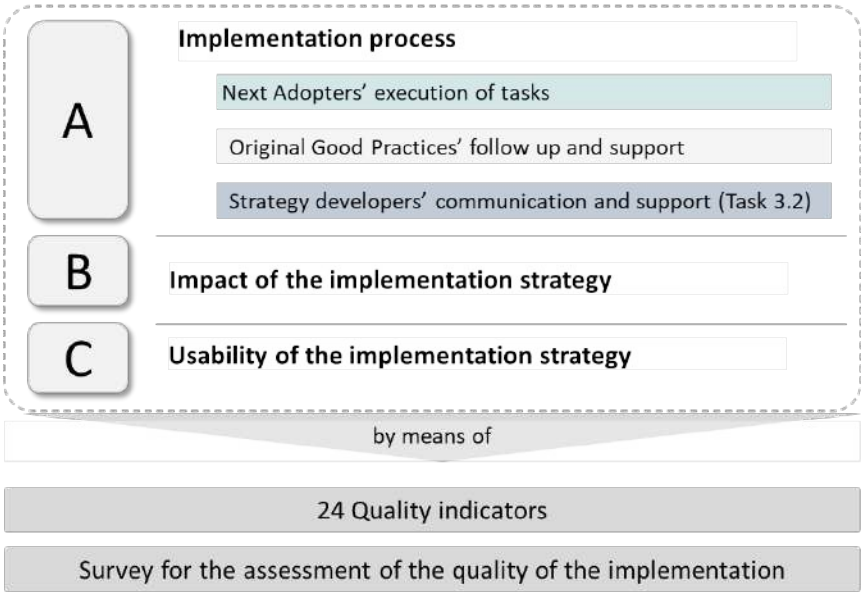


Figure 3: Evaluation of the quality of the implementation

The **evaluation of the quality of implementation** has been assessed by exploring three domains with a mixed approach as shown in the figure below. (Please, see complete detail in *D3.2 Periodic Evaluation Report*)

This section of the document presents:

- The results of **Implementation process analysis**. In this phase of the post-implementation aspects that determined the implementation success of the NAs have been specified, analysed and reported.

  Note: The results of the Reporting of the implementation are included in Deliverables 5.1, 6.1, 7.1 and 8.1.

- **Final evaluation of the quality of implementation**: divided in two sections:
  - Evaluation of the Next Adopters' execution of tasks
  - Assessment of the implementation strategy: consisting on the assessment of the original Good Practices' follow up and support, the strategy developers' communication and support and the impact and usability of the implementation strategy

5.1 Implementation process analysis

5.1.1 Methodology

In JADECARE, the implementation process analysis aimed to study the factors that might have influenced (positively or negatively) the implementation of the Local Good Practices (LGP) of the NAs by means of the Consolidated Framework for Implementation Research (CFIR). The CFIR comprises of five major domains and 39 constructs that provide a complete framework for this analysis. For the analysis, a mixed-methods approach has been employed by means of two activities: CFIR survey and CFIR Focus Groups. (Please, see complete detail in Annex 1: Implementation process).

Initially, the CFIR survey evaluated the perception of the NAs about:

- The relevance of each construct in a scale of 10 points where: 0 = not relevant at all and 10 = very relevant. For this purpose, relevance is defined as: How significant, valued, or necessary the variable has been in the Local Good Practice implementation.
- The positive or negative influence of each construct in a 5 points Likert Scale: Very negative (--) /Negative (-)/Neutral (n) /Positive (+)/Very positive (++).

Later, the CFIR Focus Group deepened in the five constructs that each NA ranked with the higher relevance in the CFIR Survey by means of three questions:

QUESTION		*RATIONALE*
1.	Why have you considered the construct of high relevance for your implementation process? Provide specific reasons for the consideration of the construct as highly relevant	*The participants are encouraged to extend the explanation given in the CFIR Survey for rating the relevance of the selected construct*

2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	*The participants are encouraged to reflect about their attitude and reaction towards the effect of the variables during their implementation process.*
3.	If you started again the implementation process, what would you do differently?	*The participants are encouraged to comment on a specific aspect that they would modify if they could repeat their implementation process*

5.1.2 Results

The CFIR survey was responded by 20 NAs while the CFIR Focus Group was accomplished by 19 out of the 21 NAs.

The NAs summarized their experience during the implementation process as follows:

Most of the NAs considered the implementation experience very challenging and complex, at the same time exciting. Moreover, they think that it fostered the cooperation, innovation and learning among those involved.

The responses to the CFIR Survey and Focus Groups have been jointly analysed and are shown below. The results are presented for each of the five domains of the CFIR: (i) characteristics of the intervention, (ii) inner setting, (iii) outer setting, (iv) the individuals involved, and (v) the process by which implementation is accomplished.

For each domain a summary table containing the information about the relevance and influence of the constructs for each NA has been prepared. Moreover, the information about the constructs that were selected to be analysed in more depth in the CFIR Focus Group is presented. Later, the justification of this assessment is presented

supported by the conclusions of the first two questions of the CFIR Focus Group. Finally, the responses to the last question of the CFIR Focus Groups are analysed and presented.

5.1.2.1 Characteristics of the intervention

Construct \ Next Adopter	ACSS	ARSTuscany	ASLNapoli	AUTH	CCUH	CIPH	CSCJA & FPS	EUSTRAS	IDIVAL & SCS	JFDPK	LOMBARDIA	MARCHE	RND	SACYL	SELBM	SMS & FFIS	UHO	USLUmbria	VH	ZZZS
1.1 Intervention Source	+	++	+	+	n	++	n	++	++	+	n.a.	+	++	+	-	+	+	+	-	+
1.2 Evidence Strength & Quality	++	-	+	++	++	++	+	++	++	++	+	++	-	++	+	+	+	n	++	+
1.3 Relative Advantage	++	-	+	-	+	n	+	+	++	+	n.a.	++	n	++	n	++	n	++	++	+
1.4 Adaptability	+	+	++	+	+	++	+	++	++	n	+	++	+	++	-	++	+	++	+	++
1.5 Trialability	+	+	++	+	++	+	+	++	++	+	++	++	++	++	++	+	++	n	+	n
1.6 Complexity	-	-	+	++	+	-	-	n.a.	++	++	-	-	-	++	--	+	-	+	+	-
1.7 Design Quality & Packaging	+	n	+	+	-	+	n	-	n	n	n	+	+	+	n	+	n	++	++	+
1.8 Cost	-	+	++	n	+	--	+	--	++	n	n.d	-	n	++	+	++	++	++	++	-

Relevance. Red: 0-4; Yellow: 5-7; Green: 8-9; Dark green: 10

Influence. --: very negative; -: negative; n: neutral; +: positive; ++: very positive; n/a: not available

Bold square: construct selected to be analysed in the CFIR Focus Group

The "Characteristics of the intervention" were considered very relevant in the implementation process of the NAs as all the constructs, except the "Design quality and packaging", were ranked with more than eight points by at least 60% of the NAs. Among them, the most relevant construct was the "Evidence strength and quality" that 75% of the NAs ranked between eight and ten points. It must also be highlighted that 35% of the NAs considered "Costs" as an extremely relevant aspect, thus, ranking it with 10 points. On the other hand, the constructs "Intervention source" and "Design quality and packaging" were considered extremely relevant (ten points) only by one NA.

When looking at the influence, it must be firstly noted that the most negative influence (- -) was very rarely perceived by NAs, as only one NA marked as so "Complexity" and two NAs "Cost". On the other hand, "Adaptability" and "Trialability" were considered the most positively influencing constructs (marked with + or ++ by 90% of the NAs), followed by "Evidence quality and strength" that was marked with + or ++ by 85% of the NAs. Moreover, "Trialability" was never considered having a negative nor very negative influence.

Finally, the constructs of this domain were selected to be deeply analysed in the CFIR Focus Group in average three times, excluding "Design quality and packaging" that was not selected by any of the NAs.

INTERVENTION SOURCE

Perception of key stakeholders about whether the intervention is externally or internally developed.

The two NAs who chose this construct agreed that having information from interventions in other countries has been an useful source of learning for their own implementation processes. These learnings have been applied to develop strategies to keep practitioners motivated and responsive to their needs. Moreover, the source of the intervention is important for engaging practitioners, whether it is public or private, internal or external.

"JADECARE has provided resources on how to motivate doctors".	*"Stepping completely out of your own context gives something special. It is very interesting to see other countries using their data".*	*"Where the initial appeal comes from is important and has a significant impact on whether staff are inclined to follow or stay with the original processes".*

Two strategies were effective to enhance the positive effect of this constructs: on the one hand, a good level of communication with the professionals, which helps to keep them involved in the process; and on the other hand, the fact that the system to be implemented was simple.

"We were listened to, I was involved in the process from the beginning, I felt that my needs were perceived and how I could improve my work with clients".

EVIDENCE STRENGTH & QUALITY

Stakeholders' perceptions of the quality and validity of evidence supporting the belief that the intervention will have desired outcomes.

Providing evidence to the stakeholders about the practice to be transferred is essential, largely because it is the basis for convincing them, not only about the quality of the good practice but also about its feasibility. Existing evidence provides information that gives a better understanding of what an implementation process entails. However, specific implementation plans have had to be developed to overcome the barriers identified by some practitioners.

The telemedicine good practice implemented by one of the NAs, for example, was evaluated very positively; considering that's it facilitates continuity of care, accessibility to patients, as well as more efficient management of their acute episodes.

"Telemedicine ensures greater continuity of care and strengthens the therapeutic alliance between the patient and the physician".	*"Actually it was very easy to convince others as we said to them that it is broadly used abroad, the evidence of the fact that it really works, makes difference was there".*	*"It was not only much information, the module gave us new knowledge, I learned a lot and it was so interesting, I can really implement this knowledge".*

While it is essential to have scientific evidence to support the implementation of a given good practice, it is necessary to develop specific strategies adapted to each context to facilitate its implementation. These strategies have consisted on providing sources of information on interventions to increase awareness; motivating and involving end-users in the evaluation of the quality of good practices; exploring closer experiences that enable the identification of elements that can facilitate the implementation process; and adapting processes to local contexts, which makes it easier for stakeholders to visualise the benefits of the good practices that are transferred.

"We have enhanced it with additional research".	*"We don't have the same system… Our doctors don't have the same infrastructure and staff. The approach needs translation and adaptation".*	*"It was hard to understand at first, but the illustrative materials promoted the formation of understanding".*

RELATIVE ADVANTAGE

Stakeholders' perception of the advantage of implementing the intervention versus an alternative solution.

Several specific aspects were mentioned as advantages in the implementation processes of the two NAWGs that have worked on this construct. On the one hand, being able to combine teleassistance with face-to-face care, especially in areas where the profiles of the patients being cared require greater contact. On the other hand, this type of pilot project can motivate professionals in terms of reduction in their workload. And finally, the benefit of teamwork between patients and professionals, which helps to overcome the excessive individuality that is sometimes perceived in the field of medicine.

"In this situation of chronic fatigue where, unfortunately, bureaucracy often prevails instead of the clinic, it takes forward-looking minds to understand that the efforts of today are an investment for tomorrow. This must not be taken for granted".	*"The virtual question loses a lot of people along the way in the courses".*

Actions taken by the NAs to enhance the positive effect of this construct have included sharing project information and highlighting its benefits, improving planning and sharing it with all participants and seeking to improve the tools to be used, such as those related to telemedicine.

ADAPTABILITY

The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.

The possibility of planning interventions adapted to local contexts is very important because it considers the particularities of these contexts, and because it allows the possible complexity of the intervention not to be considered as an obstacle for the implementation and to be carried out in a timely manner.

Adaptability is possible if NAWGs can be engaged and work together.

"Without this [the adaptability], there would be no continuum [from the piloting to the implementation]."	*"The fact that in one week we were able to organise the preliminary test, with immediate feedback, certainly made things easier."*

The strategies employed to enhance its positive effect consisted, on the one hand, on providing specific resources for the implementation of the interventions and, on the other hand, on distributing tasks among the team members. These tasks consisted on studying the local context in which the intervention was to be developed, completing the necessary administrative processes or carrying out technical tasks related to the data to be collected.

"The study of systems, the study of data, certainly was an important initial part, facilitating the inclusion and integration of this good practice within our context."	*"Different digital tools were used in combination to implement the practice: a platform for tracking patients' progresses, videoconference tools for video calls, and an additional programme was used for storing the data of chronic patients".*

TRIALABILITY

The ability to test the intervention on a small scale in the organization, and to be able to reverse course (undo implementation) if warranted.

The possibility of testing interventions on a smaller scale, in smaller contexts, has allowed the NAs to assess their effectiveness, usefulness, acceptability and feasibility, identifying the most relevant elements and then scaling them up to a higher level.

"It is about effective planning not only of time but also of economic resources."	*"It has almost been a bottom-up approach".*

Apart from providing the necessary material resources for the implementation of the interventions, in some cases, the concrete steps to be taken were defined and the most priority for each region were designed. Being able to test the interventions in local contexts has allowed them to gain experience that has later helped them in the implementation processes.

"Online visits were already performed after the COVID-19 pandemic, but the pilot allowed us to offer to patients a more structured service, complemented with the provision of general online support when needed"

COMPLEXITY

Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement.

Complexity emerged in different ways in each of the NAWGs, but the common element in all of them was that of resources. In some cases, due to the difficulty of coordinating professionals from different levels of care; in others, due to the lack of time that stakeholders had to dedicate to the intervention; on the other hand, due to the shortage of specialists in some areas relevant to the projects; and, finally, because some health systems were not prepared to carry out this type of project.

''The more complex the implementation is, the more resources are needed.''

"All external workers are regularly employed in healthcare and lack time to participate in such a project".

"It's also important not to forget about externals experts in case it's needed".

In addition to the financial resources needed to set up and carry out the interventions to be implemented, special mention has been made of the importance of communication with participants and with health policy makers and managers, especially when the implementation processes have an impact on them.

''We managed to make a pretty good product, taking into account the resources we had.''

"The federal state is away from efficiency generation (shared saving). It is time to rethink".

COST

Costs of the intervention and costs associated with implementing the intervention including investment, supply, and opportunity costs.

The implementation processes entail costs in terms of preparation of materials, equipment, software, etc. Innovation has clear costs and it is necessary for health systems to reflect on this in order to adapt and to be prepared to respond to the needs arising from new processes and projects.

"New procedures often bring with them more costs but should be cheaper in the long run".

"The ageing of society is accompanied by an increasing need for care. This in turn leads to rising costs".

The strategies employed by the NAs to diminish the negative effects of costs have been: communication with insurers, motivation of stakeholders involved in the implementation process and health promotion strategies that can have positive long-term effects on the costs associated with integrated care.

"Aim for insurers to engage proactively and create their own guidelines for the implementation of new practices."

"The increase in medical costs is considerable. If necessary, these could be slowed down by preventive measures or health promotion"

5.1.2.2 Outer setting

Construct \ Next Adopter	ACSS	ARSTuscany	ASLNapoli	AUTH	CCUH	CIPH	CSCJA & FPS	EUSTRAS	IDIVAL & SCS	JFDPK	LOMBARDIA	MARCHE	RND	SACYL	SELBM	SMS & FFIS	UHO	USLUmbria	VH	ZZZS
2.1 Patient Needs & Resources	+	n	++	++	+	++	++	+	++	++	+	n	-	++	n	+	-	n	-	+
2.2 Cosmopolitanism	++	n	+	++	++	++	+	++	++	-	n	+	-	++	n	+	+	-	++	+
2.3 Peer Pressure	+	n	n	--	n	+	n	n	n	n	n.a.	+	n	n	n	+	-	n	n	n
2.4 External Policy & Incentives	+	++	+	++	++	++	n	++	n	--	n.a.	+	+	++	+	n	n	n	+	+

Relevance. Red: 0-4; Yellow: 5-7; Green: 8-9; Dark green: 10

Influence. --: very negative; -: negative; n: neutral; +: positive; ++: very positive; n/a: not available

Bold square: construct selected to be analysed in the CFIR Focus Group

When analysing the relevance of the outer setting in the implementation process of the NAs, a very high variability can be noticed. Whereas “Patients Needs and Resources” was considered very relevant (more than eight points) by 70% of the NAs, “Peer pressure” was not for any of the NAs.

In addition, “Cosmopolitanism” was the most positively influencing aspect, considered as positive or very positive by 70% of the NAs, followed by “Patients Needs and Resources” and “External incentives” considered so by 65% of the NAs. On the other hand, “Peer pressure” was mainly considered as having a neutral influence (13 NAs out of 20) and none of the NAs considered it as very positively influent.

Going deeper into the responses of the CFIR Focus Group, and aligned with the responses of the CFIR Survey, we can clearly see the predominance of “Patients Needs and Resources” that was selected by 8 NAs to be analysed in deep, whereas none of them chose “Cosmopolitanism” and only two “Peer Pressure”.

PATIENT NEEDS & RESOURCES

The extent to which patient needs, as well as barriers and facilitators to meet those needs, are accurately known and prioritized by the organization.

It should be noted that almost half of the NAWGs chose this construct to analyse it deeply, because of the importance of the concept of patient-centred care for them. The focus has been on patient care and the benefits that new interventions could have for patients.

The aim was to respond to patients' needs in an efficient and trustful way, involving them actively and promoting their empowerment.

“Improving the care of the complex patient was the final goal of our project”.	*“Putting the patient at the centre of the system”.*	*“The most important thing is the extremely high efficacy and efficiency of the practice”.*

In order to enhance its positive effect, on the one hand, specific resources were developed and offered, such as telemedicine services, messaging or educational materials, with the aim of facilitating a more direct and closer communication with the patient. On the other hand, communication and cooperation in working teams has been promoted to help keep the focus on the implementation process. And in some cases, patient representatives have been invited to participate in the teams.

“Good use of these tools: interesting to humanize and give proximity to the patient."	*“We included him (patient representative) in all implementation activities important for patients”*

PEER PRESSURE

Mimetic or competitive pressure to implement an intervention; typically because most or other key peer or competing organizations have already implemented or are in a bid for a competitive edge.

Several sources of pressure have been identified: competition between groups presenting different projects, society's demand for change in the way things are done, and the need to adapt to new technologies.

"We always have to foster positive competition."

"The hospital establishes that new technologies must be incorporated"

In order to enhance its positive effect two strategies have been mentioned: on the one hand, working to ensure that Early Adopters do not lose focus, that they stay centred in the process; and on the other hand, collaboration and teamwork, which positively influence stakeholders.

"I've always tried to convey the message that this project has a very positive impact on patients and that should be the focus."

EXTERNAL POLICY & INCENTIVES

A broad construct that includes external strategies to spread interventions, including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.

While this may initially seem an irrelevant construct in some cases, it has become more important as the implementation process has progressed, for example, when NAs tried to integrate external data into their own systems, or when barriers related to the digitisation of information have emerged.

Two of the NAWGs agreed on the importance of being aligned with the health policy strategies of their regions.

"Health policy pressure in implementing our activities was crucial."

"There has been an evolution over time. The state is recognizing the importance of prevention"

In some cases, processes have been built on recommendations issued by regional authorities and have been supported by managers and decision-makers. More specific strategies have also been utilised, such as channelling interventions into more concrete actions, highlighting the benefits they could have in the local context.

"It was always emphasized that with our project we had the opportunity to respond to a long-standing need highlighted by health policies."

"We try to align strategies between providers"

5.1.2.3 Inner setting

Construct \ Next Adopter	ACSS	ARSTuscany	ASLNapoli	AUTH	CCUH	CIPH	CSCJA & FPS	EUSTRAS	IDIVAL & SCS	JFDPK	LOMBARDIA	MARCHE	RND	SACYL	SELBM	SMS & FFIS	UHO	USLUmbria	VH	ZZZS
3.1 Structural Characteristics	+	++	+	++	n	++	+	+	+	-	n.a.	n	+	++	n	++	+	--	n	n
3.2 Networks & Communications	n	++	+	++	+	++	++	+	++	-	+	+	n	++	+	+	n	--	++	++
3.3 Culture	+	+	++	++	n	++	+	+	++	n	n.a.	+	n	++	n	++	+	+	++	n
3.4 Implementation Climate	+	+	+	--	-	+	+	-	++	--	+	++	--	++	n	+	n	-	++	-
3.5 Tension for Change	+	+	+	++	++	+	n	+	n	--	+	-	+	++	++	+	+	n	+	++
3.6 Compatibility	+	+	n	n	-	+	n	-	n	+	n	++	+	+	n	+	+	+	++	n
3.7 Relative Priority	++	+	+	++	+	+	+	+	-	+	+	+	+	++	n	n	+	-	++	+
3.8 Organizational Incentives & Rewards	++	-	+	+	+	+	+	-	--	-	n.a.	n	n	+	n	n	n	--	n.a.	n
3.9 Goals and Feedback	+	+	+	+	+	++	+	n	-	-	++	+	n	++	n	+	n	n	++	-
3.10 Learning Climate	++	+	+	++	++	++	+	+	+	--	+	+	+	++	+	++	+	+	++	++
3.11 Readiness for Implementation	+	-	+	++	+	++	+	+	--	--	+	++	--	++	n	n	+	n	++	n
3.12 Leadership Engagement	++	++	+	++	+	++	+	+	++	-	+	+	++	++	n	++	+	--	++	+
3.13 Available Resources	-	-	n	-	+	++	++	+	-	-	n	++	-	++	n	+	+	--	++	-
3.14 Access to Knowledge & Information	+	+	+	+	+	n.a.	++	+	++	n	++	++	++	++	n	++	+	+	++	+

Relevance. Red: 0-4; Yellow: 5-7; Green: 8-9; Dark green: 10

Influence. --: very negative; -: negative; n: neutral; +: positive; ++: very positive; n/a: not available

Bold square: construct selected to be analysed in the CFIR Focus Groupe

"Inner setting" was considered a quite relevant domain as half of the constructs (five) were rated with more than eight points by more than 60% of the NAs. Moreover, all constructs except "Relative Priority" and "Goals and feedback" were selected by at least one NA to be further analysed in the CFIR Focus Groups.

"Leadership Engagement" was considered the most relevant aspect (80% of the NAs considered rating it with more than 8 points), closely followed by "Available Resources" (70% of the NAs). On the other hand, "Organizational Incentives & Rewards" was mainly considered as having a negative or neutral influence (14 NAs rating it with seven points or less) as it was "Structural characteristics" (13 NAs out of the 20 rating it with seven points or less).

Furthermore, "Learning climate" was considered as having an extremely positive influence, as it was considered positive or very positive by 95% of the NAs, followed by "Access to Knowledge & Information" that was so by 85% of the NAs. "Culture" and "Access to Knowledge & Information" were never considered as having a negative or very negative influence, and "Learning climate" was so only by 5% of the NAs.

STRUCTURAL CHARACTERISTICS

The social architecture, age, maturity, and size of an organization.

The only NAWG that chose this construct to analyse it deeply identified two structural aspects that facilitated the implementation process: the professionals involved had independence within their organisation, and the bureaucracy was not unduly burdensome.

"We had the support of our superiors form the beginning; nobody blocked our efforts. We were not required to design large reports or loose time in informative meetings. Everything just flew."

The positive effect of this construct on the implementation process was enhanced by the active involvement of all actors from beginning to end.

"Our director was the first wanting to try the solutions. I asked our nurses to participate and relied on their opinion solely to come to the conclusion."

NETWORKS & COMMUNICATIONS

The nature and quality of webs of social networks and the nature and quality of formal and informal communications within an organization.

Although networking is considered essential, it has not always been effective, sometimes because of the professionals' resistance and sometimes because the flow of information in large organisations is more complex. On the other hand, in the development of projects, communication is essential to transmit objectives, plans and timelines, so that everyone involved has a common understanding.

"There is a feeling that they're coming to tell me what to do, and they don't know what my problem is."

"Many stakeholders are involved (in the implementation), and without joint communication, each of them could not do anything for themselves."

The involvement of the local project leaders has been very important, because they have promoted networking and strategies to foster mutual learning. On the other hand, the need to continuously promote communication and information exchange between the agents involved has been highlighted, to ensure that everyone understands the project and the tasks to be carried out.

"If it hadn't been for the idea of implementing through a network based on local leaders, I don't think it would have happened."

"With constant mutual information sharing."

CULTURE

Norms, values, and basic assumptions of a given organization.

In one of the organisations, they evaluated positively the fact that they were able to learn different ways of working with data, fostering a new culture, shifting the focus more from the individual to the population level. In the other organisation, they highlighted having been able to involve those responsible for innovation, to promote change and not generate so much resistance.

"Although medical science is very nature scientific, there has been little focus on the population approach. We have learned a different way of working with data and create a new culture."

"It is important to take inspiration from abroad, even though the systems may be different. A change of mindset is important."

The two NAWGs that have chosen this construct to analyse it deeply have agreed on the importance of involving policy makers and management, especially when it comes to economic issues. Working on concrete projects such as JADECARE makes it possible to present economic management proposals that could be beneficial for the organisations.

"We introduce our clinicians to other data types with inspiration from Spain and Germany to make decisions. JADECARE is something other than research and evidence."

IMPLEMENTATION CLIMATE

The absorptive capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of that intervention will be rewarded, supported, and expected within their organization.

For one NAWG this construct was important because it helped them to generate resources to overcome initial barriers and foster an environment favourable to the implementation process. In this sense, the involvement of professionals who have acted as leaders and promoters of the project, as well as the collaborative work between different levels of care, have been facilitating elements.

"We have reduced the distance between the hospital and Primary Care."

In this case, two elements have boosted the positive effect of this construct: on the one hand, the involvement of some professionals who have acted as project leaders, training other colleagues; and, on the other hand, being able to show the effectiveness of the practice to be implemented, which has favoured its acceptance.

"It shows where there has been leadership."

TENSION FOR CHANGE

The degree to which stakeholders perceive the current situation as intolerable or needing change.

The pandemic has driven the shift towards increased use of technology and with it, the opportunity, among other things, to involve the patient in decision-making. However, technology also generates tensions, both because of the perception that it may lead to a reduction in staff and also because of the additional burden it places on already overburdened professionals.

"Technology can do certain things that the professional does."

"The ageing of society is accompanied by an increasing need for care. This in turn leads to rising costs and, against the backdrop of a shortage of skilled workers, to bottlenecks in care."

Change in itself implies a new way of doing things, and even if professionals agree on the need for change and are clear about the benefits, they need to be given the resources to make it a reality.

"Four words: real need for change."

"The changes must also have positive effect on the work condition of the health care workers and patientcare."

COMPATIBILITY

The degree of tangible fit between meaning and values attached to the intervention by involved individuals, how those align with individuals' own norms, values, and perceived risks and needs, and how the intervention fits with existing workflows and systems.

In one case, the fact that the project matched the values and needs of the professionals was crucial in motivating them to participate. In other case, there was already a good attitude towards innovation in general and moreover, the project was received as an opportunity to introduce new ways of doing things, to improve current care practice.

"These things had been talked about for years, it was time to figure out how to do them and this project was the opportunity."

"I really admired its coherence, I mean same things and it made up a whole system, there was logic, and it fitted really nicely into our developments."

The fact that the projects to be implemented were aligned and responded to previously detected needs was a fundamental element in motivating the participants. Likewise, the possibility of participating and working on innovative projects has generated enthusiasm, a feeling of belonging and of contributing added value to the organisation.

"The fact that we always wondered whether a specific action would have brought an added value to professionals was fundamental to the activities."

"It is just our way of doing things, now we have one extra tool to use."

ORGANIZATIONAL INCENTIVES & REWARDS

Extrinsic incentives such as goal-sharing awards, performance reviews, promotions, and raises in salary, and less tangible incentives such as increased stature or respect.

Incentives were not useful in either of the two cases in which this construct was analysed. In one of them, it did not help to motivate the participating professionals; moreover, the activities to be carried out were not well delimited, which led to confusion. In the other case, it was not possible to motivate the professionals involved in any way, even though it was considered that it could have had a positive effect.

"The incentive was not a determining factor in encouraging good practices to participate."

The negative effect of having given the incentives at the beginning was counteracted by informing all professionals of this fact, including those who did not participate. In the organisation in which it was not feasible to give incentives to the professionals, they tried to maximise their motivation and to accompany them in the process.

LEARNING CLIMATE

A climate in which: a) leaders express their own fallibility and need for team members' assistance and input; b) team members feel that they are essential, valued, and knowledgeable partners in the change process; c) individuals feel psychologically safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation.

The NAWG that has addressed this construct has pointed out that this learning environment has been generated thanks to the active collaboration between managers and practitioners and the commitment acquired by all, which has led to excellent results.

"The learning climate has been highly collaborative, prioritizing the collective/group over individual roles."

The aspects that were most important in enhancing this construct were the willingness to work on the implementation process and the time devoted to it, as well as the atmosphere of unity and collaboration in the working group.

"Promoting group identity and achieving our work objectives."

READINESS FOR IMPLEMENTATION

Tangible and immediate indicators of organizational commitment to its decision to implement an intervention.

This construct was fundamental to the organisation, especially during the pandemic. At that time, it was essential to be able to access data quickly and this was possible thanks to the commitment of the managers and their proactive attitude towards the implementation process.

"I have seen this readiness which was actually not only useful but even essential for being within the deadlines and setting up such a complex project."

The strategies employed to enhance this positive attitude towards implementation were: 1) to encourage policy makers' commitment to the project; 2) to disseminate the results to managers; 3) and to promote awareness of the tool within the organisation.

"[…presenting/disseminating the project at different levels of the organisation has been useful] to arouse that interest, which is fundamental and without which the activity would be an end in itself."

LEADERSHIP ENGAGEMENT

Commitment, involvement, and accountability of leaders and managers with the implementation.

In two of the NAWGs, the support and involvement of the managers and leaders of the implementation processes were perceived. This support and helpful attitude facilitated the creation of active networks that enabled the tasks arising from the projects to be carried out. In the other organisation, the commitment of the project leaders was perceived, but the managers' involvement was lacking.

"It is difficult to get higher up the management level, since we have had a dialogue with all directors."

"Having competent, decisive and collaborative leaders has been definitive and decisive."

This construct has been enhanced thanks, on the one hand, to the work of the leaders of the implementation processes, which has made it possible to achieve the objectives and, on the other hand, to the efforts to involve managers.

In other cases, this involvement has not been perceived, nor have the managers been able to perceive the benefits of the good practices for the organisation's own objectives.

"The leader has encouraged and accompanied the work of each member in their development and has united human labour and the product."

"The feeling of little interest on the part of the health management puts a brake on the expectations of success of the process."

AVAILABLE RESOURCES

The level of resources dedicated for implementation and on-going operations, including money, training, education, physical space, and time.

This has been considered a fundamental construct by the four NAWGs that have chosen it. Without resources, it is impossible to carry out implementation projects of this nature. The resources mentioned were financial, economic, technological and material. Among the human resources, the dedication of the professionals to the projects and the work of the process leaders to carry out and promote the activities were highlighted. However, it has also been pointed out that staff shortages in health systems can negatively affect projects.

"Available, economic resources that translated into human resources were crucial."

"It can be very clear what needs to be done, but if there are no resources you cannot do it. So, it is fundamental."

The efficient use and the sharing of available human, technological and information resources has been key. In other cases, the NAWGs have worked with the motivation to facilitate patient care, to respond to their needs and to work proactively.

"Bringing together the different skills and focusing them on the project areas was important."

"The use of the available resources in a new modular platform will enable new advances in the future, allowing adaptation to changing needs and facilitating proactivity."

ACCESS TO KNOWLEDGE & INFORMATION

Ease of access to digestible information and knowledge about the intervention and how to incorporate it into work tasks.

The NAWG members who chose this construct felt that having the knowledge and information that was generated when the good practice was first designed and implemented was very important in deciding to adopt it.

"Professionals have to know the project in detail (have to have access to the information and the previous knowledge), what improvements it implies and they must also be trained in what is new."

Using corporate tools and training resources that were already active for other projects made it easier to implement the new good practice.

"They made use of training strategies from other projects."

5.1.2.4 Characteristics of the individuals

Construct \ Next Adopter	ACSS	ARSTuscany	ASLNapoli	AUTH	CCUH	CIPH	CSCJA & FPS	EUSTRAS	IDIVAL & SCS	JFDPK	LOMBARDIA	MARCHE	RND	SACYL	SELBM	SMS & FFIS	UHO	USLUmbria	VH	ZZZS
4.1 Knowledge & Beliefs about the Intervention	+	+	+	++	++	n	+	++	++	+	+	++	+	++	n	+	+	++	+	++
4.2 Self-efficacy	++	n	+	--	n	n	n	-	n	+	n	++	n	++	n	++	+	n	+	n
4.3 Individual Stage of Change	++	n	++	+	+	n	n	++	+	+	n.a.	+	n	+	n	++	n	-	+	+
4.4 Individual Identification with Organization	+	+	+	n	-	+	n	-	+	-	n.a.	+	+	++	n	++	+	--	+	n
4.5 Other Personal Attributes	+	n.a.	+	++	-	++	n	++	+	-	n.a.	+	n	++	n	++	n	n.a.	+	n

Relevance. Red: 0-4; Yellow: 5-7; Green: 8-9; Dark green: 10
Influence. --: very negative; -: negative; n: neutral; +: positive; ++: very positive; n/a: not available
Bold square: construct selected to be analysed in the CFIR Focus Group

The characteristics of the individuals was the most irrelevant domain for the NAs. At least 30% of them rated three of the five constructs with less than four points or relevance. Moreover, only 5% of the NAs rated with nine or ten points the constructs "Individual Stage of Change" and "Individual Identification with Organization". Aligned with it, the constructs of this domain were selected only by two NAs in average to be further analysed in the CFIR Focus Groups.

On the other hand, this domain was considered quite neutral or positive, as all its constructs were considered so by at least 16 out of the 20 NAs. We must highlight, that "Knowledge & Beliefs about the Intervention" seemed very positively influent as 90% of the NAs considered it positive or very positive in their implementation process.

KNOWLEDGE & BELIEFS ABOUT THE INTERVENTION

Individuals' attitudes toward and value placed on the intervention as well as familiarity with facts, truths, and principles related to the intervention.

These implementation processes have been useful, among other things, to demonstrate the importance of sharing knowledge within organisations and among professionals with the motivation to participate and maintain new projects and initiatives over time.

The expectation is that participation in these projects will increase the demand for tele assistance as a tool for health care and as an element that facilitates the active role of patients.

"Participating patients became much more involved in their own recovery."

"It is important to underline each time that the idea is not about creating new things but rather to align them better and facilitate exchange of information between the actors and also to help them increase their number of clients."

The strategies employed can be summarised in two: on the one hand, actively involving all stakeholders in the implementation processes, working to overcome barriers and change attitudes towards the use of new technologies. On the other hand, the fact that the project deals with an aspect that was already being actively discussed and worked on (in this case, prevention), which facilitates the implementation process.

"Overcoming the resistance of the professionals has been a problem at first."

SELF-EFFICACY

Individual belief in their own capabilities to execute courses of action to achieve implementation goals.

This construct was evident in the leadership of individual professionals or teams of professionals, who facilitated the implementation of good practices, putting their personal resources at the service of the projects and facing the challenge of maintaining the interest of adopters. Moreover, the availability of technological tools has enabled professionals to improve patient care.

"There's always a group of people that get ahead and feed the others."

"The commitment of dermatology services is important; they have seen an opportunity with this tool and there has been a clear commitment."

In one case, participating professionals were selected on the basis of their self-efficacy skills. In other implementation case, the training of professionals and the sharing of information between health centres was promoted.

"Training has improved, sharing cases with colleagues in Primary Care and if you have any doubts, you can consult through remote consultation."

INDIVIDUAL IDENTIFICATION WITH ORGANIZATION

A broad construct related to how individuals perceive the organization, and their relationship and degree of commitment with that organization.

For the NAWG that chose this construct, an important motivation during the implementation process was that their personal values were in line with the mission of their organization.

"Since we work in public health, our approach was aligned with the mission of the implementation process. That is our strength."

Confidence in the work being done during the implementation was fundamental to maintain the motivation of the stakeholders involved in the process.

OTHER PERSONAL ATTRIBUTES

A broad construct to include other personal traits such as tolerance of ambiguity, intellectual ability, motivation, values, competence, capacity, and learning style.

This construct is considered to be closely related to the previous one, as it refers to the personal attributes of the professionals. It is necessary for them to have confidence and perceive the need for digitalisation in healthcare, in order to promote its implementation in daily practice.

The project has brought about changes in the attitudes of some professionals towards digitalisation in healthcare. More work needs to be done in this direction to ensure that the changes take hold.

"The majority have changed beliefs about the digitalization of healthcare but there is a lot of work remain."

5.1.2.5 Process

Construct \ Next Adopter	ACSS	ARSTuscany	ASLNapoli	AUTH	CCUH	CIPH	CSCJA & FPS	EUSTRAS	IDIVAL & SCS	JFDPK	LOMBARDIA	MARCHE	RND	SACYL	SELBM	SMS & FFIS	UHO	USLUmbria	VH	ZZZS
5.1 Planning	++	++	+	+	+	++	+	n	++	+	+	++	++	++	n	+	++	--	++	+
5.2 Engaging	++	++	+	+	++	++	+	+	+	-	n.a.	+	+	++	n	++	+	-	++	++
5.3 Opinion Leaders	+	n	+	+	+	+	n	+	++	++	n.a.	n	n	++	+	++	+	++	++	+
5.4 Formally Appointed Internal Implementation Leaders	++	++	+	++	+	+	+	+	++	+	n.a.	++	+	++	n	++	+	++	++	+
5.5 Champions	++	++	+	+	++	+	n	+	n	++	n.a.	++	n	++	n	++	n	+	++	+
5.6 External Change Agents	++	+	n	+	+	n	n	+	++	++	n.a.	n	n	++	+	n	n	--	++	+
5.7 Executing	++	++	+	++	n	++	n	n	-	-	+	++	+	++	n	+	+	n	+	-
5.8 Reflecting & Evaluating	++	+	++	++	+	+	n	n	++	++	++	++	n	++	n	+	+	n	++	+

Relevance. Red: 0-4; Yellow: 5-7; Green: 8-9; Dark green: 10

Influence. --: very negative; -: negative; n: neutral; +: positive; ++: very positive; n/a: not available

Bold square: construct selected to be analysed in the CFIR Focus Group

The domain "Process" was considered very relevant in the implementation process of the NAs, as five out of its eight constructs were ranked with more than eight points by at least 70% of the NAs (14 out of 20). Among them, the most relevant construct was the "Formally Appointed Internal Implementation Leaders", with 95% of the NAs ranking it between eight and ten. In addition, "Planning" and "Reflecting & Evaluating" were rated with less than four points only by six NAs and five NAs, respectively.

When looking at the influence, it must be noted that the more negative influence (- -) was only perceived by one NA referred to "Planning" and "External Change Agents". Complementarily, six out of the eight constructs of this domain were ranked as positive or very positive by at least 70% of the NAs.

The selection of the constructs of this domain for the CFIR Focus Group was quite heterogeneous, ranging between one and six NAs choosing to analyse each construct deeply.

PLANNING

The degree to which a scheme or method of behavior and tasks for implementing an intervention are developed in advance, and the quality of those schemes or methods.

This has been one of the constructs chosen by most implementers (six NAWGS). All of them highlighted the importance of planning as an element of success for any project, in order to be able to carry it out effectively and efficiently. Specific aspects mentioned in the focus groups that are related to planning are: the provision of resources; the coordination of the participants in the implementation; the training of professionals; the organisation of roles, tasks and necessary resources; or the support of process leaders.

For good planning it is important to have tools that facilitate the work. The tools cited by the NAWGs were: CFIR, SWOT, PDSA, guidelines and templates for monitoring the progress of interventions. The importance of planning ahead, with resources to deal with any deviations that may arise, was also highlighted.

"It [methodology and tools] allowed us to assess well all the various stages of the process and gather a whole series of information that we might not have been able to see on our own".	*"Planning is key: the administration must plan and optimize the use of resources".*	*"Step-by-step, the roles were clear, it laid foundation for all process, I know what to expect and there were really alternatives discussed if something would not work".*

One of the strategies employed within this construct has been constant cooperation and communication, on the one hand, within the working teams to monitor the implementation processes, carrying out the activities and adapting the planning when necessary. On the other hand, there has also been cooperation with the services involved in the projects, as well as with external entities and administrations, in order to keep them up to date and to inform them of the results. In addition, tools have been adapted when necessary, which has allowed for flexibility in the implementation processes.

"We had so many meetings and we talked a lot and explanation was provided, and we could really ask all questions, very supportive atmosphere".	*"Many details were discussed… many ideas and alternative options were discussed and some of them had to be even implemented".*	*"We did prepare several worksheets, and they were tested and updated".*

ENGAGING

Attracting and involving appropriate individuals in the implementation and use of the intervention through a combined strategy of social marketing, education, role modeling, training, and other similar activities.

The success of projects depends in part on selecting and involving the people who can contribute the most. In the focus groups, some of the characteristics that these people must have in order for the projects to work better and have better results were mentioned: readiness to participate in the projects and to share their expertise; curiosity and willingness to learn. This is fundamental, as it will help to create solid work teams, in which roles are clear, everyone supports each other and shares their knowledge.

"We were lucky with the NAWG selection. Enthusiasts and the best experts in the field."

"I was supported, we discussed the progress and we also shared the challenges we faced."

This construct has been enhanced by creating robust teams, made up of professionals with different profiles and expertise, who could be put at the service of the projects. And in this engagement work, the role of the leaders has been fundamental, to face the challenge of maintaining motivation, especially when difficulties or doubts have arisen.

In addition, it has also been important to share information about the project itself, the activities to be carried out and the best available evidence in relation to the good practice to be implemented.

"Through the preparation of articles and promotions at conferences."

FORMALLY APPOINTED INTERNAL IMPLEMENTATION LEADERS

Individuals from within the organization who have been formally appointed with responsibility for implementing an intervention as coordinator, project manager, team leader, or other similar role.

The role of the leaders is of particular relevance for the project and for the implementation processes in general, judging by the comments gathered in the focus groups. Part of the success of the projects is related to the active and efficient role of the leaders.

Leaders act as guides for the processes, as reference points for all participants, especially when difficulties have arisen, thanks to their ability to manage and deal with them. Leaders show a high degree of commitment, work capacity and willingness to cope with challenges; they also share and transmit their knowledge to others and provide guidance on the activities to be carried out.

"If there is someone who brings you back on the right path, allows you to do things, to get to the goal…."

"A project of this depth, if you do not have the clear and serious drive of the leaders of the organisation and the certainty that they will continue to drive it despite the difficulties that arise, this type of project usually fails."

Process leaders must have a thorough knowledge of the oGPs to be implemented. This allows them to control the activities to be carried out, the roles of the team members, to motivate them, empower them and create solid

teams. These elements will strengthen the projects and provide resources to deal with difficulties and changes that may arise.

"But my effort was both to hold the threads of all the activities to be done, on the one hand integrating them into our daily work, and on the other hand trying to divide up the roles, but then really trying to create this integration and the transfer of skills and knowledge of each one to the others, so that they could both enrich themselves and grow the whole organisation".

"The development of the piloting of the application is due in large part to the involvement of internal managers."

CHAMPIONS

"Individuals who dedicate themselves to supporting, marketing, and 'driving through' an [implementation] overcoming indifference or resistance that the intervention may provoke in an organization."

This construct refers both to project leaders in general, which has already been described in the previous construct, and to specific practitioners who have carried out specific actions, such as training in the good practices that have been implemented. In all cases, the term "champions" refers to people who have extended the projects, reported on their results and promoted them.

"It is important that there is a reference in each of the teams".

"People who are interested, who believe in the approach, who know how it could work and who are engaged in making it happen are essential."

In addition to the project leaders themselves, it has been important to involve other professionals in specific actions, such as training or coordination with specialists from different levels of care. In some cases, these champions have not been present from the beginning, but have been identified throughout the implementation process. In any case, these figures have always strengthened the teams and could be fundamental in boosting the projects in the future.

"The leader should not assume the work, but motivate the rest of the interested people."

EXTERNAL CHANGE AGENTS

Individuals who are affiliated with an outside entity who formally influence or facilitate intervention decisions in a desirable direction.

The only NAWG that selected this construct to analyse it deeply highlighted the leadership of the organisation that promoted the implementation process and the coordination work it carried out. This leadership has been key to moving the project forward.

"The merit is yours [leader of the NAWG] and the follow-up meetings were good to create the need to deliver results every month."

REFLECTING & EVALUATING

Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience.

In the two NAWGs that chose this construct, both quantitative (satisfaction questionnaires) and qualitative techniques (meetings with participants in the implementation process on the one hand, and with team members on the other) were used to help reflect on the work being carried out and to draw conclusions and actions for improvement.

"We had internal discussions among professionals, also involving other more sceptical colleagues; we exchanged opinions, we should consider that the practice implies a change in our work habits".

"We collaborated well, we discussed on the end-of-trial reports and on the satisfaction questionnaires; we also had structured meetings before implementing the practices on the use of the platform."

The follow-up meetings served to bring to the table the difficulties being encountered, as well as possible solutions. This made it possible to establish adjustment measures to improve implementation processes.

Moreover, the evaluation exercises that have been carried out have also shown the need for good quality data in order to be able to make more reliable evaluations.

"The objective of the evaluation was not to provide scientific evidence but to use local routine data to proof effectiveness and show that it is possible with local data."

5.2 Final evaluation of the quality of the implementation

5.2.1 Evaluation of the NAs execution of tasks

The final evaluation of the Quality assurance of implementation, completed by month 36 of the project, compiles the information for the evaluation of the Execution of the tasks performed by the Next Adopters during the Implementation and post-implementation phases between October 2021 and September 2023. This means that information for indicators Q10 to Q24 has been compiled.

Moreover, indicator Q1 has been totally collected, referring to the phases of the implementation strategy accomplished between months 18 and 36 and the reports consequently completed. The results of these indicators are shown here.

- ✓ **Q1. No of reports completed and sent/total No of reports to be completed, considering the reports for the following phases: templates for the four PDSA steps (Plan, Do, Study and Act), CFIR and SQUIRE 2.0**

This indicator can be reported for the phases completed between months 18 and 36: Roll out of the LAP, analysis of the implementation process and results and reporting of the implementation.

- Q1. Roll out of the LAP

  1st PDSA Cycle

  - Plan: 21/21
  - Do: 20/21
  - Study: 20/21
  - Act: 20/21

  2nd PDSA Cycle

  - Plan: 21/21
  - Do: 21/21
  - Study: 20/21
  - Act: 20/21

- Q1. Analysis of the implementation process and results:

  CFIR Survey: 20/21

  CFIR Focus Group: 18/21

  Q1. Reporting of the implementation (SQUIRE): 20/21

<u>Monitoring of the implementation phase</u>

1st PDSA Cycle

- ✓ **Q10.1. No of action defined in the 1st PDSA Cycle**

WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
106	52	50	144	75	**427**

✓ **Q11.1 Distribution of the NAs according to the % of implementation progress of the LGP achieve in the 1st PDSA Cycle**

0-25%	25-50%	50-75%	75-100%	TOTAL
3	9	8	1	21

✓ **Q12.1 No of actions in the LAP with reported deviations/No of total action of the 1st PDSA cycle**

49% of the action defined in the 1st PDSA Cycle had deviations compared to what was planned.

✓ **Q13.1 Distribution of reported deviations in the LAP of the 1st PDSA Cycle**

Category	WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
Managerial	12	7	10	26	6	**61**
Clinical	3	7	2	1	3	**16**
Technical	10	6	11	12	8	**47**
TOTAL	**25**	**20**	**23**	**39**	**17**	**124**

✓ **Q14.1 Distribution of the impact of the mitigation actions in the LAP of the 1st PDSA Cycle**

Impact	WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
Positive	12	10	7	19	6	**54**
Neutral	8	5	10	10	4	**37**
Negative	0	1	5	0	1	**7**
TOTAL	**20**	**16**	**22**	**29**	**11**	**98**

✓ **Q15.1 Distribution of the actions of the LAP decided to be maintained/adapted/abandoned after the 1st PDSA Cycle**

Impact	WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
Maintained	17	12	14	23	18	**84**
Adapted	21	13	22	22	15	**93**
Abandoned	3	13	3	2	2	**23**
TOTAL	**41**	**38**	**39**	**47**	**35**	**200**

2nd PDSA Cycle

✓ **Q10.2 No of actions defined in the 2nd PDSA Cycle**

WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
57	54	36	118	86	**351**

✓ **Q11.2 Distribution of the NAs according to the % of implementation progress of the LGP achieved in the 2nd PDSA Cycle**

0-25%	25-50%	50-75%	75-100%	TOTAL
0	0	8	12	20[6]

Meetings' monitoring

✓ **Q17. No of organizations participating in the PDSA meetings**

In average, 5 organizations per each of the NAs participated in the PDSA meetings.

✓ **Q18. No of PDSA meetings in which NAWG members participate/Total No of meetings arranged**

100% of the NAWG members participated in the meetings arranged.

[6] In the second PDSA Cyle the NAs of MoHRS did not reported the DO, STUDY and ACT steps

Implementation conclusions

- ✓ **Q19. No of actions of the LAP with reported deviations compared to the No of actions maintained /adapted/abandoned in the 2nd PDSA cycle**

In average, 92% of the activities with reported deviations were maintained, 93% decided to be adapted and 93% decided to be abandoned.

Monitoring of the implementation phase

Analysis of implementation results (KPIs of the LAPs)

- ✓ **Q12.2 No of action sin the LAP with reported deviations/No of total action of the 2nd PDSA cycle**

In average, 44% of the actions defined suffered deviations.

- ✓ **Q13.2 Distribution of reported deviations in the LAP of the 2nd PDSA Cycle**

Category	WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
Managerial	9	6	5	20	6	**46**
Clinical	0	2	1	0	0	**3**
Technical	6	7	15	18	3	**49**
TOTAL	**15**	**15**	**21**	**38**	**9**	**98**

- ✓ **Q14.2 Distribution of the impact of the mitigation actions in the LAP of the 2nd PDSA Cycle**

Impact	WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
Positive	6	8	5	13	3	**35**
Neutral	0	0	8	14	0	**22**
Negative	4	1	0	0	0	**5**
TOTAL	**10**	**9**	**13**	**27**	**3**	**62**

✓ **Q15.2 Distribution of the actions of the LAP decided to be maintained/adapted/abandoned after the 2nd PDSA Cycle**

Impact	WP5	WP6	WP7	WP8	MIX AND MATCH	TOTAL
Maintained	6	12	21	20	13	**72**
Adapted	10	14	7	24	6	**61**
Abandoned	8	3	0	0	2	**13**
TOTAL	**24**	**29**	**28**	**44**	**21**	**146**

✓ **Q20. No of KPIs that have achieved the target defined in the PLAN step**

This KPI could finally not be measured due to the lack of consistency in the reporting of the KPIs of the NAs.

✓ **Q21. No of NAs that have implemented successfully at least one of their LCFs**

100% of the NAs implemented successfully at least one of their LCFs.

Analysis of the implementation process (CFIR)

✓ **Q22. No of CFIR assessments completed by the NAs**

- CFIR Survey: 20/21
- CFIR Focus Group: 18/21

✓ **Q23. Distribution of factors that influenced negatively/neutrally/positively the implementation process per domain of CFIR**

This KPI could finally not be measured.

Reporting of implementation results (SQUIRE 2.0)

✓ **Q24. No of SQUIRE 1.0 reports completed by the NAs**

- Reporting of the implementation (SQUIRE): 20/21

5.2.2 Assessment of the implementation strategy

The assessment of the implementation strategy includes the evaluation of the key aspects for the development and roll up of the implementation strategy. This evaluation was conducted by means of two surveys:

- Survey for the assessment of the satisfaction of Next Adopters with the original Good Practices' leaders support and follow-up. This survey aimed to assess the guidance and assistance provided by the oGP leaders along the implementation process.
- Survey for the assessment of the implementation strategy. This survey evaluated the communication and support provided by the strategy developers' (Task 3.2 leaders) and the perception of the impact and usability of the implementation strategy.

5.2.2.1 Satisfaction of Next Adopters with the original Good Practices' leaders support and follow-up

This survey aimed to assess the support that the oGPs' leaders provided to the implementers along the implementation process. It was launched after the end of the pre-implementation phase (month 14-November 2021) and the implementation phase (month 29-February 2023) as these were the two phases of the implementation process when the guidance and help of the oGP leaders was more demanding. (Please, see complete detail in Annex 2: Survey for the satisfaction of Next Adopters with the original Good Practices' leaders support and follow-up).

Fort the complete information about the survey launched after the pre-implementation phase, please see *Deliverable 3.2 Interim Evaluation Report*. The information about the survey launched after the implementation phase can be found in Section 6 Impact assessment; more precisely in I21: Satisfaction degree of project beneficiaries.

5.2.2.2 Survey for the assessment of the implementation strategy

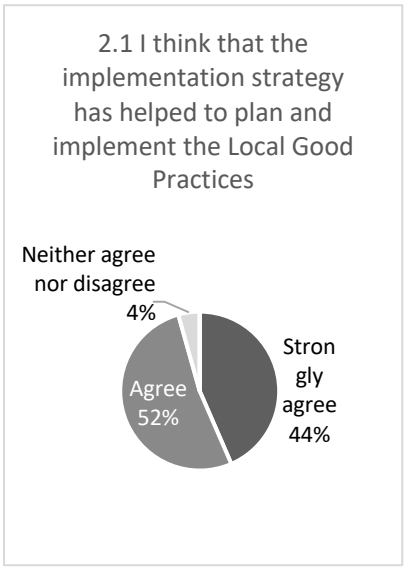
This survey evaluated the strategy developers' communication and support (Task 3.2 leaders) and the impact and the usability of the implementation strategy. The survey was launched in month 34 (July 2023). (Please, see complete detail in Annex 3: Survey for the assessment of implementation strategy).

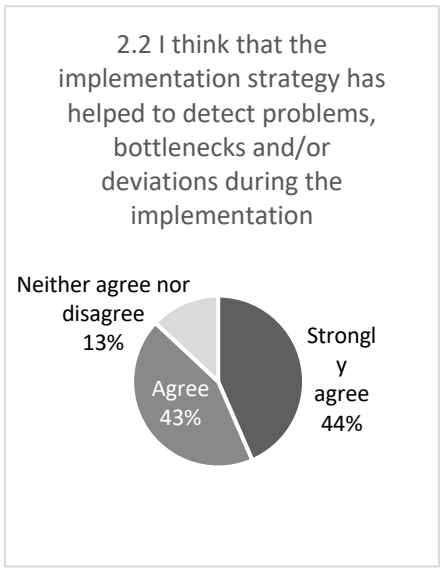
The survey was responded by 19 out of the 21 NAs out of the project and by all the eligible oGP leaders (three oGP leaders) (Kronikgune as leader of the Basque Good Practice did not answer due to conflicts of interest as they were responsible for the development of the strategy and the survey). The responses are presented for the following three fields of study:

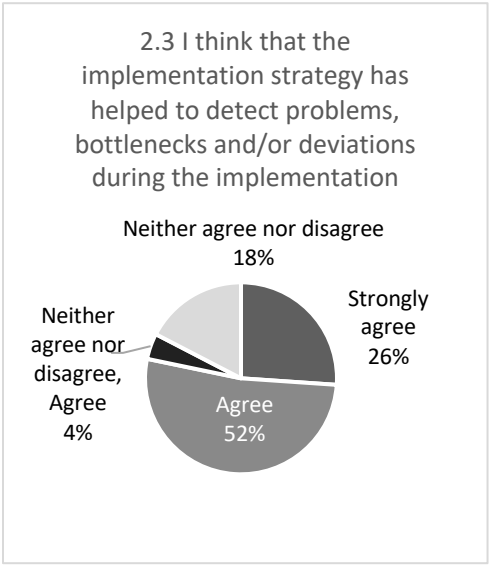
- Implementation process
- Impact of the implementation strategy
- Usability of the implementation strategy

IMPLEMENTATION PROCESS

For the analysis of the implementation process, a total of three questions addressed how the strategy helped designing, planning and implementing the Local Good Practices, how it supported problem or deviation identification as well as the definition of mitigation actions definition.







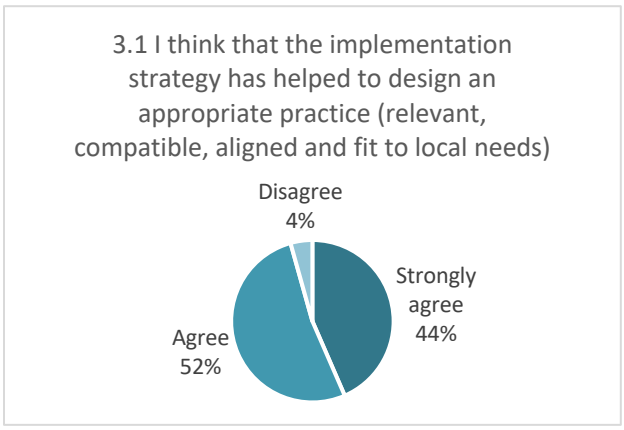
It must be highlighted that there were no respondents that disagreed or strongly disagreed with any of the questions. Moreover, at least between 78% and 96% of them agreed or strongly agreed with the assumptions.

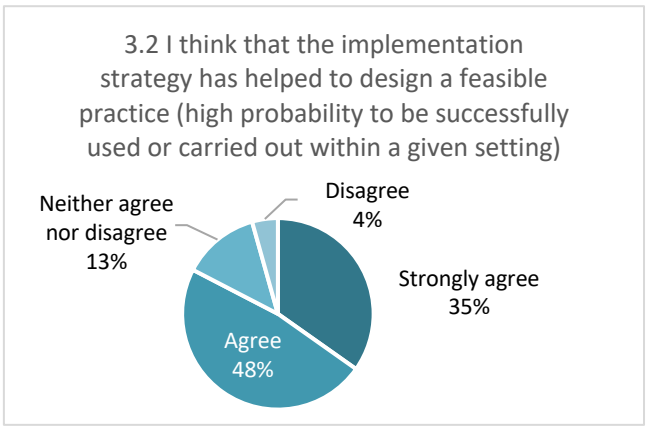
In addition, two open text questions asked about the communication and guidance provided by the developers of the implementation strategy (Task 3.2 leaders). The responses to these questions reported that it is very helpful to have a clear detailed methodology and reporting templates as well as organising short webinars at the beginning of each phase of the implementation process to explain it in detail and that also include examples to accompany the theory. It was also very useful to store all the documentation in one unique online folder as well as sending clear short emails indicating the activities to be done with links for documentation. In sum, the support and guidance of implementation developers was defined as: useful, helpful, quick reacting, very good, valuable, professional, closeness, "barely noticed them, which means they were very effective", but also improvable for one respondent.

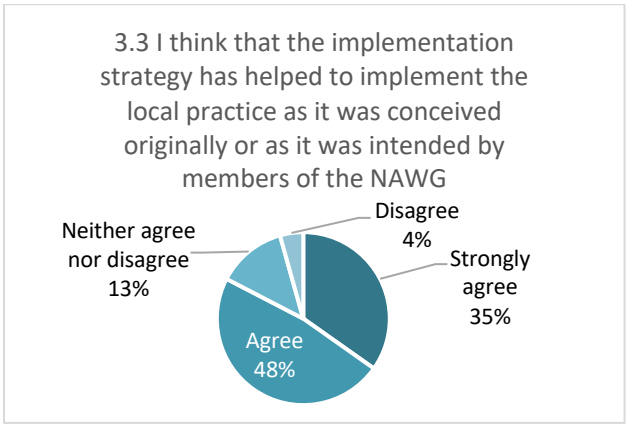
IMPACT OF THE IMPLEMENTATION STRATEGY

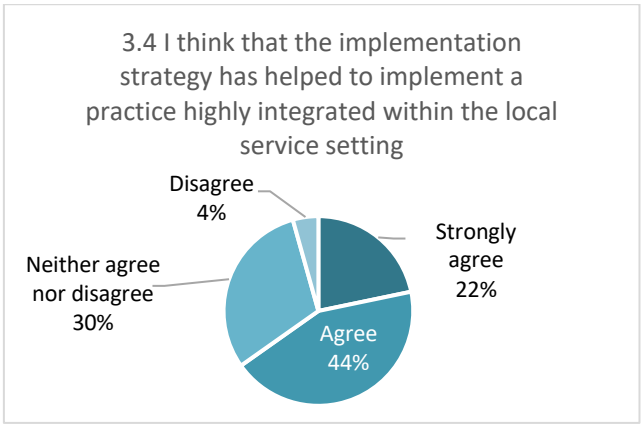
It was also considered important to acknowledge the potential impact of the JADECARE implementation strategy in achieving implementation outcomes, meaning the effects of deliberate and purposive actions to implement new practices and services. The dimensions investigated have been related to some of the outcomes in implementation research described by Proctor[7]: appropriateness, feasibility, fidelity, penetration and sustainability.

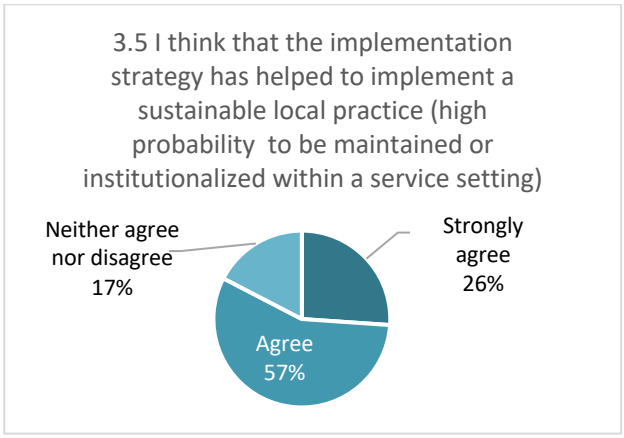
[7] Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38 (2):65-76. doi:10.1007/s10488-010-0319-7











Generally, the respondents considered that the implementation strategy had a positive impact in the design of their local good practices. Four out of the five questions were agreed or strongly agreed by 78% or more respondents. In addition, 96% of the respondents perceived that the implementation strategy supported them to design an appropriate practice; meaning relevant, compatible, aligned and fit to local needs.

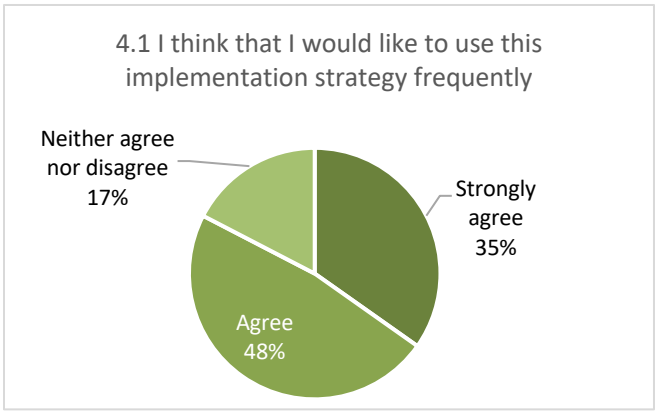
On the other hand, these questions encountered disagreement by maximum 4% of the respondents and none of them received strong disagreement. Finally, the development of a practice that is highly integrated within the

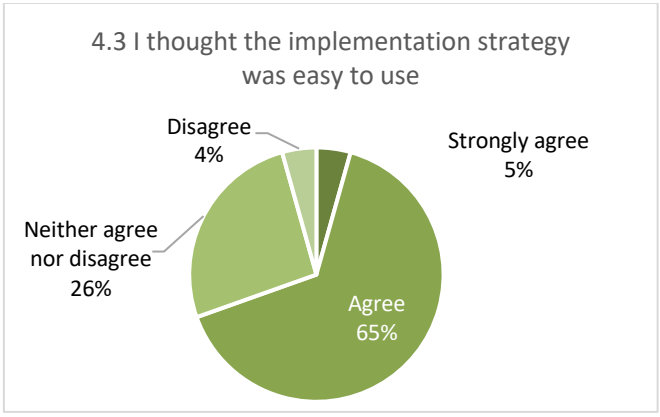
local service setting was considered to be the most neutral aspect of the implementation strategy, as it was neither agreed nor disagreed by 32% of the respondents.

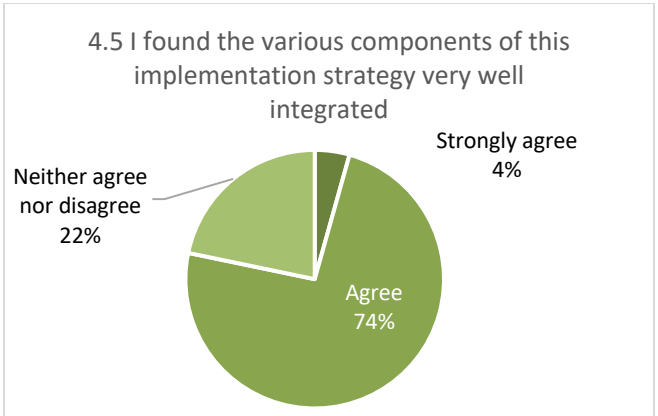
USABILITY OF THE IMPLEMENTATION STRATEGY

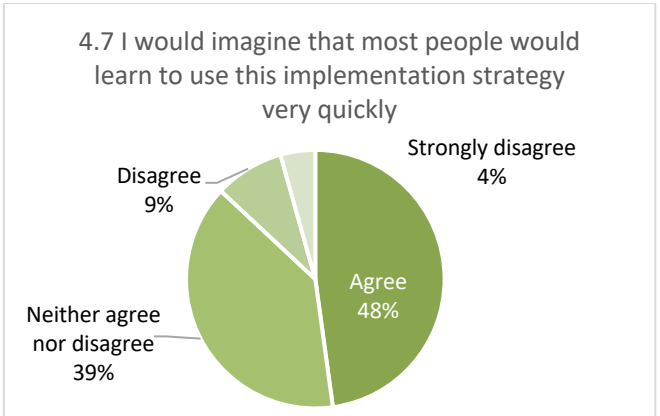
The assessment of the usability of the implementation strategy was done by means of a ten-item *Implementation Strategy Usability Scale (ISUS)*[8]. The objective was to assess the structure, content and complexity of the implementation strategy. The *ISUS* has been used to assess the content in overall (consistency, integration of elements, easy-to-use concept) of the implementation as part of the survey for the assessment of the quality of the implementation. Additionally, an open text question allowed respondents to give their feedback on any other relevant issue.

Five questions asked in a positive sense about the usability of the implementation strategy.

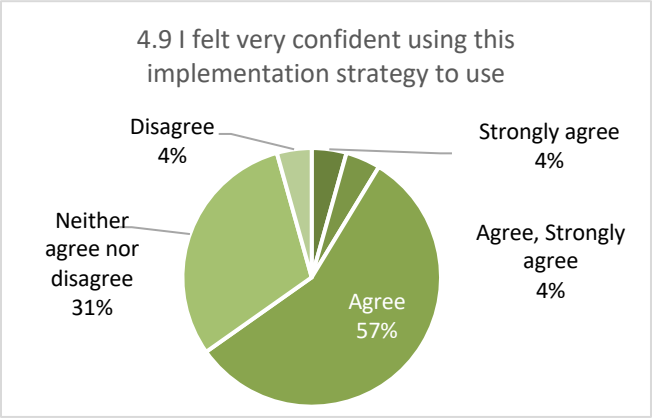






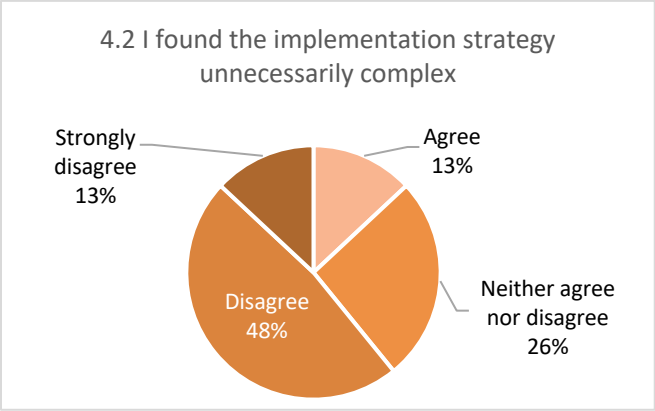


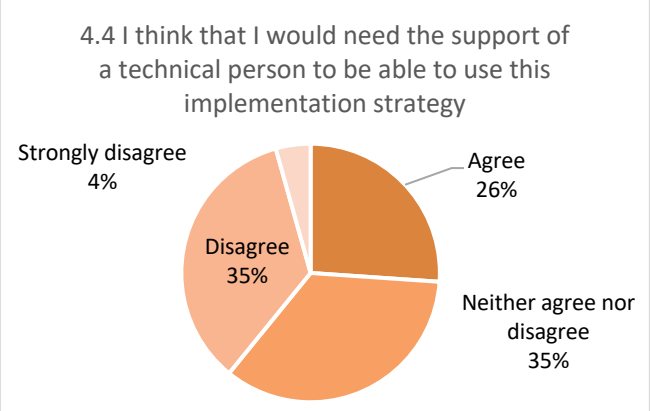
[8] Lyon, A.R., Coifman, J., Cook, H. et al. The Cognitive Walkthrough for Implementation Strategies (CWIS): a pragmatic method for assessing implementation strategy usability. Implement Sci Commun 2, 78 (2021). https://doi.org/10.1186/s43058-021-00183-0

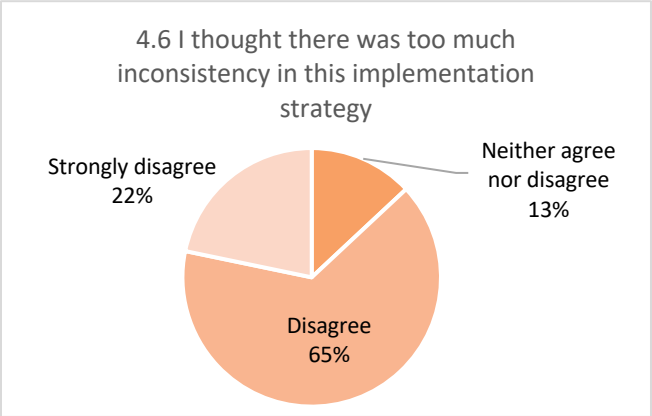


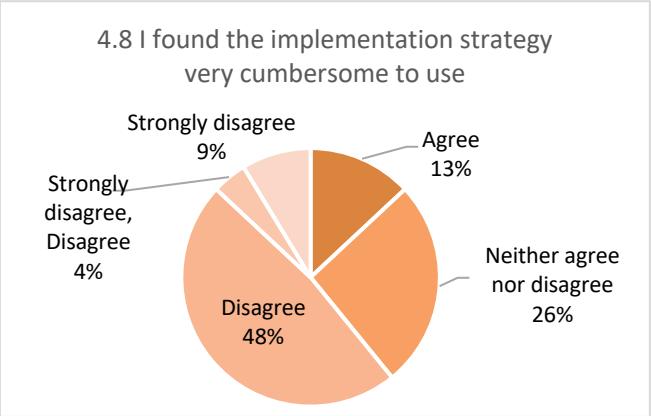
There is a notable variability on how the different usability variables were perceived by respondents. The willingness to use the strategy frequently and the integration between the various components of the implementation were highly agreed or strongly agreed (83 and 78% of the respondents, respectively). Meanwhile the perception about the other aspects remained mainly neutral, thus, the respondents neither agreed nor disagreed with the statements speaking about the ease of using the strategy, the idea of the willingness of the people to learn to use the strategy and the confidence when using the strategy.

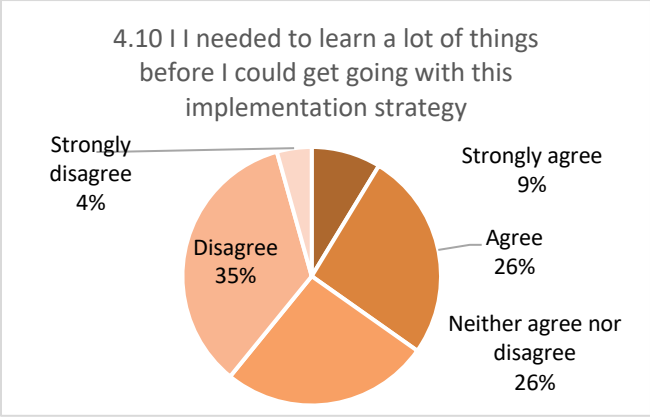
On the other hand, another five questions asked in a negative sense about the usability of the implementation strategy.











In this case, it must be highlighted that most of the respondents disagreed with the inconsistency of the implementation strategy (86% of them). On the other hand, they agreed with feeling the need of learning a lot of things before they could get going with this implementation strategy (36% of respondents agree or strongly agreed) and with needing the support of a technical person to be able to use this implementation strategy (23% agreed).

5.2.2.3 Discussion

In sum, the implementation strategy was considered impactful as well as useful by its users in JADECARE, including both owners of the oGPs and implementers (NAs). The users mainly considered that the implementation strategy helped to plan and implement the Local Good Practices, that it supported them to design an appropriate practice; meaning relevant, compatible, aligned and fit to local needs and that they would like to use this implementation strategy frequently.

6 Impact assessment

6.1 Impact Evaluation Framework

The impact anticipated at the Next Adopter level was influenced by broad factors like the scope and degree of oGP adoption, changes in care pathways and patient management, the involvement and commitment of key stakeholders, the implementation experience, continuity and sustainability of the practice, and improvement/increase of digitalized processes at organization's level of readiness to adopt digitalization. Additionally, digital transformation related to the infrastructure of digital health systems, risk stratification and data analytics, use of technologies like the electronic health record and personal health record as well as electronic prescriptions, citizen empowerment and the use of patient-reported data, reorganization of care pathways, workforce roles and skills, training and research programs, accessibility to health services, management of change towards digitalization, and ethical considerations of digitalization are also discussed.

This impact assessment chapter outlines the proposed approach regarding the JADECARE Impact Assessment Plan and suggests the methodology based on a modified version of the Reach Effectiveness Adoption Implementation Maintenance (RE-AIM) Framework for meeting the objectives set out in the GA. This modified version follows a sequential process for translation of impact through two phases: Research and Reporting. The RE-AIM framework was adjusted and modified to better fit the contextual diversity of the local needs of the impact assessment framework in JADECARE and to evaluate implementation activities and the integration of oGPs' in the contextual environment. A modified version of RE-AIM Framework is illustrated below as a conceptualization of the processes involved during the evaluation of the Impact through this framework.

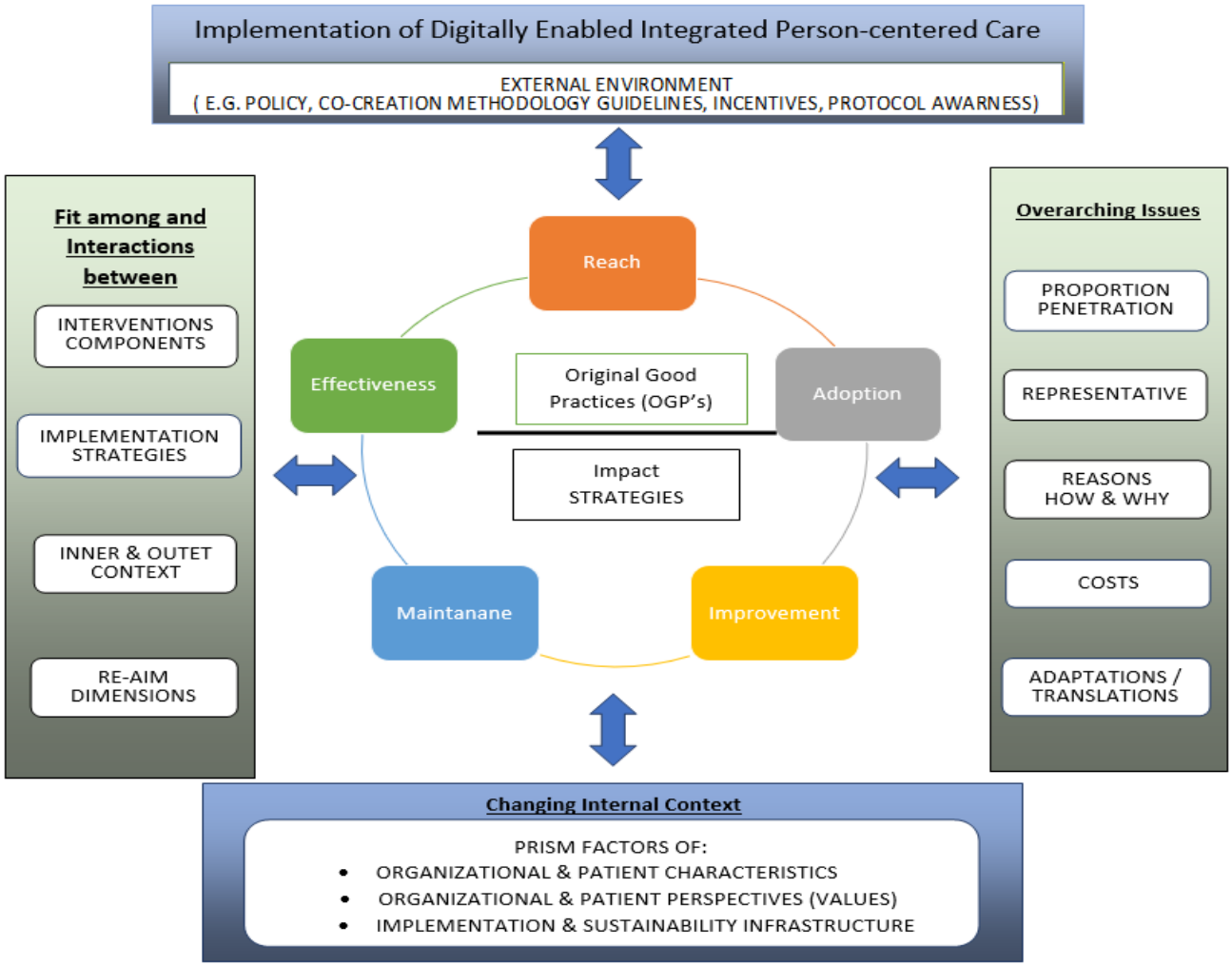


Figure 4: Modified version of RE-AIM Framework made by AUTH for conceptualization of the Impact Assessment of JADECARE

6.2 Methodology

As previously explained the RE-AIM evaluation framework was selected based on the suitability and flexibility to be adjusted and modified on different contextual conditions. The RE-AIM framework includes five dimensions, which correspond to the letters in the designation: Reach, Effectiveness, Adoption, Implementation, and Maintenance. For each of the RE-AIM dimensions, there is a technically correct definition and a "who, what, where, how, and when" question to guide its pragmatic use.

Reach: Is a measure of participation at individual level, incorporating the number, proportion, and representativeness of the participants involved in the intervention or policy change, and refers "to the absolute number, proportion, and representativeness of individuals who participated in activities"

Effectiveness: Represents the intervention impact on main outcomes. This should consider both positive and negative impact (i.e., intended and undesired impact). The technical definition refers to "the impact of an initiative on outcomes, including potential negative effects, heterogeneity, quality of life, and economic outcomes as well as the reasons why (qualitative)" and the practical use refer to "WHAT is the most important benefit LGPs' are trying to achieve and what is the likelihood of negative outcomes?".

Adoption: Is a measure of participation at the organizational level, incorporating the number, proportion, and representativeness of the settings involved. It refers "to the absolute number of the representativeness of settings and agents, and the reasons why (qualitative)" and the practical use considers "WHERE will it be applied and WHO will apply it?".

Implementation: Is the extent to which an intervention is delivered in the specific setting as originally intended, representing a measure of fidelity of implementation and technically refers to "the Fidelity to the intervention protocol, and including adaptations, time, and cost as well as the reasons why (qualitative), the consistency of delivery as intended, adaptations made, and the time and cost of the intervention. The key pragmatic considerations are "How consistently is or was the delivered result?"

Maintenance: Reflects the extent to which an intervention becomes institutionalized or a part of routine practices and policies. This dimension also refers to the sustained observation of outcomes, at individual and organizational levels. The technical definition refers to "The extent to which an implementation becomes institutionalized at the setting level or sustained at an individual level as well as the reasons why (qualitative). As mentioned before, due to the limited duration of JADECARE, in the present impact assessment plan for this dimension an interpretation reflecting the future reality may not be provided.

6.2.1 Data Collection Methods

For the data collection and according to the associated designs, different sources were used, such as:

Management information (project documents and reports)

- National or local health statistics
- Baseline-end line surveys (target group, key informants)
- Stakeholders' consultation through semi-structured Interviews (general or key informants)
- Focus groups (discussions with patients, caregivers, and healthcare providers)

Identification of the entity responsible for the data collection

- Demonstration and development of the data collection procedures
- The data collection instruments need to be tested and modified, as necessary and checked with WP3 leader for consultation.

Responsible for all the data collection is Task 3.3 leaders, the team of AUTH. While they may be responsible for the collection, they have requested and received input from all WPs, from 1 to 8, depending on the indicator under investigation. The quality of the data will be ensured at the time point of each data collection. All the data collection instruments were in the English language to ensure full understanding of the language. All data

collection procedures were consistent, guaranteeing good quality of the data, which was ensured by the AUTH team.

6.3 Collection of Impact Assessment Indicators

I1 No. of NAs with specific process, pathway reorganisation and change management activities performed				**Due**	M30
Justification	Specific process, pathway reorganization and change management				
Data Collection Instrument	Survey			Recipients:	WP5-WP8
Completed	M30	Reason for Delay	N/A		

I2 Number of oGPs´ features covered in transfer process				**Due**	M30
Justification	Scope and degree of adoption of original oGPs				
Data Collection Instrument	Feedback from NA based on Scope definition			Recipients	WP5-8
Completed	M30	Reason for Delay	N/A		

I3 Estimated target population in JADECARE				**Due**	M36
Justification	Target population of JADECARE				
Data Collection Instrument	D5.1-8.1			Recipients	WP5-WP8
Completed	M36	Reason for Delay	N/A		

I4 No of NAs that increased capacity to implement Digitally-Enabled Integrated Person Centred Care (DEIPCC)				**Due**	M30
Justification	This is one of the main objectives of the JA JADECARE				
Data Collection Instrument	Input from WP5-8 after implementation			Recipients	WP3
Completed	M30	Reason for Delay	N/A		

I5 No of NAs with small scale deployment of DEIPCC	**Due**	M30

Justification	Measure the number of NAs that carry out a deployment of DEIPCC in JADECARE		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I6 No of NAs with large scale deployment and/or extended institutionalization of DEIPCC		**Due**	M30
Justification	Measure the number of NAs that carry out a large scale deployment and/or extended institutionalization of DEIPCC in JADECARE		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I7 Perception that JADECARE will support further building up the capacity of national and regional authorities to organize and deliver DEIPCC, as expressed by Policy Board members		**Due**	M36
Justification	Gather the opinion from the Policy Board members about the further building up capacity of national and regional authorities		
Data Collection Instrument	Survey	Recipients	Policy Board members
Completed	M36	Reason for Delay	N/A

I8 Estimated audience of JADECARE dissemination channels		**Due**	M24 & M36
Justification	Measure the number of people reached through the JADECARE dissemination channels		
Data Collection Instrument	JADECARE's dissemination activity reports (Dissemination events, website…)	Recipients	WP2
Completed	M35	Reason for Delay	The data were requested in advance to avoid delays

I9 Estimated audience of JADECARE dissemination channels	**Due**	M24 & M36

Justification	Evidence of intersectoral collaborations (meetings, participation in events, publications and/or emails) with other partnerships		
Data Collection Instrument	Degree of collaboration with other projects, initiatives in fields related to DEIPCC	Recipients	WP2
Completed	M36	Reason for Delay	N/A

I10 No. of MoH of MSs that are not partners of JADECARE, but participate in the Policy Board Dialogues		**Due**	M24 & M36
Justification	The involvement and commitment of policy makers of the MS that are not part of JADECARE		
Data Collection Instrument	List of partners of JADECARE & Participants' list from Policy Board meetings	Recipients	WP3
Completed	M36	Reason for Delay	N/A

I11 No. of DG SANTE and HaDEA representatives in the Policy Dialogues		**Due**	M24 & M36
Justification	Involvement of EU institutions in the policy dialogues		
Data Collection Instrument	Participants' list from Policy Board meetings	Recipients	WP3
Completed	M36	Reason for Delay	N/A

I12 No. of Policy Dialogues of the Policy Board members		**Due**	M24 & M36
Justification	The involvement and commitment of policy makers		
Data Collection Instrument	Participants' list from Policy Board meetings	Recipients	WP3
Completed	M36	Reason for Delay	N/A

I13 Perception of external stakeholders' on the impact of JADECARE in policy setting, and scientific, industrial, and general debates and fora	**Due**	M24 & M36

Justification	Further building up the capacity of national and regional authorities to organize and deliver integrated person-centred care including integration in policies		
Data Collection Instrument	Surveys	Recipients	Stakeholders' network established for JADECARE
Completed	M36	Reason for Delay	The indicator was collected during the 3rd Stakeholders forum

I14 No. of MoH of JADECARE Competent Authorities represented in the Policy Board		**Due**	M24 & M36
Justification	The involvement and commitment of policy makers		
Data Collection Instrument	Participants' list from Policy Board meetings Report	Recipients	WP4
Completed	M36	Reason for Delay	N/A

I15 % of NAs with changes in digital services are confirmed (digital health system infrastructure; data analytics and use of technologies, citizen empowerment tools and patient reported data)		**Due**	M30
Justification	Measure the changes in the digital health system infrastructure of the NAs		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I16 % Perceived improvement of digital services by end users		**Due**	M36
Justification	Perceived improvement of digital services by end users		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	The collection of the indicator was synchronized with the rest of post-implementation indicators

I17 No of software programs improved and updated due to JADECARE	**Due**	M30

Justification	Perceived improvement of digital services by end users		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	The collection of the indicator took place after the finalization of the implementation and the collection of all documents

I18 Perceived probability that the developed practice will be sustainable after the end of JADECARE, according to members of local/regional/national networks among Next Adopters		**Due**	M30
Justification	Project sustainability		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I19 No. of reports including recommendations to Next Adopters sustainability plans		**Due**	M30
Justification	Ensure that all the NAs are implementing sustainability plans to implement actions beyond JADECARE		
Data Collection Instrument	Sustainability reports of the next Adopters	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I20 % Stakeholders who consider the Project useful		**Due**	M30
Justification	Usefulness of JADECARE		
Data Collection Instrument	Survey	Recipients	Project Participants
Completed	M36	Reason for Delay	The collection of the indicator took place during the 3rd Consortium meeting

I21 Satisfaction degree of project beneficiaries	**Due**	M24 & M36

Justification	Degree of satisfaction of the project participants		
Data Collection Instrument	Survey	Recipients	Project Participants
Completed	M36	Reason for Delay	N/A

I22 % of professionals that improve their knowledge and skills		**Due**	M30
Justification	Number of professionals participating in the implementation of JADECARE that increase their knowledge and skills		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I22 % of professionals that improve their knowledge and skills		**Due**	M30
Justification	Number of professionals participating in the implementation of JADECARE that increase their knowledge and skills		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I23 % of core features implemented/total number of core features selected (per Next Adopter)		**Due**	M30
Justification	To outline the real transfer of the core features compared to the expected plan		
Data Collection Instrument	Scope definition & PDSA reports	Recipients	WP5-8
Completed	M30	Reason for Delay	N/A

I24 No. of needs covered by the implementation of JADECARE at NA sites		**Due**	M30
Justification	Measure the number of needs covered by the implementation of JADECARE at NA sites		

Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I25 Availability of Blueprint on learning from Good Practice		**Due**	M35
Justification	The implementation experience		
Data Collection Instrument	D4.2	Recipients	WP4
Completed	M35	Reason for Delay	N/A

I26 No of digital infrastructures (hardware) available to be used due to JADECARE		**Due**	M30
Justification	To obtain information regarding the available infrastructure of each NA		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I27 No. of individuals accessing newly implemented services and infrastructure		**Due**	M30
Justification	Gather the information on the population that have access to newly implemented services and infrastructure deployed in JADECARE		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I28 Target population that has been stratified using the risk stratification tool implemented during JADECARE		**Due**	M30
Justification	Measure the usefulness of the risk stratification approaches implemented during JADECARE		
Data Collection Instrument	D5.1-8.1	Recipients	WP5-WP8 leadership

Completed	M30	Reason for Delay	N/A

I29 Ratio of healthcare services digitalized/targeted			**Due**	M30
Justification	Measure the level of digitalization of healthcare services at NA sites in JADECARE			
Data Collection Instrument	D5.1-8.1		Recipients	WP5-WP8 leadership
Completed	M30	Reason for Delay	N/A	

I30 No. of citizens using citizen empowerment platforms or tools			**Due**	M30
Justification	Measure the usefulness of citizen empowerment platforms or tools			
Data Collection Instrument	D5.1-8.1		Recipients	WP5-WP8 leadership
Completed	M30	Reason for Delay	The indicator was collected once the deliverables were completed	

I31 No. of NAs that consider Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)			**Due**	M30
Justification	Measure the number of NAs that consider PROMs and PREMs			
Data Collection Instrument	D5.1-8.1		Recipients	NAs
Completed	M30	Reason for Delay	The indicator was collected once the deliverables were completed	

I32 No. of new or improved health policies, systems, products and technologies, and services and delivery methods for integrated care reorganization pathways implemented during JADECARE			**Due**	M30
Justification	Measure improvements due to the implementation of the LGPs in JADECARE			
Data Collection Instrument	D41. And D5.1-8.1		Recipients	WP5-8 leadership

Completed	M30	Reason for Delay	N/A

I33 No. of training and research programs launched		**Due**	M30
Justification	Measure the number of training and research programs launched by the NAs		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

I34 No. of participants in training and research programs		**Due**	M30
Justification	Measure the degree of participation in training and research programs deployed in the implementation of the LGPs		
Data Collection Instrument	Survey	Recipients	NAs
Completed	M30	Reason for Delay	N/A

6.4 Results of Indicators

6.4.1 Reach

I1: No. of NAs with specific process, pathway reorganization and change management activities performed.

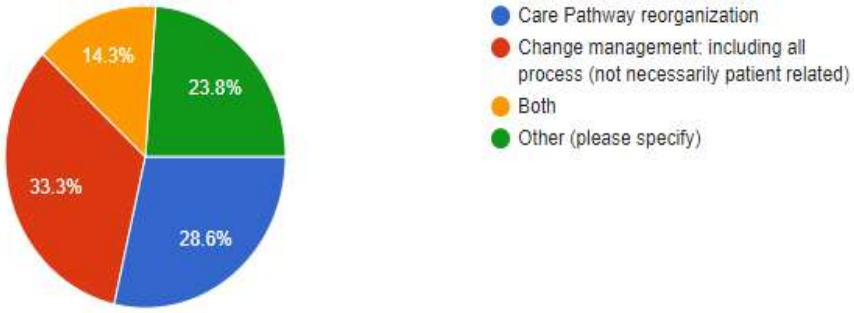


Figure 5: NAs with specific process, pathway reorganization and change management

7 (33.3%) NAs experienced actual change management, while 6 (28,6%) engaged in care pathway reorganization. For 3 (14,3%) of the responders, both change management and care pathway reorganization came as a result of their participation in JADECARE. Finally, 5 (23,8%) chose the option of "other", where they were asked to further elaborate. The most common comment was towards the direction of not having yet experienced either any change management or pathway reorganization, but believing that the change will come as a result of JADECARE in the following years. Finally, some participants highlighted the role of JADECARE on the newly introduced online pathway for both the physicians and the patients. One participant indicated that they did not experience any change due to the activities of the project.

I3: Estimated target population in JADECARE

Next Adopter	Estimated target population	Participation in pilot studies
North Denmark Region (RND)	• 590.439 inhabitants in North Jutland region • 5.627 active diabetes patients	-
Local Health Authority (USL Umbria 1)	• 1.200.000 people affected by heart failure	• 20 patients affected by heart failure (patient empowerment)
Regional Health Agency Tuscany (ARS Tuscany)	• Complex patients with multi-chronicity and management difficulties Piana di Lucca District Zone	• 76 chronic patients identified (target: 100) • 41 chronic patients enrolled • Assessment of 36 chronic patients
Central Administration of the Health System Portugal (ACSS)	• 1.004.546 inhabitants in three regions of the country (Norte, Centro e Alentejo)	-
University Hospital Olomouc (UHO)	• Patients, seniors in homes for the elderly, shelter house clients, people with life-threatening, life-limiting illnesses.	• 10 identified complex patients were included in the "ICP (Individual Care Plan) Folder" of the outpatient EHR (target: >= 10 patients)
Croatian Institute of Public Health (CIPH)	• Patients with leading chronic non-communicable diseases (NCDs) (COPD, hypertension, diabetes mellitus, multimorbidity) with special accent on patients with Diabetes mellitus	• 0 diabetes mellitus patients used the digital platform (target: 25)

Ministry of Health of the Republic of Serbia (MoHRS)	• 360.000 adults Primary Healthcare centres in two Belgrade municipalities pilot project sites: PHC „Zemun “, PHC „Novi Beograd “Gerontology Centre „Beograd “(social care institution in Belgrade with primary healthcare service providing)	-
4th YPE/Aristotle University of Thessaloniki (AUTH)	• 2.000 patients at Hippokration General Hospital, AHEPA General University Hospital, Thessaloniki	• 150.000 for patient classification (target 30.000) • 150 for patient empowerment
Marche Region, I (MARCHE)	• ~1,500,000 habitants in Marche region	-
Viljandi Hospital, EE (VH)	• ~50.000 habitants in Viljandi county	-
Jahn Ferenc South-Pest Hospital and Clinic, HU (JFDPK)	• Multimorbid type 2 diabetes patients with the risk of lower limb minor amputation in the care area of the Jahn Ferenc South Pest Hospital (approx. 100 persons/year) Jahn Ferenc South-Pest Hospital and Clinic	• 15 of patients participated in the risk assessment • 15 patients participated in the Identification of key Medical History Elements • 10 patients got their patient pathway according to the new protocols • 10 patients were assessed with the new health literacy assessment method • 10 patients involved in the education utilising the implemented postoperative complex diabetic and dietetic education system tailored for patients with different health literacy level supported by written and audiovisual tools • 10 patients were involved in the consultation as part of the rehabilitation system

ASL Napoli 2 Nord, I (ASL NA2)	• Health district of ASL NAPOLI 2 NORD	• 3.306 patients were involved in Activity 4 of LCF 2 – Implementation of interoperability between the Platforms (ddPAST, HOMECARE)
The Eurometropole of Strasbourg, France (EUSTRAS)	• 46.530 insured persons in 3 districts in Strasbourg	-
The German speaking community in Belgium – Dienststelle für selbstbestimmtes Leben (DSL)	• ~78.000 inhabitants	-
The Health Insurance Institute of Slovenia (ZZZS)	• 360.000 adults	-
Consejería de Salud y Consumo Junta de Andalucía & Fundación Pública Andaluza Progreso y Salud, Spain, CSCJA & FPS (regional Ministry of Health and Consumer Affairs)	• ~ 125.000 complex chronic patients in Andalusia (patients, approx.). A sample of 500 of these patients will be included in the Andalusian pilot	• 200.000 prioritised complex chronic patients • 23.369 complex chronic patients were included in the Teleconsultation programme • 85.210 (5.852 in 2021, 79.358 in 2022) PCCP enrolled in the Proactive Follow-up programme
Servicio Cántabro de Salud & Instituto de Investigación Marqués de Valdecilla, Spain, SCS & IDIVAL	• Elderly people in nursing homes in Santander Health Area. Cantabria. Spain Cantabria Health Service & Regional Ministry of Health of Cantabria	• 82 participants were involved in the activity “online management of the psychological and behavioral disorders of the elderly with dementia institutionalized in nursing homes” (target 80) • >300 elderly patients registered in the platform (target 50)
Gerencia Regional de Salud de Castilla y León, Spain SACYL	• 2.300.000 inhabitants in Castilla y León region	-

Servicio Murciano de Salud & Fundación para la Formación e Investigación Sanitario de la Región de Murcia, Spain, SMS & FFIF	• Patients who come to the Rehabilitation Service for a physiotherapist treatment. Rehabilitation Service and Physiotherapy Service of the Morales Messenger Hospital, Murcia, Spain.	• 45 participants
Regione Lombardia	• 775.273 inhabitants Lombardy Region	• 60 patients involved in in implementing the Telepsychiatry Core Feature and the Digital Rehabilitation Core Feature
Childrens Clinical University Hospital (CCUH)	• 359.000 children in Latvia • 70.000 patients annually in Emergency department (CCUH) • 17.000 patients are being treated in Inpatient units of CCUH	• -

Table 27: Target population

I8: Estimated audience of JADECARE dissemination channels

For the years 2022 and 2023 (first two quarters), the number of visits to the JADECARE website were the following

Quarter	Unique visitors	Visits	Page views
22-q1	2205	4253	11796
22-q2	2813	4202	11274
22-q3	3259	6726	15721
22-q4	3223	6788	15083
23-q1	2826	8866	16534
23-q2	5029	21703	33270

Table 28: Visitors of JADECARE Website 2022-2023

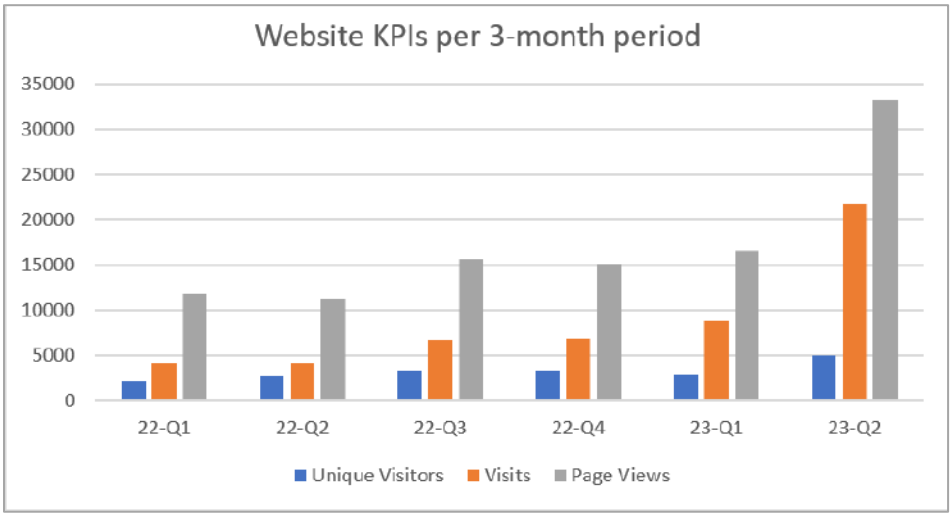


Figure 6: Visitors of JADECARE Website 2022-2023

The Linkedin page currently has over 300 followers

I10: No. of MoH of MSs that are not partners of JADECARE, but participate in the Policy Board Dialogues

During the JADECARE project, 3 policy board meetings took place, on an annual basis. The results of the first Policy board meetings were presented in D3.2: Interim Evaluation report.

The countries that have representatives in the Policy Board of JADECARE outside the consortium are Ireland, Poland and the United Kingdom (UK). The participation of representatives of each of these countries can be found in the following table:

Policy Board Meeting	Ireland	Poland	Uk
2nd	n.a.	n.a.	n.a.
3rd	n.a.	n.a.	n.a.

Table 29: MoH of MSs that are not partners of JADECARE, but participate in the Policy Board Dialogues

I11: No of DG SANTE and HaDEA representatives in the Policy Dialogues

The number of representatives of DG SANTE and HaDEA in the 2nd and 3rd Policy Board meetings can be found in the following table:

Policy Board Meeting	DG Sante representatives	HaDEA representatives
2nd	2	1
3rd	n.a.	n.a.

Table 30: DG SANTE and HaDEA representatives in the Policy Dialogues

I14: No of MoH of JADECARE Competent Authorities represented in the Policy Board

The competent authorities of JADECARE represented in the 2nd and 3rd Policy Board meetings are presented in the following table:

Policy Board meeting	MoHs of CAs represented	Total number
2nd	Croatia Slovenia Italy Greece Estonia Spain Serbia	7/16
3rd	n.a.	n.a.

Table 31: MoH of JADECARE Competent Authorities represented in the Policy Board

I28: Target population that has been stratified using the risk stratification tool implemented during JADECARE

100.000, 3 stratified 100.000-1.000.000 and 2 stratified more than 1.000.000 people.

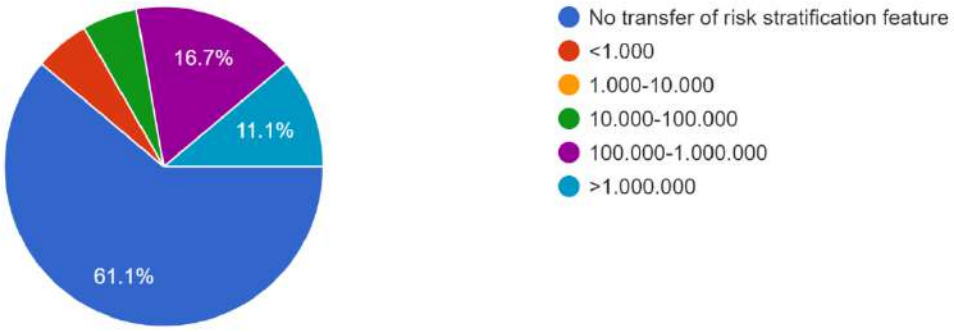


Figure 7: Target population that has been stratified

6.4.2 Effectiveness

I4: No of NAs that increased capacity to implement Digitally-Enabled Integrated Person Centred Care (DEIPCC)

100% of the NAs, when questioned regarding the increase of their capacity to implement DEIPCC, they replied positive. Among them, 9 NAs (42,9%) stated that their capacity to implement DEIPCC has indeed increased very much due to their participation in the JADECARE project. 8 (38,1%) reported that they observed a moderate increase while 3 (14,3%) a slight increase. 1 NA reported an extreme increase in capacity.

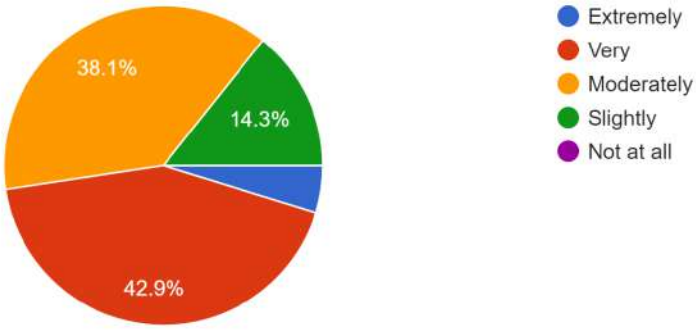


Figure 8: NAs that increased capacity to implement Digitally-Enabled Integrated Person Centred Care (DEIPCC)

I7: Perception that JADECARE will support further building up the capacity of national and regional authorities to organize and deliver DEIPCC, as expressed by Policy Board

After the conclusion of the 2nd Policy Board meeting, a survey was launched towards the participants. All of the responders to the survey stated that the knowledge transferred during the meeting will help to increase the impact of the achieved implementation and transformation results towards DEIPCC.

I13: Perception of external stakeholders' on the impact of JADECARE in policy setting, and scientific, industrial, and general debates and fora

This KPI could finally not be assessed due to lack of responses to the survey.

I16: % Perceived improvement of digital services by end users

1 NA (4,8%) stated that the digital services have undergone extreme improvement due to JADECARE. 5 NAs (23,8%) noticed a high improvement, while 7 (33,3%) moderate. Finally, 4 NAs (19%) had a slight improvement and another 4 no improvement at all.

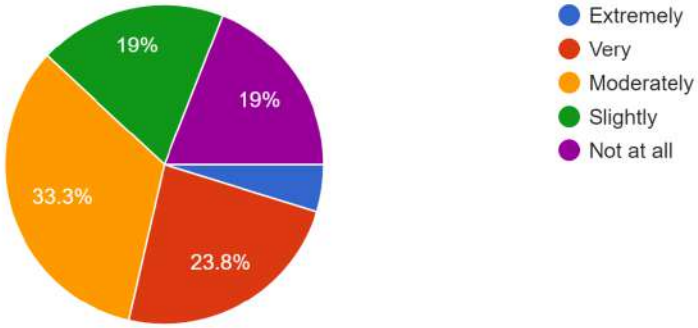


Figure 9: Perceived improvement of digital services by end users

Among the comments for clarification of the answers were the following:

- The awareness/support of key stakeholders is crucial to achieve this kind of improvement
- We are still developing processes and applications, waiting for some decisions that will enable the use of systems faster, e.g. through identification via bank identity, etc.
- Most of them are satisfied with the proposed changes
- There has been a delay in implementation, so that only the teleconsultation could be fully deployed.
- As for now, the perceived improvement is related to patients and physicians involved in the JADECARE project; more specifically, in the Local Implementation Sites implementing the practices of Telepsychiatry and Digital Rehabilitation.

At the moment it is distributed only among the pilot participants, in the next phase, after having distributed the features on a large scale, we will be able to evaluate the actual satisfaction of the end users.

I17: No of software programs improved and updated due to JADECARE

4 NAs (19%) did not purchase, improved or updated any software programs. 2 NAs (9.5%), either improved or updated software programs at digital health system infrastructure and information and process management systems, 5 (23.8%) at data analytics at individual or population level, 4 (19%) at coordination and communication

systems, 6 (28.6%) at citizen empowerment tools, patient reported data and tele-medicine. 1 NA (4.8%) stated that they used other funding for the upgrade, while another that the tools they developed are not yet integrated within the IT systems. The number of upgraded programs varied between 1 and 2.

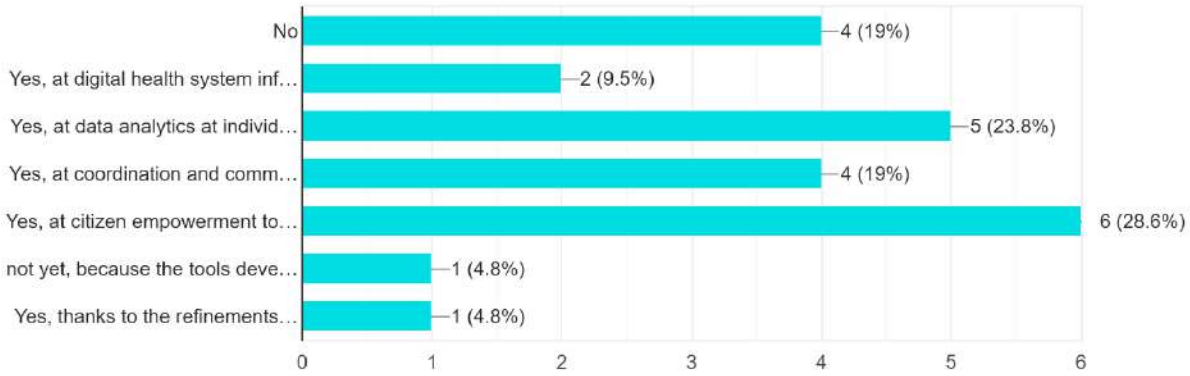


Figure 10: Software programs improved and updated due to JADECARE

I22: % of professionals that improve in knowledge and skills

2 NAs (9,5%) stated that the professionals participating in the implementation of JADECARE extremely improved their knowledge and skills on transfer methodologies. 10 (47,6%) saw a high improvement while 6 (28,6%) a moderate one. 3 NAs (14,3%) noticed a slight improvement, while there were no professionals with no knowledge improvement at all.

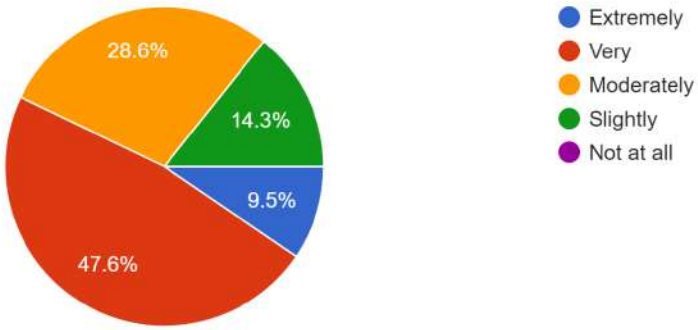


Figure 11: Professionals that improve in knowledge and skills

Among the received comments were:

- The multiprofessionality of the NAWG allowed the members to learn by each other, guided by the project manager and the oGPs
- But these are very important experiences for future development.

- Due to COVID-19 pandemic, the response of professionals was but we expect more involvement in further activities.
- The involved professionals are really satisfied with the experience.
- JADECARE has allowed us to strengthen our knowledge and skills in this field (we already had previous experience in adapting and implementing good practices developed in other contexts).

I24: No of needs covered by the implementation of JADECARE at NA sites

3 NAs (14,3%) stated that their needs were extremely covered by the implementation, while 6 (28,6%) identified a high coverage. 11 NAs (52,4%) achieved a moderate coverage of needs, while 1 (4,4%) just a slight.

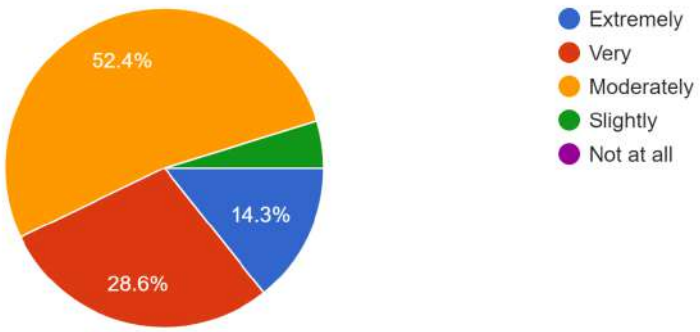


Figure 12: Needs covered by the implementation of JADECARE at NA sites

I26: No of digital infrastructures (hardware) available to be used due to JADECARE

5 NAs (23,8%) reported that due to JADECARE they employed data analytics at individual or population level. 3 (14,3%) used citizen empowerment tools and patient reported data, and while 2 (9,5%) coordination and communication systems were made available during the implementation. 1 (4,8%) used a digital health system infrastructure and information and process management systems. Finally, 1 NA stated that the tools developed (algorithm and dashboard) are not yet integrated in the regional IT infrastructure and 10 NAs (47,6%) did not update or improve any digital infrastructures or hardware. They were asked to specify the reasons and among the most common answers were that no budget for equipment or for hardware/infrastructure was provided during the project. But the need for improvement and the organization of the processes emerged and were facilitated by the JA.

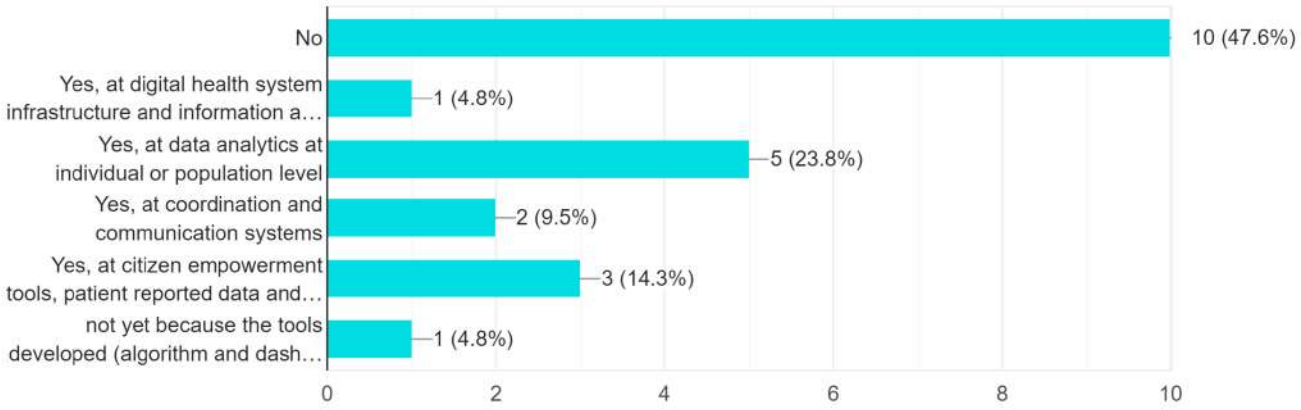


Figure 13: Digital infrastructures (hardware) available to be used due to JADECARE

I32: No of new or improved health policies, systems, products and technologies, and services and delivery methods for integrated care reorganization pathways implemented during JADECARE

4,76% of the NAs reported having extremely created or modified any health policies as a consequence of the implementation conducted in JADECARE, 14,28% reported that they very did it, 28,57% moderately, 28,57% slightly and 23,8% confirmed that they did not do it at all.

6.4.3 Adoption

I2: Number of oGPs´ features covered in transfer process

There were five NAs (ARS Tuscany, USL Umbria 1, AUTH, ACSS, MoHRS) interested in transferring Core Features solely from the Basque integrated care oGP, three NAs interested in the Catalan Innovation Hub oGP (MARCHE, JFDPK, ASL NA2), three NAs focused on the Optimedis model (EUSTRAS, DSL, ZZZS), and six NAs chose features from the Danish roadmap towards integrated care oGP (CSCJA & FPS, SCS & IDIVAL, SACYL, SMS & FFIF, Regione Lombardia, CCUH). On the other hand, four NAs chose a Mix and Match approach, i.e. to adopt Core Features from different good practices: 2 NAs mixed the Basque practice with the South Denmark Region practice (CIPH, UHO), 1 NA the Basque good practice with the Optimedis practice (RND), and 1 NA (VH) the Catalan oGP with the Optimedis practice. Core features from almost all the blocks consisting the oGPs were chosen for transfer except from B4- Innovative assessment and regulatory aspects (The Catalan Innovation Hub oGP).

oGP	Block	NAs	Number of NAs
Basque integrated care	B1-Risk stratification	RND, USL Umbria 1, ARS Tuscany, ACSS, CIPH, MoHRS, 4TH YPE/AUTH	7
Basque integrated care	B2- Integrated Care in the Basque Country	USL Umbria 1, ARS Tuscany, ACSS, UHO,	6

		CIPH, MoHRS	
Basque integrated care	B3- Patient empowerment	USL Umbria 1, CIPH, MoHRS, 4TH YPE/AUTH	4
The Catalan Innovation Hub	B1-Health Risk Assessment: population-based and enhanced clinical decision making	MARCHE, VH, JFDPK	3
The Catalan Innovation Hub	B2-Promotion of healthy lifestyles	JFDPK	1
The Catalan Innovation Hub	B3- Vertical and Horizontal integration experiences adopted in Catalonia	JFDPK, ASL NA2	2
The Catalan Innovation Hub	B4- Innovative assessment and regulatory aspects	-	0
The Catalan Innovation Hub	B5- Digital support of integrated care services	JFDPK, ASL NA2	2
Optimedis model	B1 - Shared savings contract with reimbursement/commissioning organizations (statutory health insurance company)	VH, EUSTRAS, DSL, ZZZS	4
Optimedis model	B2 - A model including strong stakeholder engagement	VH, EUSTRAS, DSL, ZZZS	4
Optimedis model	B3 - Electronic integration across provider	DSL, ZZZS	2
Optimedis model	B4 - Patient involvement and empowerment	EUSTRAS, DSL, ZZZS	3
Optimedis model	B5 - Data-driven management	RND, EUSTRAS, DSL, ZZZS	4
Optimedis model	B6 – Prevention, health promotion and public health	EUSTRAS, DSL, ZZZS	3
The Danish roadmap towards integrated care	B1 - Cross-sectorial digital communication: Standards and Agreements	CIPH, SACYL, CCUH	3
The Danish roadmap towards integrated care	B2 - Cross-sectorial digital communication: Additional solutions to support complex disease areas	UHO, CIPH, CSCJA & FPS, SCS & IDIVAL, SACYL, SMS & FFIF, Regione Lombardia, CCUH	8

Table 32: oGPs´ features covered in transfer process

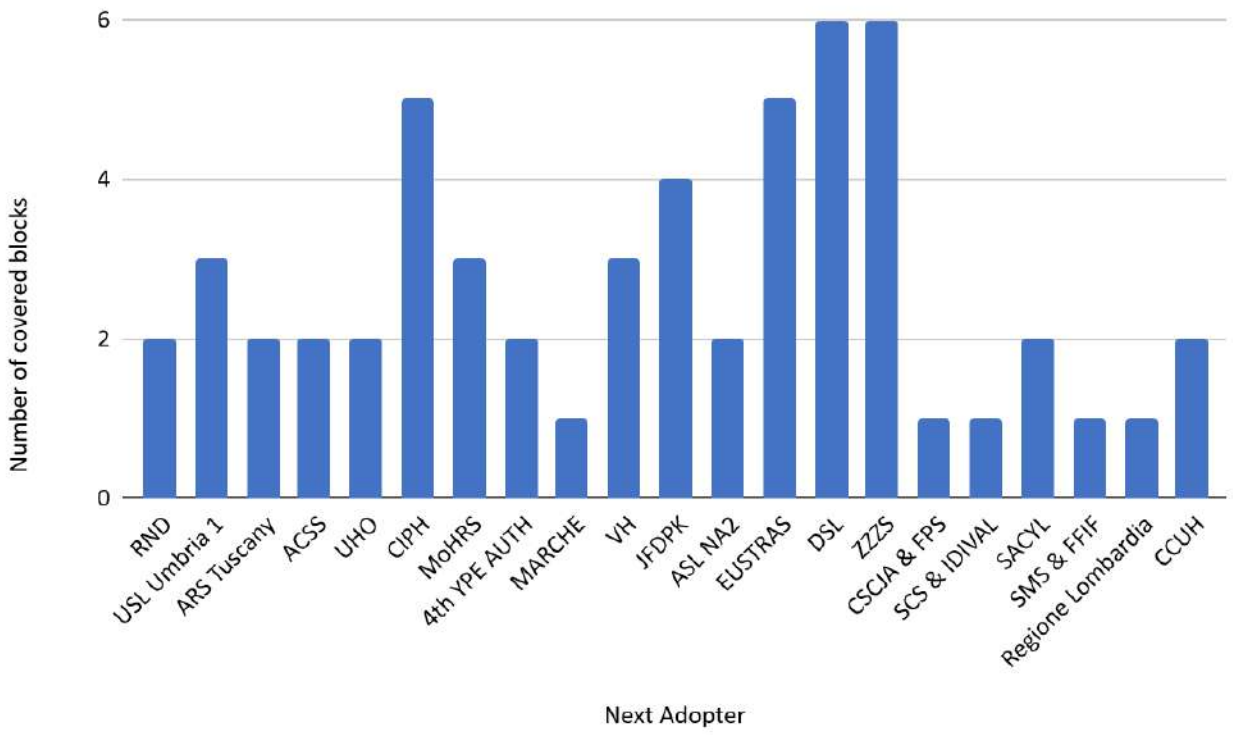


Figure 14: Transferred blocks per Next Adopter

I5: No of NAs with small scale deployment of DEIPCC & I6: No of NAs with large scale deployment and/or extended institutionalization of DEIPCC

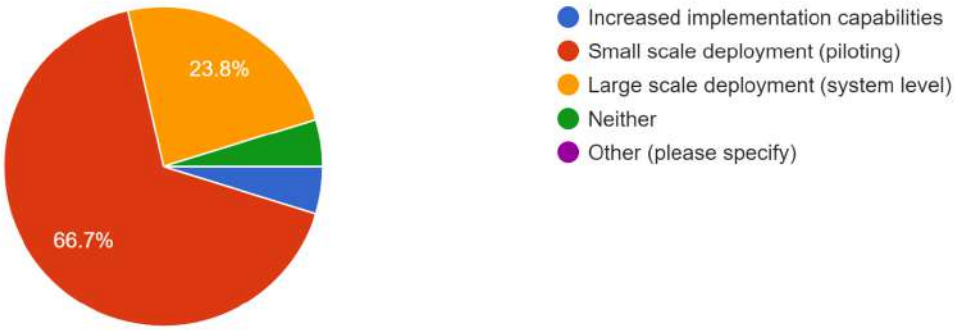


Figure 15: NAs with small scale or large scale deployment and/or extended institutionalization of DEIPCC

14 NAs (66,7%) implemented a small-scale deployment during JADECARE. The deployment reached the status of an initial pilot in a small population group and served as an exploratory phase with the possibility of further improvement. 5 NAs (23,8%) proceeded in a large scale deployment of DEIPCC, with implementation reaching a

system level. 1 NA (4,8%) implemented no deployment at all, but rather increased their implementation capacities, paving the road for future work. Finally, 1 NA reported no deployment and no capabilities increased.

I15: % of NAs with changes in digital services are confirmed (digital health system infrastructure; data analytics and use of technologies, citizen empowerment tools and patient reported data)

5 NAs (23,8%) reported a change in coordination and communication system, while another 5 reported a change in data analytics at individual or population level. 4 NAs (19%) experienced change at citizen empowerment tools, patient reported data and tele-medicine, while 2 (9,5%) in digital services and more specifically at digital health system infrastructure and information and process management systems. Finally, 6 NAs (28,6%) did not confirm any changes in digital services due to the JADECARE implementation.

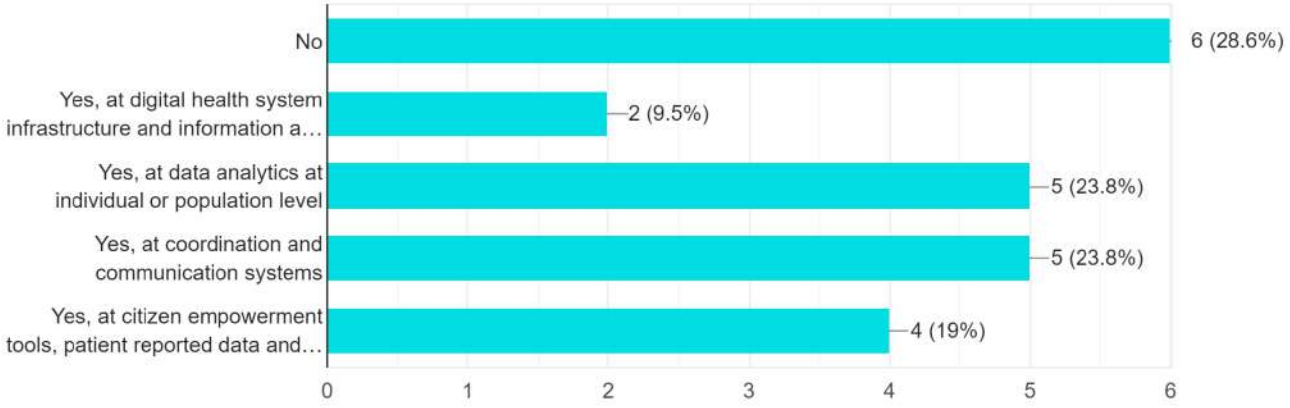


Figure 16: NAs with changes in digital services are confirmed

The NAs that reported changes in digital services were asked to provide a ratio of healthcare services digitalized over the healthcare services targeted to be digitalized at local sites. The received answers were the following:

- Created a new population dashboard
- Our vision is to apport changes at the levels selected; We are actually working to guarantee the prompt and complete operation of the algorithm and the dashboard. Next step will be to integrate these tools in the regional IT infrastructure, in order to achieve our goal
- Teledermatology: in all the health areas
- Telepresence: in CCU (Continuity Care Units), in three Health Areas (11 Health Areas in total)
- 80% face-to-face 20% virtual, in the worst case.
- 50%
- 2/2
- local
- 50%
- The complexity of data management led to delays

- This distribution varies depending on the services and pathologies. Nevertheless, the tele-assistance was positive in all cases, but it could not be enough for all cases.
- The digitalisation that we planned will happen outside the JADECARE timeline

I23: % of core features implemented/total number of core features selected (per Next Adopter)

Next Adopter	% core features implemented/features selected
North Denmark Region (RND)	100
Local Health Authority (USL Umbria 1)	83.3
Regional Health Agency Tuscany (ARS Tuscany)	66.7
Central Administration of the Health System Portugal (ACSS)	100
University Hospital Olomouc (UHO)	100
Croatian Institute of Public Health (CIPH)	75
Ministry of Health of the Republic of Serbia (MoHRS)	75
Aristotle University of Thessaloniki (AUTH)	66.7
Marche Region, I (MARCHE)	100
Viljandi Hospital, EE (VH)	100
Jahn Ferenc South-Pest Hospital and Clinic, HU (JFDPK)	100
ASL Napoli 2 Nord, I (ASL NA2)	100
The Eurometropole of Strasbourg, France (EUSTRAS)	80
The German speaking community in Belgium – Dienststelle für selbstbestimmtes Leben (DSL)	100
The Health Insurance Institute of Slovenia (ZZZS)	100
Consejería de Salud y Consumo Junta de Andalucía & Fundación Pública Andaluza Progreso y Salud, Spain, CSCJA & FPS	100
Servicio Cántabro de Salud & Instituto de Investigación Marqués de Valdecilla, Spain, SCS & IDIVAL	100
Gerencia Regional de Salud de Castilla y León, Spain SACYL	100

Servicio Murciano de Salud & Fundación para la Formación e Investigación Sanitario de la Región de Murcia, Spain, SMS & FFIF	100
Regione Lombardia	50
Childrens Clinical University Hospital (CCUH)	100

Figure 17: Core features implemented

I30: No of citizens using citizen empowerment platforms or tool

8 NAs employed citizen empowerment platforms and/or tools. The total number of people using it is calculated to be over 600.000.

Among the received comments were the following:

- Patient empowerment features, indirectly impacted patients and their empowerment within the app modifications.
- Site is still in demo version so we do not yet have active end users.
- 35000 could potentially use the developed tools as "empowerment features". Mainly people from rehabilitation and school of patients services.
- All target population (200000 prioritised complex chronic patients)
- About 10 patients coming from each of the 3 Implementation Sites have been involved in implementing the Telepsychiatry Core Feature.
- About 10 patients coming from each of the 3 Implementation Sites have been involved in implementing the Digital Rehabilitation Core Feature.
- All chronic kidney disease, that will enter into the treatment process.
  Tthe information transferred by professionals to patients being treated for heart failure is known and attributable to the number of patients treated in the pilot group;
- Citizens reached through online channels or printed material cannot be quantified exactly

I31: No of NAs that consider Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs)

4 NAs (19%) used PREMs for the evaluation of the LGP, while only 1 (4,8%) employed PREMs. 2 NAs (9,5%) considered both measures. The majority of NAs (14, 66,7%) did not use any patient reported measures.

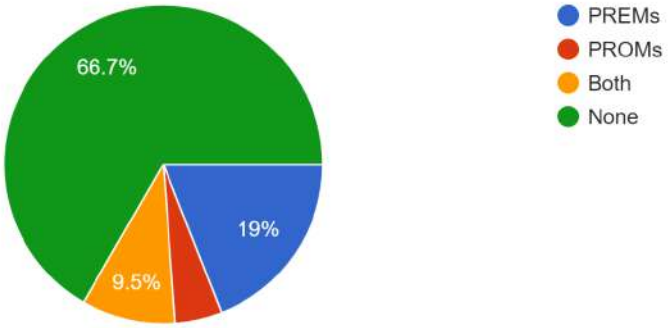


Figure 18:Employment of PREMs and PROMs

Among the received comments, belonging to responders who did not use either PREMs or PROMs were:

- Not immediate use of PREMs or PROMs, but consideration for the long-term
- The evaluation will take place after the conclusion of the project
- Use of not standardized questionnaires, but rather self-designed ones

I33: No of training and research programs launched

Among the 9 NAs that launched either a training or a research program, 3 NAs launched 1, 4 NAs launched 2, 1 NA launched 5 while 1 NA launched 8 training and research programs during the duration of the project.

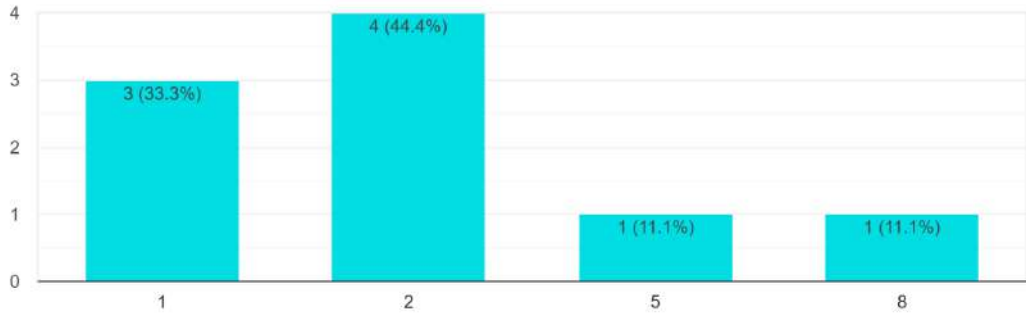


Figure 19: No of training and research programs launched

6.4.4 Implementation

I2: Evidence of intersectoral collaborations (meetings, participation in events, publications and/or emails) with other partnerships

Regarding intersectoral collaborations, the coordination team has participated in the following meetings and events:

- Organisation of the Final Conference of JADECARE within the program of the EHFG 2023. Moderation of the event by Ewout van Hineneken, from the European Observatory on Health Systems and Policies
- Meetings with European Observatory on Health Systems and Policies to seek collaboration possibilities. Preparation of an article for a special issue of the journal Eurohealth, the journal of the European Observatory on Health Systems and Policies.
- Meeting with the implementation team of the Joint Action JACARDI, to share knowledge based on the JADECARE experience as coordinators and implementation developers during July-August-September 2023 + Preparation of material for the development of the implementation methodology based on JADECARE experience
- Meeting with the Coordination team of the JA ImpleMENTAL for knowledge transfer of key learnings of coordination of a Joint Action in January 2023
- Meeting with the Coordination team of the Joint Action Care4Diabetes in June 2023 to share knowledge about the JADECARE implementation strategy + meeting with partners of the Joint Action to assess about specific methodology used during the implementation process in JADECARE
- Meeting with HaDEA and DG Sante in March 2023 to update on the state of play of the project
- Presentation of the JADECARE Joint Action and the implementation strategy by the Coordination team in the Systems Medicine course, core subject of the Master's Degree in Clinical Research at the University of Barcelona, in November 2022.

I12: No of Policy Dialogues of the Policy Board members

In total 3 Policy Dialogues took place during the JADECARE project. The first one was reported in D3.2: Interim Evaluation.

The 2nd Policy Dialogue took place on November 17th 2022, while the 3rd one on 22nd of June 2023.

I12: % Stakeholders consider Project useful

Among the 47 responders, 14 (29.8%) consider JADECARE extremely useful, 24 (51.5%) consider it useful, while 9 (19.1%) consider the project moderately useful. There were no negative responses, or even responses towards slight usefulness of JADECARE.

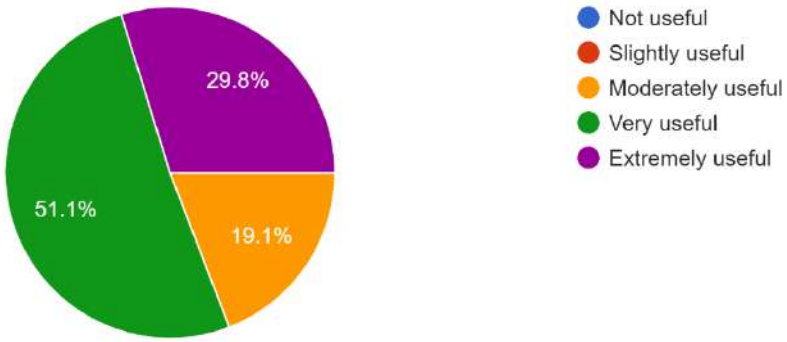


Figure 20: Stakeholders consider Project useful

I21: Satisfaction degree of project beneficiaries

D3.2 included the satisfaction of the NAs with the pre-implementation phase.

To complement these results, the Satisfaction of NAs with the oGPs leader's support and follow-up during implementation period is presented below:

Basque Health Strategy in Ageing and Chronicity: Integrated Care

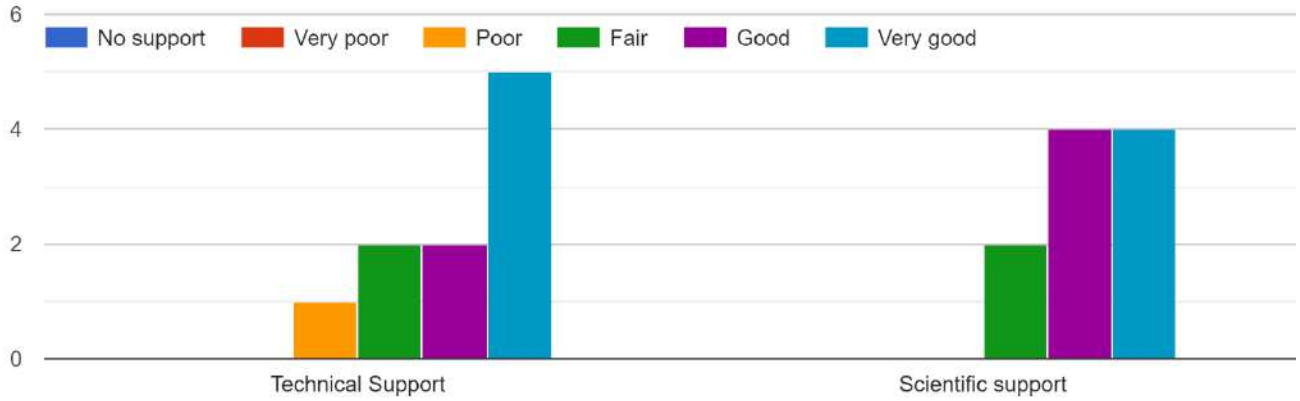


Figure 21: Perceived technical and scientific support received by the Basque oGP, NAs

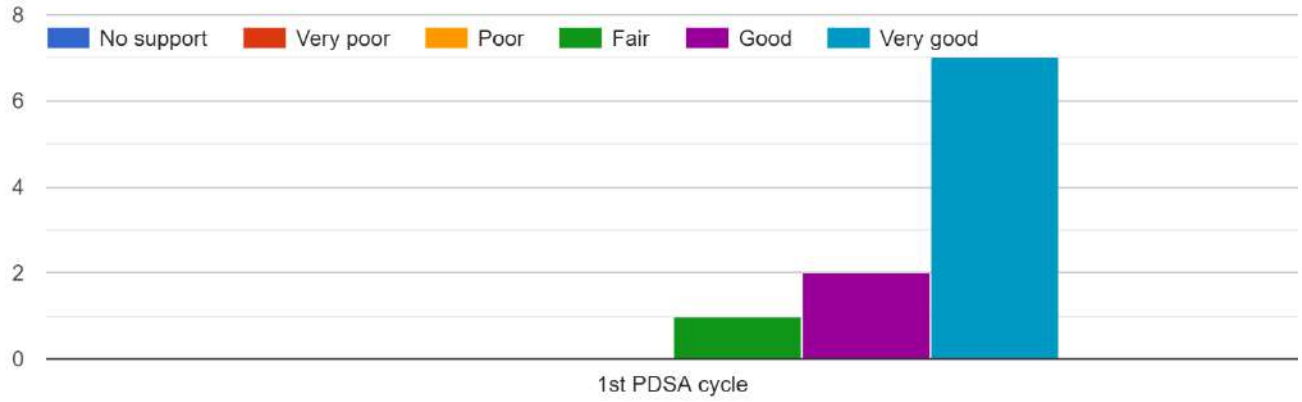


Figure 22: Perceived support received during 1st PDSA cycle by the Basque oGP, NAs

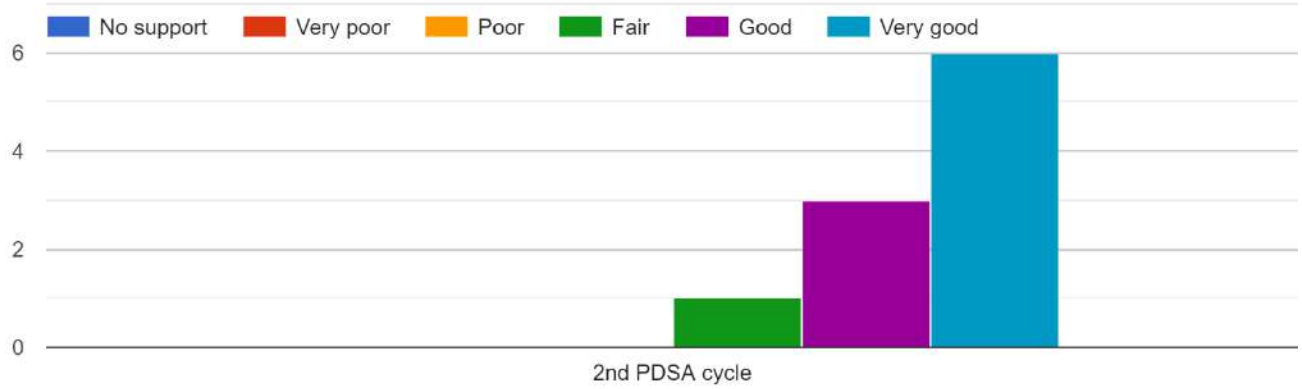


Figure 23: Perceived support received during 2nd PDSA cycle by the Basque oGP, NAs

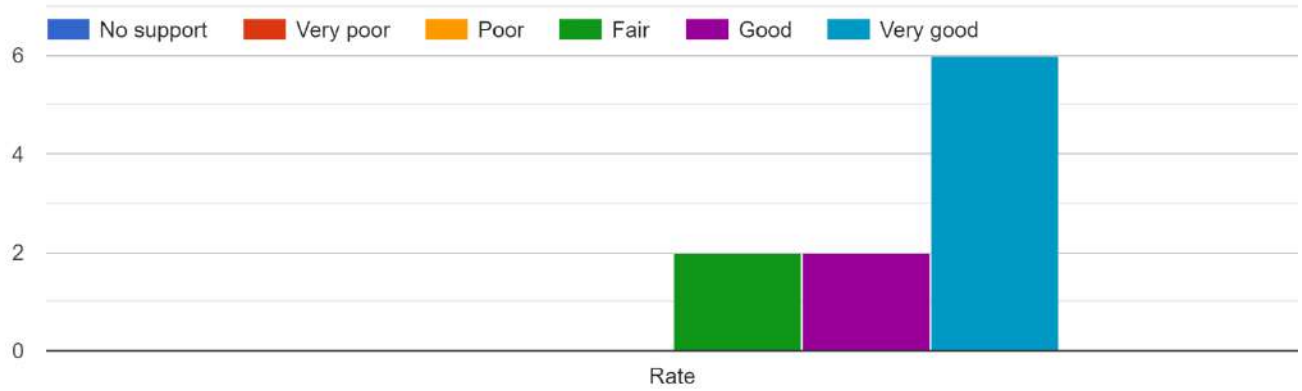


Figure 24: Perception of information provided by the oGP leaders and access to materials that enable the transfer of the practice by the Basque oGP, NAs

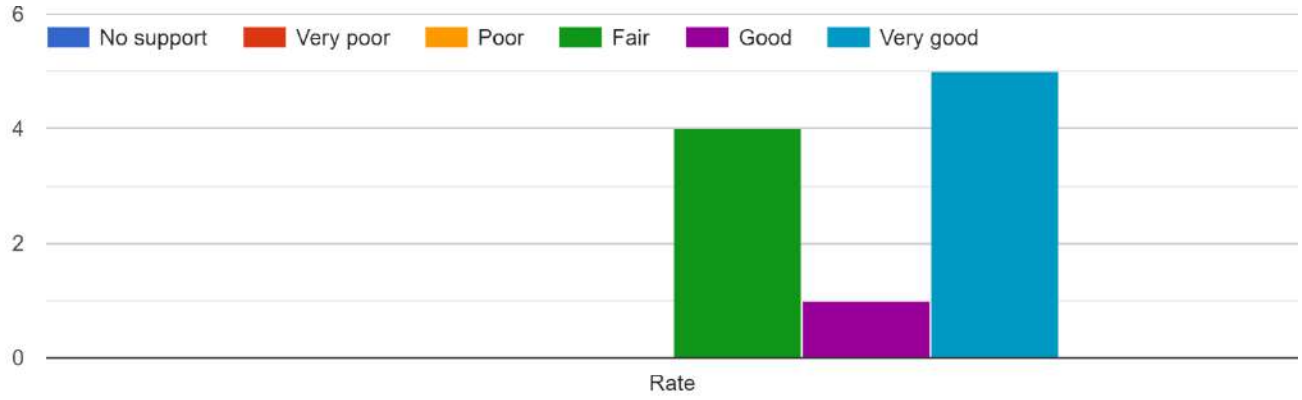


Figure 25:Pperceived satisfaction with access to more precise topics, contact with experts of the oGP by the Basque oGP, NAs

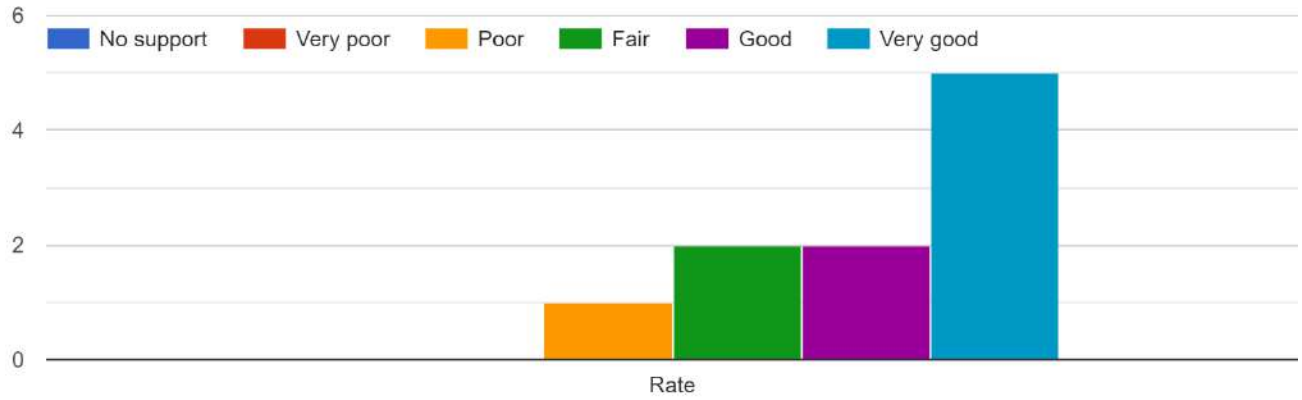


Figure 26: Perceived satisfaction with feedback provided by the oGP leaders to the work developed by the NAWG, by the Basque oGP, NAs

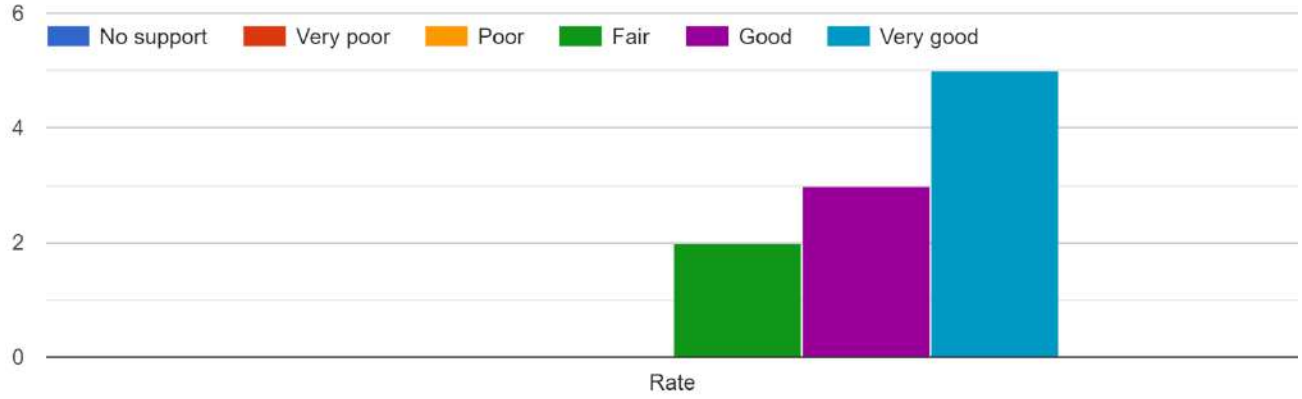


Figure 27: Perceived satisfaction with the frequency of follow-up meetings organized by the oGP leaders, the content and how they were conducted by the Basque oGP, NAs

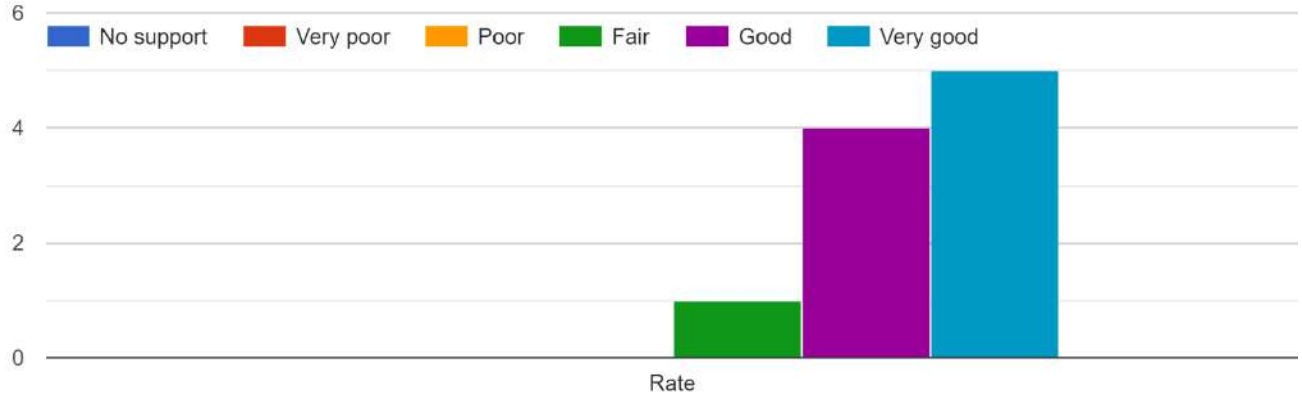


Figure 28: Perceived satisfaction with the bilateral attention and answers provided by the oGP leaders, in case particular questions were sent by the Basque oGP, NAs

The Catalan Open Innovation Hub on Ict-Supported Integrated Care Services for Chronic Patients

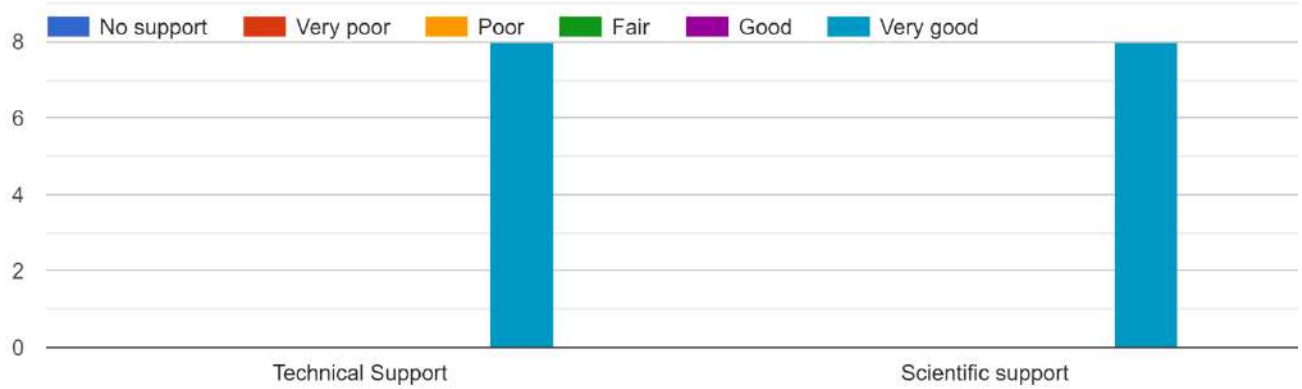


Figure 29: Perceived technical and scientific support received by the Catalan oGP, NAs

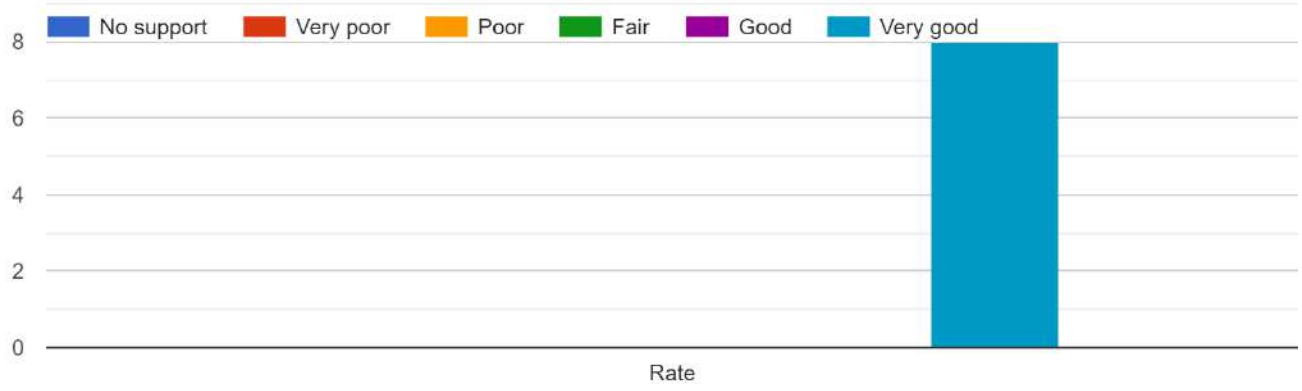


Figure 30: Perceived support received during 1st PDSA cycle by the Catalan oGP, NAs

Figure 31: Perceived support received during 2nd PDSA cycle by the Catalan oGP, NAs

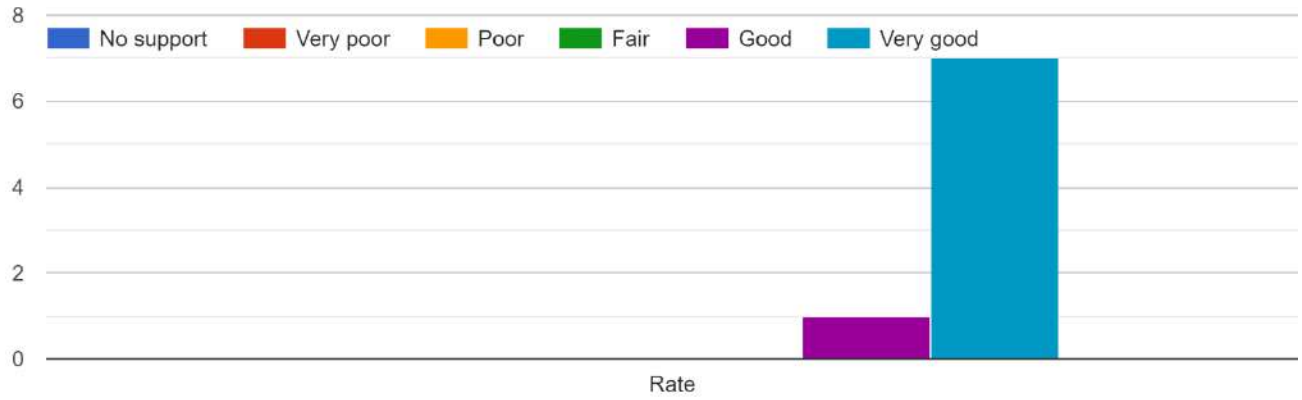


Figure 32: Perception of information provided by the oGP leaders and access to materials that enable the transfer of the practice by the Catalan oGP, NAs

Figure 33: Perceived satisfaction with access to more precise topics, contact with experts of the oGP by the Catalan oGP, NAs

Figure 34: Perceived satisfaction with feedback provided by the oGP leaders to the work developed by the NAWG, by the Catalan oGP, NAs

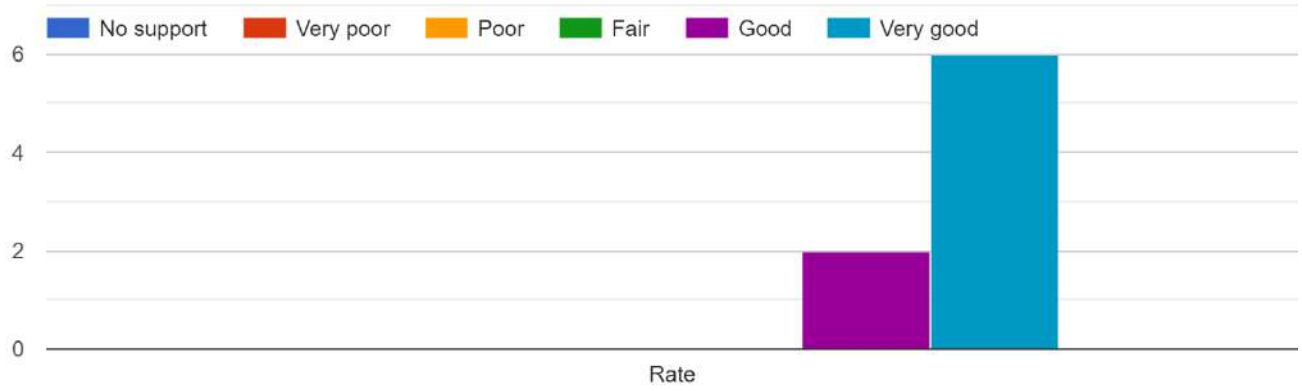


Figure 35: Perceived satisfaction with the frequency of follow-up meetings organized by the oGP leaders, the content and how they were conducted by the Catalan oGP, NAs

Figure 36: Perceived satisfaction with the bilateral attention and answers provided by the oGP leaders, in case particular questions were sent by the Catalan oGP, NAs

Optimedis Model-Population-Based Integrated Care (Germany)

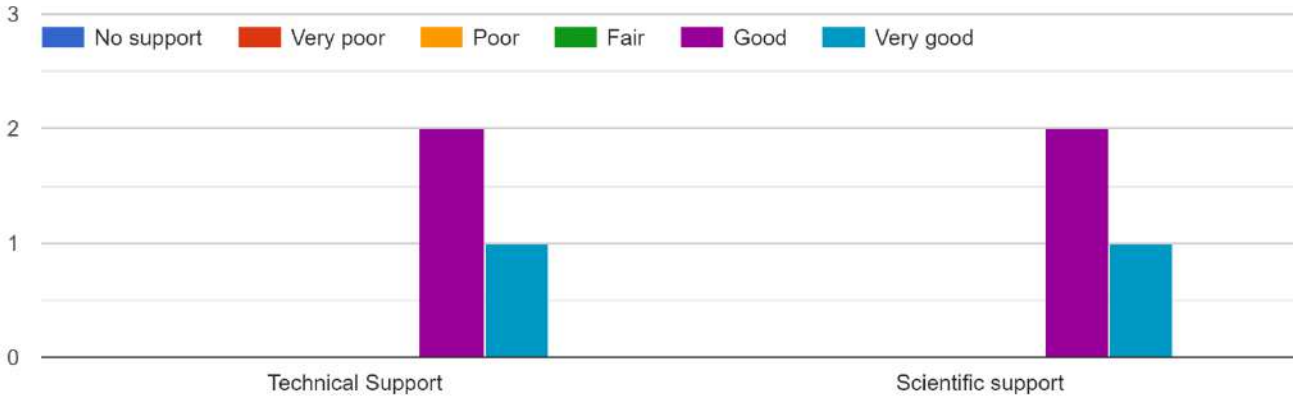


Figure 37: Perceived technical and scientific support received by the Optimedis oGP, NAs

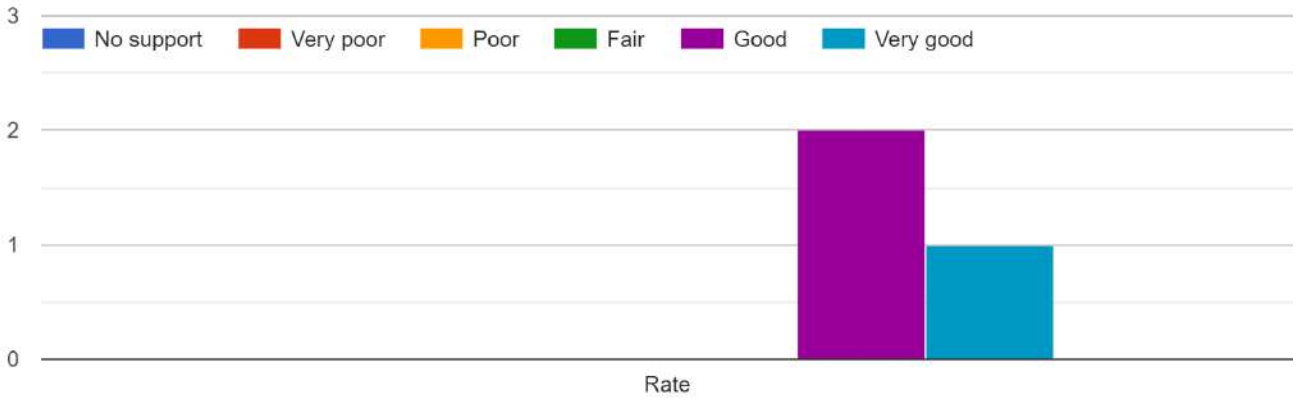


Figure 38: Perceived support received during 1st PDSA cycle by the Optimedis oGP, NAs

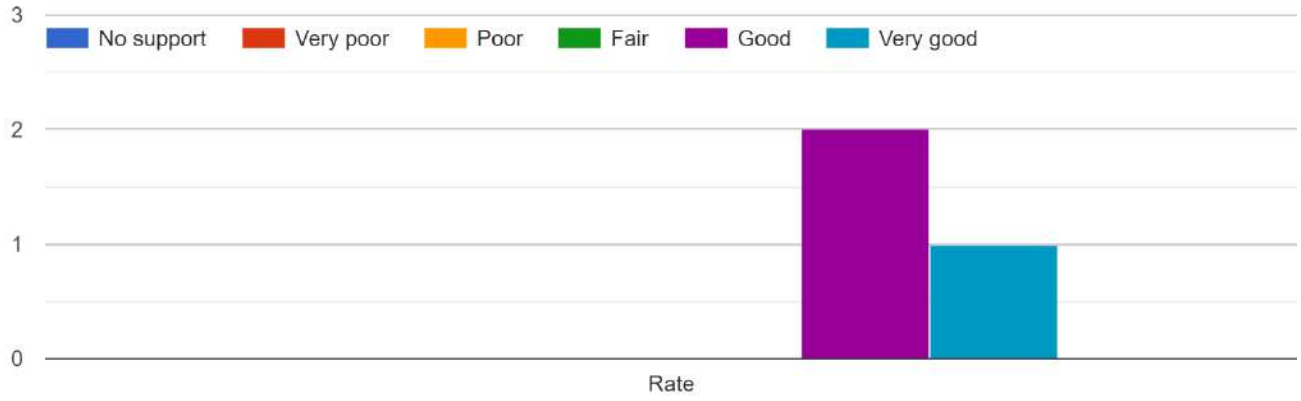


Figure 39: Perceived support received during 2nd PDSA cycle by the Optimedis oGP, NAs

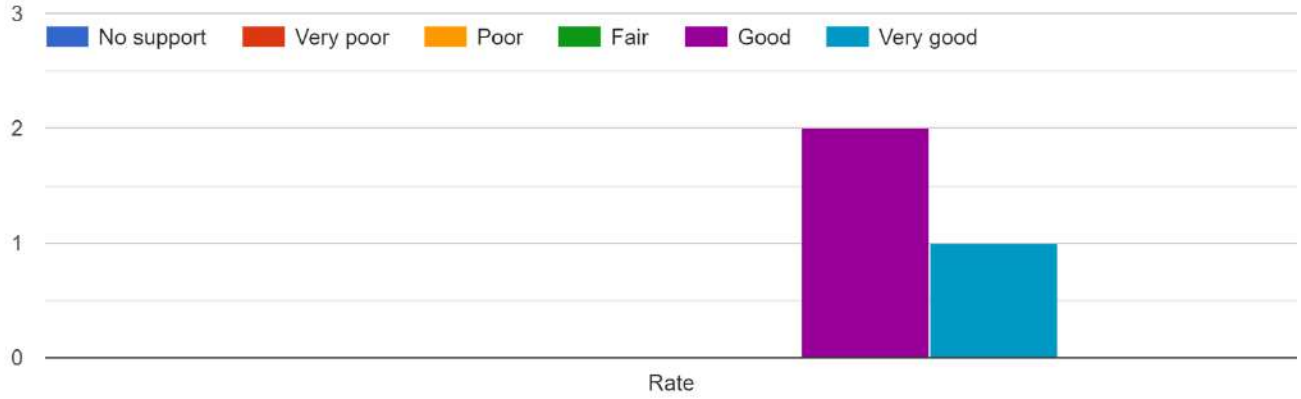


Figure 40: Perception of information provided by the oGP leaders and access to materials that enable the transfer of the practice by the Optimedis oGP, NAs

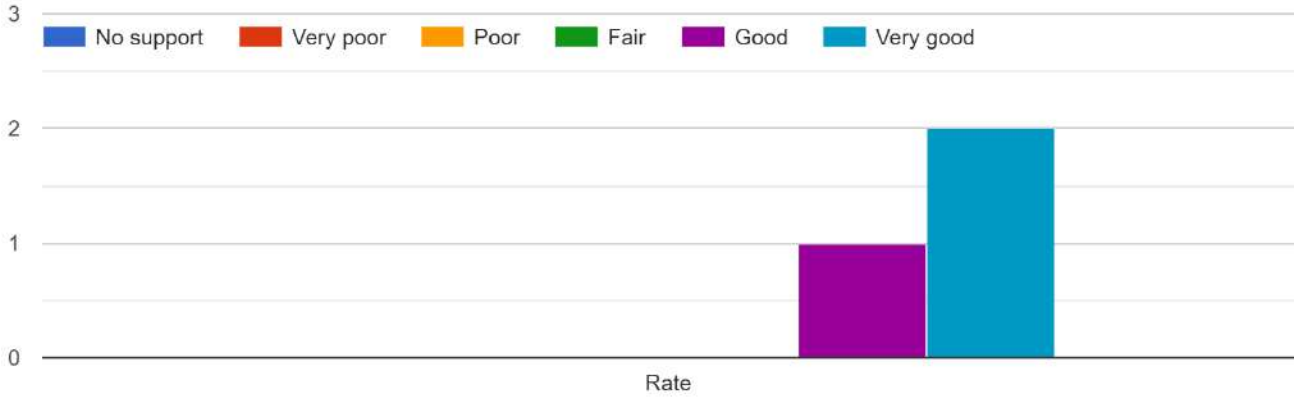


Figure 41: Perceived satisfaction with access to more precise topics, contact with experts of the oGP by the Optimedis oGP, NAs

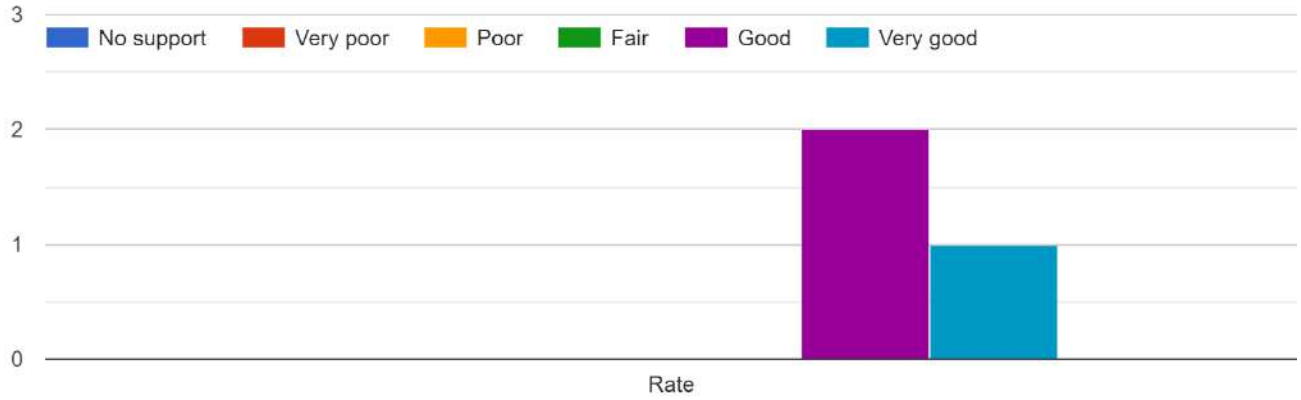


Figure 42: Perceived satisfaction with feedback provided by the oGP leaders to the work developed by the NAWG, by the Optimedis oGP, NAs

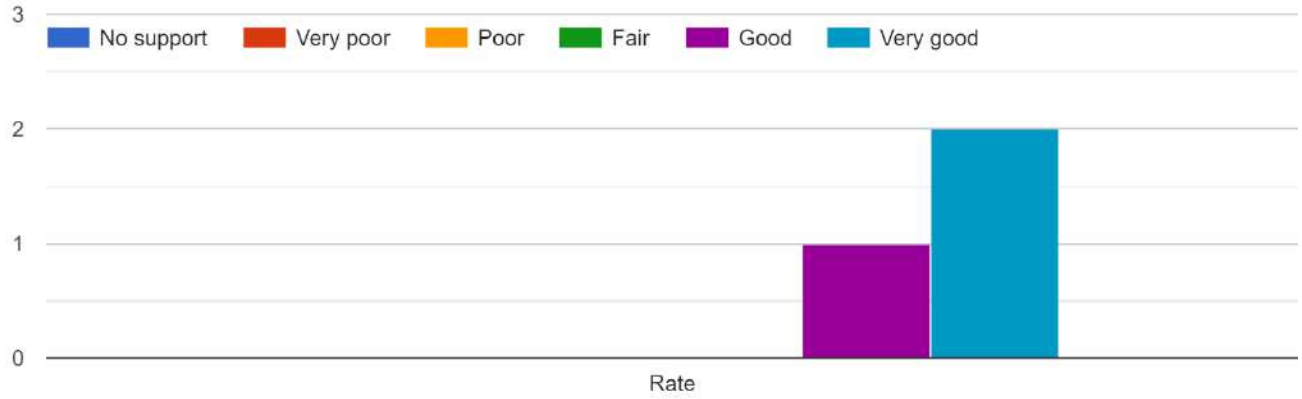


Figure 43: Perceived satisfaction with the frequency of follow-up meetings organized by the oGP leaders, the content and how they were conducted by the Optimedis oGP, NAs

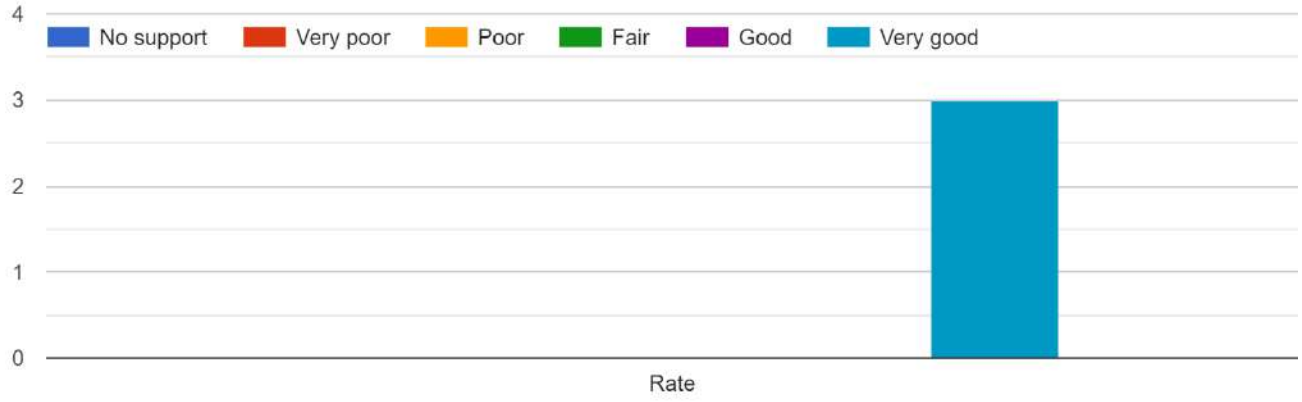


Figure 44: Perceived satisfaction with the bilateral attention and answers provided by the oGP leaders, in case particular questions were sent by the Optimedis oGP, NAs

Digital Roadmap towards an integrated Health Care Sector (Region of South Denmark)

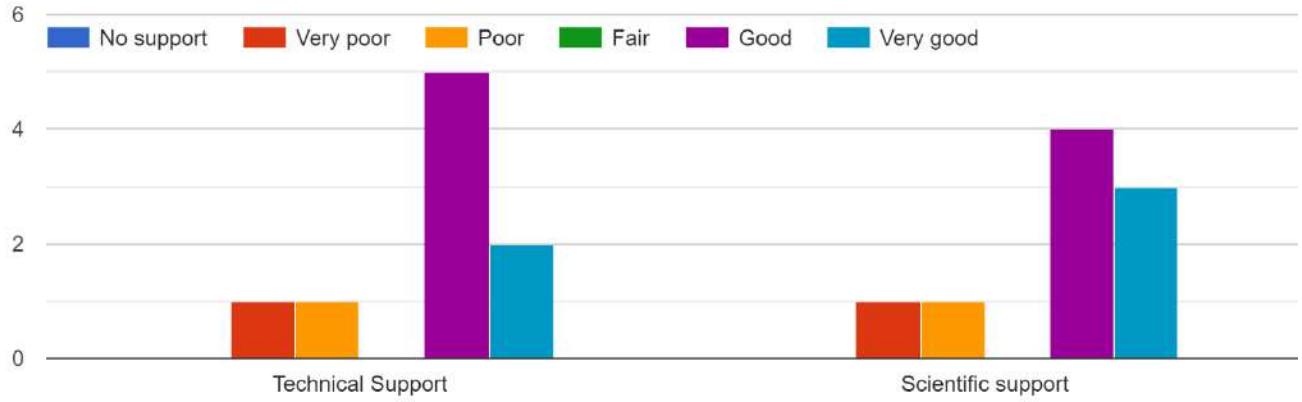


Figure 45: perceived technical and scientific support received by the Danish oGP, NAs

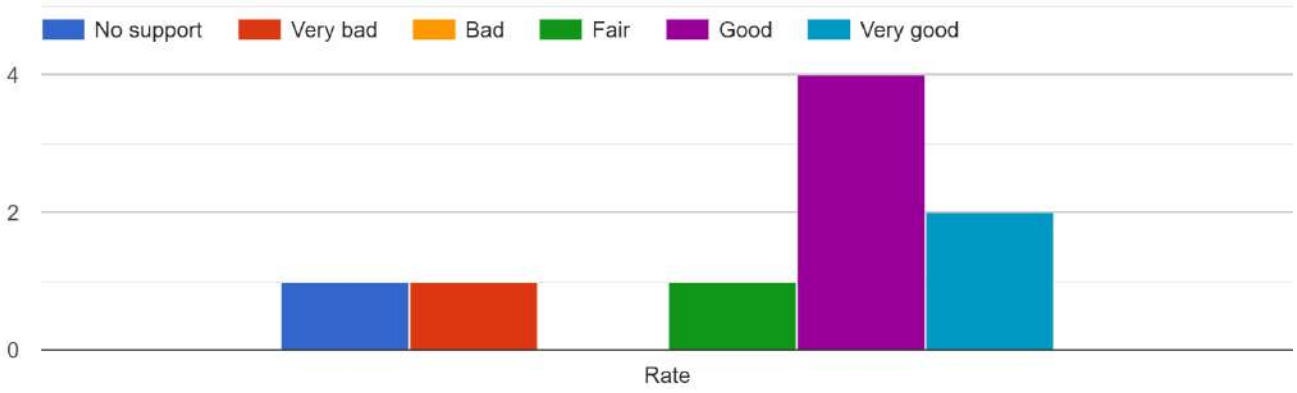


Figure 46: Perceived support received during 1st PDSA cycle by the Danish oGP, NAs

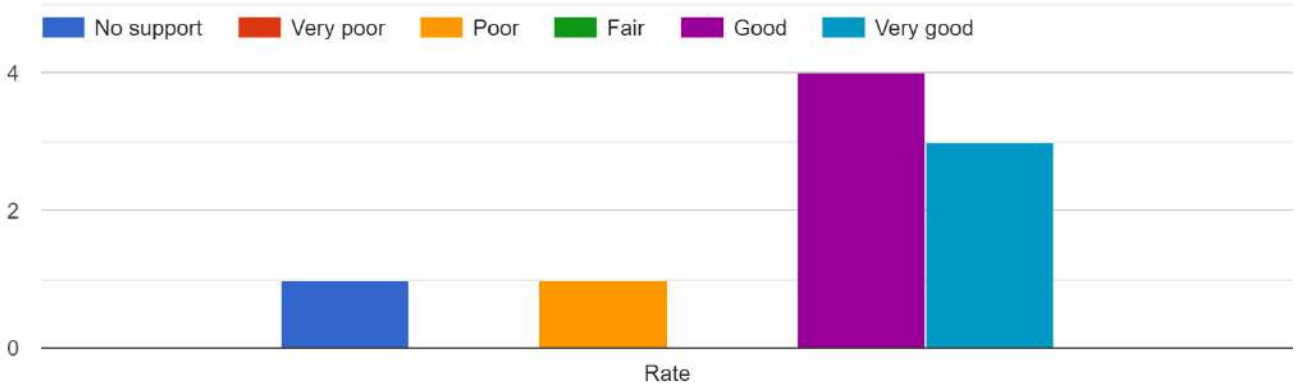


Figure 47: Perceived support received during 2nd PDSA cycle by the Danish oGP, NAs

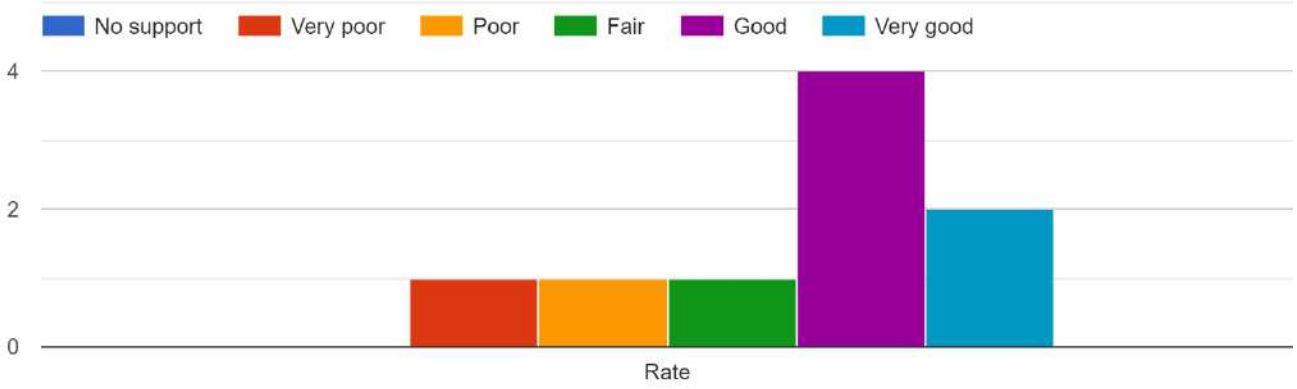
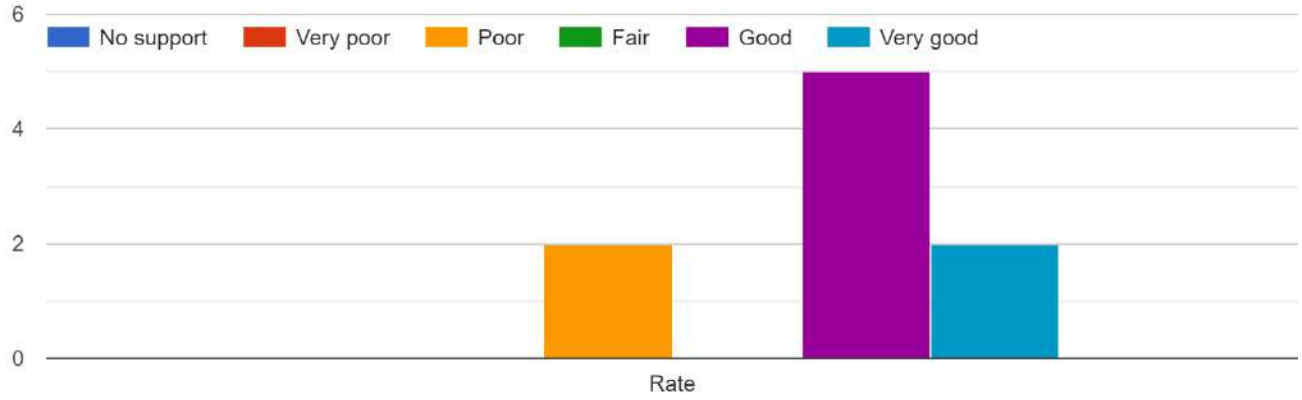


Figure 48: Perception of information provided by the oGP leaders and access to materials that enable the transfer of the practice by the Danish oGP, NAs



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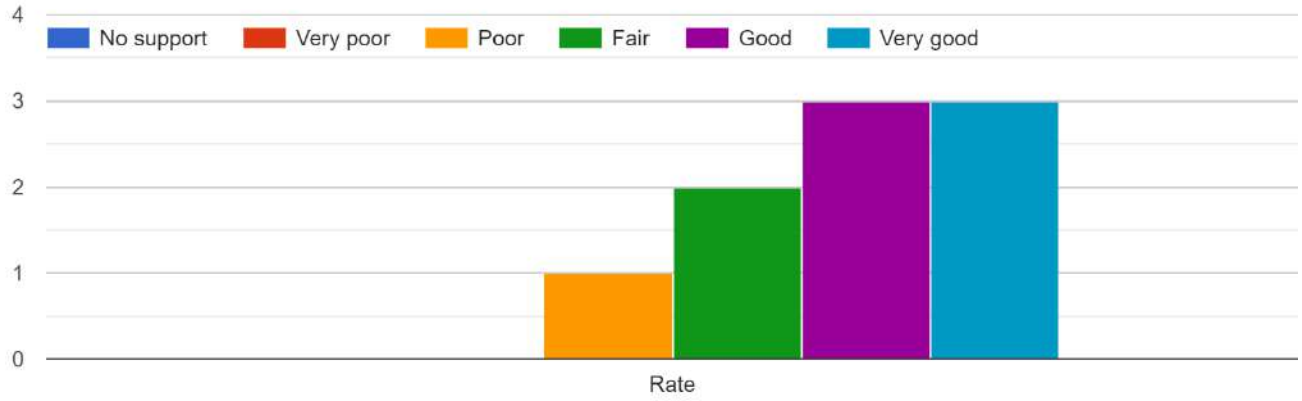


Figure 50: Perceived satisfaction with feedback provided by the oGP leaders to the work developed by the NAWG, by the Danish oGP, NAs

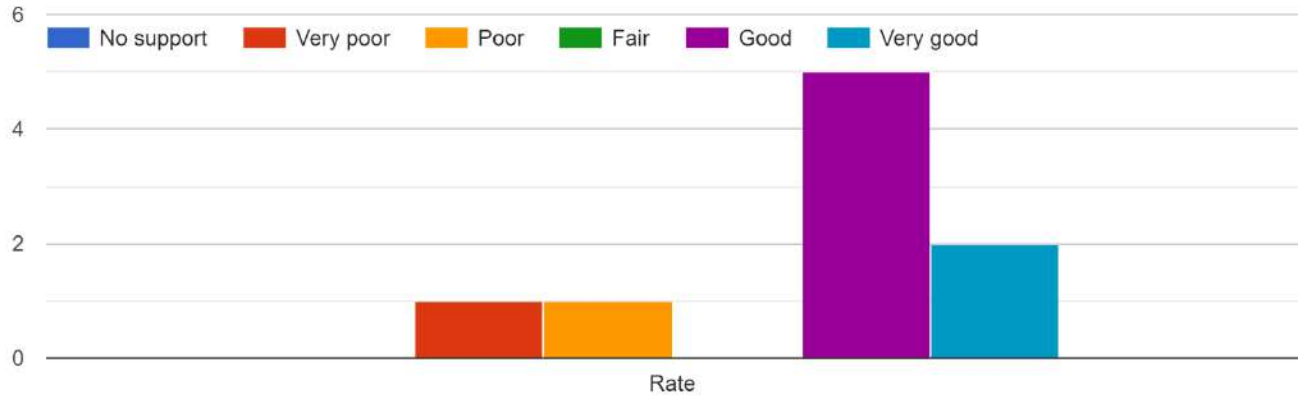


Figure 51: Perceived satisfaction with the frequency of follow-up meetings organized by the oGP leaders, the content and how they were conducted by the Danish oGP, NAs

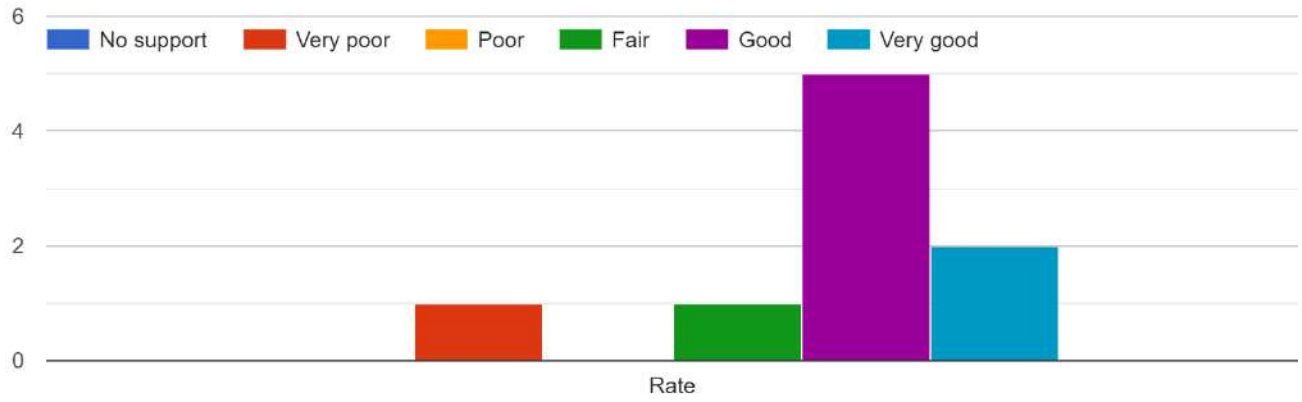


Figure 52: Perceived satisfaction with the bilateral attention and answers provided by the oGP leaders, in case particular questions were sent by the Danish oGP, NAs

The satisfaction degree of the consortium members was also measured during various key events within the lifecycle of the project. The most important ones were the:

Thematic workshops

98,5% of the respondents stated that the knowledge acquired during the workshops met their needs and was applicable to their implementation process. The exact responses can be found in Annex 4.

Key learning workshops

All respondents agreed that the amount of knowledge acquired during these workshops met their needs and was applicable to their implementation and sustainability process. Furthermore, they all stated that the workshops helped build the capacity to respond to the needs of the NAWG and that their understanding about the key issues related to working on the implementation and sustainability of their practice increased. The exact responses can be found in Annex 5.

Stakeholders' forum:

90,5% of the respondents agreed that the knowledge they received was applicable for using digital tools to enhance integrated patient centered care. All respondents stated that the knowledge they received met their needs and helped them building the capacity to use digital tools to enhance integrated patient centered care. The exact responses can be found in Annex 6.

Consortium meetings:

The overall satisfaction of the project beneficiaries with the consortium meetings were high. Among the highest rated factors were: The format of the agendas, the facilitation, the schedule, the take home resources and the shared presentations.

Among the received comments were:

- Agenda and time for interactions was great.
- The Consortium Meeting gave a good overall overview of the status quo of the but it would have been nice to get get a bit of a deep dive into at least one implementation topic (possibly this was done through networking among those on the ground though)
- meeting was excellently prepared and well moderated, there could have been more time for discussions, but considering the few questions, which arose, maybe not
- good place, and schedule, great organization. maybe the room meeting could be better to see us all members.
- very successful meeting, was a pleasure to meet and discuss with all participants

I27: No of individuals accessing newly implemented services and infrastructure

3 NAs stated that no individuals had access to newly implemented services and infrastructure. 8 NAs estimated that less than 100 individuals had access, 3 NAs gave a range of 100-1000 individuals, 2 NAs estimated 1000-100000, while 4 NAs estimated that more than 100000 individuals could access newly implemented services and infrastructure due to JADECARE.

I29: Ratio of healthcare services digitalized/targeted

6 NAs (28,6%) did not digitalize any service. For the other 15, the responses varied between 50-100%.

6.4.5 Maintenance

I18: Perceived probability that the developed practice will be sustainable after end of JADECARE, according to members of local/regional/national networks among Next Adopter

Among the NAs, 5 (23,8%) believe that the LGP will be extremely sustainable, 10 (47,6%) find it very possible, while 6 (28,6%) believe that there are moderate chances towards the sustainability of the implementation.

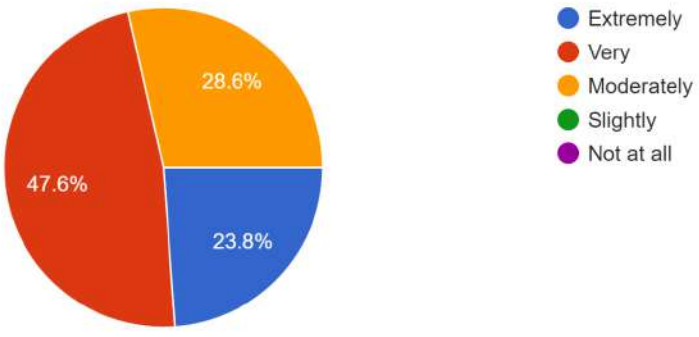


Figure 53: Perceived probability that the developed practice will be sustainable

I19: No of reports including recommendations to Next Adopters sustainability plans

Sustainability plans have been designed by WP4: Sustainability for each NA. They have been extensively discussed with each NA and further validated. This resulted in the production of 20 sustainability plans.

I25: Availability of Blueprint on learning from Good Practice

D4.2: Blueprint on learning from Good Practice has been submitted for review by the WP4 partner AGENAS. It provides guidelines and operational procedures for the transfer of JADECARE good practices, along with key elements to ensure scale-up and sustainability after the end of the project.

6.5 Discussion

Throughout the Impact Assessment Section of this deliverable, the project was evaluated within the 5 domains of the RE-AIM Framework. Looking at the Reach dimension, JADECARE achieved an audience of more than 500.000 people, either directly involved in the activities (participants of pilots etc) or indirectly involved (stratified etc). Additionally, JADECARE achieved a large audience from the dissemination channels. The effectiveness of the JA was measured subjectively, evaluating the perceived importance on various levels like improvement in digital skills and usefulness. Again, the results showed that internal and external stakeholders agreed on the fact that the project was, beyond any doubt effective on local and on broader levels. The Adoption of the proposed oGPs features was high. Although there were cases of NAs who could not complete the implementation as it was originally designed, still the coverage of features was high and the results revealed the successful implementation of at least one feature per NA. Regarding the Implementation aspect, JADECARE was a project creating ties with external stakeholders and other projects, ensuring the communication of the results and taking measures towards the production of high-quality documents that may serve as guides for future implementations. Finally, the Maintenance sector revealed a high-probability of sustainability towards most of the implementations, through the creation of separate sustainability strategies.

7 Conclusions

This document included the final evaluation of the JADECARE JA. More specifically, the progress, quality and impact of the implementations and the project results was evaluated. The evaluation followed a multi-disciplinary approach, adopting a variety of frameworks to achieve the creation of a holistic approach, integrating various factors within. Although the JADECARE projects has come to the conclusion, the quality of the produced results and the impact of the implementations, ensure the sustainability of the project and the reusability of the produced results.

8 Annexes

8.1 Annex 1: Implementation process analysis

Numerous interventions prove to be effective in health services research studies, however, they fail when they are intended to be transferred to different contexts and translated into results in patient care. It is estimated that two thirds of the efforts that organizations invest in implementing these changes do not obtain successful results. The barriers that hinder implementation affect various levels of health care provision: patient, care provision groups, health organization or policy. Consequently, there is a clear need to assess the extent to which the implementation of an intervention is effective in a specific context, with the aim of optimizing the benefits thereof, prolonging its sustainability and encouraging the dissemination of discoveries to other areas[9].

In JADECARE, the implementation process analysis aims to study the factors that might have influenced (positively or negatively) the implementation of the Local Good Practices (LGP) through the Consolidated Framework for Implementation Research (CFIR).

The CFIR provides a framework of constructs arranged across five domains that have been associated with effective implementation and can be easily customized to diverse settings and scenarios. It promotes consistent use of constructs, systematic analysis, and organization of findings from implementation studies. The CFIR offers an overarching list of constructs to promote theory development and verification about what works where and why, across multiple contexts. The objective of CFIR is to provide researchers with a framework in which they can select the most relevant constructs in the particular field of their study and use them to diagnose the context of the implementation, evaluate the progress of this process, explain the results and improve the quality of the initiatives[10, 11].

It comprises of five major domains (the intervention, inner and outer setting, the individuals involved, and the process by which implementation is accomplished) and 39 constructs. The domains interact in rich and complex ways to influence implementation effectiveness.

[9] Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implement Sci IS. 2009 Aug 7;4:50.
[10] Birken SA, Powell BJ, Presseau J, Kirk MA, Lorencatto F, Gould NJ, et al. Combined use of the Consolidated Framework for Implementation Research (CFIR) and the Theoretical Domains Framework (TDF): a systematic review. Implement Sci IS [Internet]. 5 de enero de 2017; Available at:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5217749/
[11] Gomes B, Higginson IJ. Factors influencing death at home in terminally ill patients with cancer: systematic review. BMJ. 2006 Mar 2;332(7540):515–21.

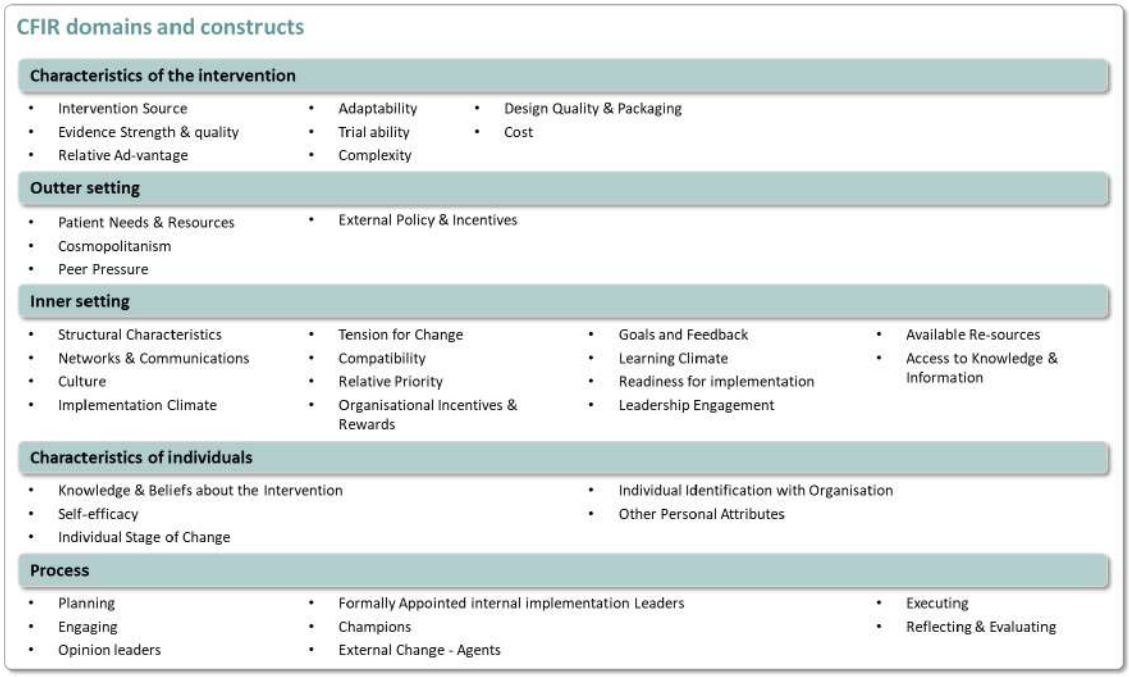


Figure 54: CFIR domains and constructs overview

7.1.1 Objectives

The main objectives of the analysis of the implementation process through the CFIR framework are:

- To reflect on the factors that have influenced the transfer and implementation process of good practices to heterogeneous contexts in the frame of JADECARE.
- To identify the main barriers and facilitators of the implementation process for each implementer.
- To analyze the degree of positive or negative influence of the variables affecting the implementation process.

7.1.2 Methodology

For the evaluation, a mixed-methods approach is employed which has the advantage of using multiple methods (quantitative and qualitative) to explore the same research question, getting more information from different perspectives. The mixed-method research collects, integrates and analyzes data using both quantitative and qualitative methods in a single study. By means of this approach, the goal is to strengthen the data obtained by different ways, providing a broader understanding of what each approach has achieved, and how or why these outcomes have occurred. The two activities performed are:

- Quantitative: CFIR survey
- Qualitative: CFIR Focus Groups

After that, Kronikgune, as developer of the implementation strategy of JADECARE conducts a global analysis of the results of both activities. (Please see complete detail in the document: Analysis of the implementation process: CFIR Protocol).

CFIR survey

Firstly, through a survey, the Next Adopter Working Groups (NAWGs)[12] review and reflect on the potential variables that could have had an impact on their implementation process, highlighting the factors that have acted as barriers or facilitators.

The CFIR survey comprises three parts:

- Evaluation of the relevance of each construct in a scale of 10 points where: 0 = not relevant at all and 10 = very relevant. For this purpose, relevance is defined as: How significant, valued, or necessary the variable has been in the Local Good Practice implementation.
- Evaluation of the positive or negative influence of each construct in a 5 points Likert Scale (Very negative/Negative/Neutral/Positive/Very positive).
- Explanation of the reasoning behind the scores for the relevance and influence.

Each NAWG provides a single and consensual response by converging the responses of the different NAWG members in a single template.

CFIR Focus Group

CFIR Focus Groups are organized to get deeper into the evaluation process, in the scheme of thinking of the participants, thus providing a multi-perspective approach to the implementation experience. Through this qualitative methodology, we try to better understand the situations, interpret phenomena and develop concepts in their natural context, emphasizing the meaning, experience and views of the participants.

Global analyses

Based on the results of the two activities (the CFIR survey and the CFIR Focus Groups), a global analysis of the implementation process is performed to summarize the factors that have most influenced the implementation processes in JADECARE and the reasoning behind it.

With the information collected, a thematic content analysis is carried out by inductive method of reading and recoding. It will aim on generating an explanatory framework obtained from the empirical data. Thematic analysis is mainly described as "a method for identifying, analyzing and communicating patterns (themes) within the data". The aim is to find out how participants describe and understand their experience from the themes that emerge in the focus groups and interviews.

A second step in the process is to validate the results. To do so, what is known in qualitative methodology as triangulation is used. It consists on using different methods, sources of information, theories or researchers to analyze the data, in order to check the validity through the convergence of information from these sources.

[12] Member of the NAWGs are comprised by the stakeholders using the implementation strategy in each local site.

In the case of the JADECARE project, triangulation of methods and sources of information will be used to compare and complement the results obtained. This comparison will allow for multiple observations that will add breadth and perspective to the data. The triangulation of methods will be done complementing the results obtained by the CFIR Surveys and the CFIR Focus Groups. The triangulation of sources of information in this case will involve the participation of the NAWGs of the different regions.

7.1.3 CFIR results

8.1.1.1 ACSS

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	8				X		Internally, it was an old desire and need to implement the level I diabetic foot consultation at the primary care centre, as well as to improve the articulation between the different levels of care and improve electronic records. The external lever was the JADECARE project. Internal and external intervention was perceived by the team as fundamental to the success of the project. Internally, the internal involvement of the stakeholders in the process had a very positive influence on the success of the implementation. Everyone's involvement, including top management, was crucial.
Evidence Strength & Quality	10					X	Although the working group has the perception that the designed model responds to the problem, only with the implementation in the field will it be possible to observe what needs to be improved and that will take several years. The Intervention was built on existing evidence both in studies and in previous projects. Existing clinical evidence (in the literature and in the field) and the user´s experience have a lot of relevance and influence on professionals because they easily recognized the quality and validity of this evidence.
Relative Advantage	9					X	Advantages of implementing the project: - Specialized surveillance in the primary care level I consultation for all users at high risk of developing diabetic foot ulcers, carried out by professionals trained in the field of diabetic foot; - Beginning of preventive treatment for non-ulcerative pathologies for all users at high risk of developing foot ulcers. With regard to the alternative solution, we do not have any, so it seems that a realistic plan like this will be advantageous compared to the alternative. The existing alternative (in the hospital) is geographically distant, does not have an articulation with Primary Health Care as proposed in the pathway. The relative advantage of the project was perceived by all project stakeholders. Evidencing the advantages of implementation, for example, care pathways, as an alternative to what currently exists, it easily led professionals to adhere to its implementation. Implementation will be more sustained if it has the support of the people. We had support from the top and from those on the field.
Adaptability	10				X		Completely possible: - The essence of the care path could be maintained despite the differences in the teams and infrastructure. - there is the need of continuous quality improvement, making it necessary to implement, evaluate and apply corrective measures. The adaptation of the project to the local needs and to the characteristics of the hospital was essential. The care pathways made it possible to rethink the current flows The pathways were adapted to the local reality
Trialability	9				X		Quite relevant since testing the new features can help identify priority actions. However, given the length of the Joint action, testing was not possible. Completely possible. The fact that we have a single hospital and a single primary care provider allocated to the process makes it possible to put it into practice in a more manageable way and fine-tune the implementation as necessary, without impacting on the quality of care. It will certainly be possible to test the project, adjust it and later expand it to a larger number of patients.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							It is very important in order to fine-tune what needs to be improved and see the resistances/bottlenecks.
Complexity	9		x				Quite relevant and of great influence, since the length of the project and the complexity and number of steps was a challenge for the development of the project. The difficulty in implementation was related to: - Lack of human and technical resources - Lack of decision-makers interest to implement diabetic foot consultation at the various levels of care. - Motivation of professionals to work on the diabetic foot since the results are not immediate. The Jadecare project is complex because it involves a multidisciplinary team, in several providers, involving several teams and different geographic locations. The complexity of the hospital organizations themselves and the steps and resources needed had sometimes a negative influence. It is a change of the current processes, so it is complex to change.
Design Quality & Packaging	7				X		The interventions were presented in a simple way which facilitated the engagement, understanding and adoption.
Cost	10		X				The materials needed are affordable, however there is lack of human and technical resources. The adaptation of the information systems is slow. It will be required further professional training. The opportunity costs associated with the resources needed for the project had some relevance, given the existing limitations.
II. Outer setting							
Patient Needs & Resources	10				X		Needs and barriers are known, however not prioritized and not translated in actions to overcome them. The lack of human resources is a well known barrier to implemente the project, however there is no action to overcome it. Training of health professionals would help. We tried to do our best with the existing resources. Patients were involved to better understand the needs.
Cosmopolitanism	10					X	The project was carried out together with other organizations and had the full involvement of the professionals from primary and hospital care. The project encompasses a connection between several sectors of the hospital and the primary care. Articulation between the different entities in building the project was achieved. We were able to extend the network beyond healthcare.
Peer Pressure	6				X		There are already hospitals with pathways, for example, but they are more distant for our patients, and therefore we feel the pressure to implement here. There is the pressure to put the project into practice, due to the need of the population. Competitive pressure has a positive side for development, but it can also have a negative effect by rushing the implementation without filling all the quality criteria. Although the Hospital seeks differentiation in the provision of care compared to its peers, competitiveness is not relevant, nor does it have any influence on its way of providing care. Yes, it is important, but not decisive.
External Policy & Incentives	8				X		External opinions were taken into consideration, as they have value and credibility to support the project. The promotion of the intervention by various entities reinforced the intervention and improved its probability of success by pooling knowledge and resources.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							Payment models are relevant, however are not aligned with this kind of interventions, which made it much more difficult to implement but we did it anyway.
III. Inner setting							
Structural Characteristics	6				X		Some organizations involved are small compared to their counterparts but committed to the project. An attempt was made to make a project suitable for the available resources.
Networks & Communications	6			X			Inter-institutional communications need to be further developed (faster, more effective). Existing IT applications do not facilitate communication/collaboration at different levels in this same process. The organization is connected through the various forms of communication that exist today. We were able to do it despite the constraints.
Culture	7				X		There was previous work done on organizational culture, which was positive for the implementation process.
Implementation Climate	10				X		We have organizations leaderships support for the implementation and start the change to improve the care provided. The receptivity of the project by the group was good. There was previous work done to prepare the field for the change.
Tension for Change	8				X		Everyone was aware of the need for this quality step in the provision of care, in order to reduce amputations, for example, improve the health literacy of users and their families. Perception of tension helped the change. There were previous work underway to support the change.
Compatibility	10				X		The action plan was developed based on the needs identified by health professionals and was therefore very relevant and had an extremely positive impact. It was necessary to reorganize workflows, but this will be largely overcome by the gains obtained. It helped to understand the need for changing some professional roles. It is a continuous work of influencing professionals and engaging them in the process.
Relative Priority	10					X	The relevance and influence of implementing the plan was always recognized among the group. Full perception of those involved. All elements agree with the importance that the implementation of the project has for the population. The professionals involved believe in the health gains and in the benefits, they will be able to obtain in their workflows, with the implementation of the project. The ministry of health is not aligned with the same relative priority
Organizational Incentives & Rewards	10					X	Do not exist. However, if they existed, they could perhaps contribute to speed up of the process and would be relevant. The recognition of the work carried out is very important, for the adherence and implementation, however the project does not foresee any reward. This concept does not exist in the NHS – neither from the top nor at the local level. Internally, there are some kind of incentives such as training.
Goals and Feedback	8				X		Goals are defined and clear. Goals and performance evaluation criteria were defined and are clear. there is a local JADECARE management strategy to give this information to everyone.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Learning Climate	9					X	The team was and is involved, there is sharing and space for everyone to contribute with what they know how to do best. However, there is a lack of time, considering all the other tasks that we still must be performed, and more time would be needed to dedicate to a project of this size. Among team members there is sharing of experiences, difficulties, and knowledge. The contribution of all stakeholders facilitates the development of the intervention and its suitability. There is support for learning.
Readiness for Implementation	8				X		Some activities and indicators were aligned with the recovery and resilience plan. The partners established criteria, goals, and a patient care plan to be put into practice.
Leadership Engagement	10					X	Full commitment to implementation. There was involvement of all team members, namely the leaders. The involvement of middle and top managers allowed a greater commitment of other professionals There is leadership involvement.
Available Resources	10		X				Funding is expected through the PRR; to further implement what has been designed. There is a need to revisit good practices, training, physical space to implement the primary care consultation, and training of motivated professionals. The project was carried out considering the cost-benefit ratio of the disease in the population. The existence of available resources is extremely relevant to the project, but they had a negative influence, given the existing limitations. There was an overload of work, which negatively influenced the implementation of the project. Always scarce and with great personal effort from those involved.
Access to Knowledge & Information	8				X		Need for more access to information and guidelines, to support the intervention. The information is accessible to professionals. There is access to information and sharing.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	8				X		Team of health professionals for whom the diabetic foot is a concern and who they deal with daily, being familiar with the assumptions that make the intervention needed. Motivation and perception of value allowed for greater adherence and prioritization.
Self-efficacy	9					X	The will exists and we believe that further training will help to increase the belief. The continuous professional's involvement was important. It was essential to overcome obstacles.
Individual Stage of Change	9					X	Professionals are motivated to integrate the intervention in the daily clinical practice. So far, we just designed the intervention, the next step will be the implementation. This will be more important in the LGP implementation. Not all professionals are on the same stage of awareness for the change. Suitability is important. Raising awareness of the need for change is a process and not all stakeholders are at the same stage. Suitability is important
Individual Identification	8				X		The goals of the organization and individuals are aligned, the intervention will help to improve the organization capability to attend to patients needs. Knowledge sharing and discussion were important to increase team knowledge and commitment.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
with Organization							
Other Personal Attributes	10				X		The cooperation among all of those involved contributed to the project. The leadership's ability to perceive individual differences and motivations and deal with it, was important for the development of the project.
V. Process							
Planning						X	It was based on current best practices. A quality planning was the guarantee of greater implementation success It was crucial for the success of the project to plan the tasks and actions to be implemented
Engaging						X	Peer training about this new intervention might attract new human resources. The involvement of the community, hospital health professionals and primary care was low in this phase but expected to increase in the future. The project increases hospital visibility. Proper selection of the project team was important. The team was able to involve stakeholders in the project and motivate them to implement.
Opinion Leaders					X		Opinion leaders spread the word about the relevance of the project. Networking was importante for this purpose.
Formally Appointed Internal Implementation Leaders						X	There was apointed a project coordinator. It would have been important to have several leaders. It is relevant that the team leaders have enough time dedicated for the project development
Champions						X	It is relevant to achieve the goals. The champions were important to establish a support network. Champions were identified - doctors and nurses. Not used.
External Change Agents						X	ACSS and 1 municipality
Executing						X	The development of the implementation plan was essential for carrying out a survey of the needs identified by health professionals and the main priority lines of action, as well as the inherent implementation plans. The execution of the defined plan gave special relevance to the project, as the team and all involved begun to see the results of all the work previously developed and create motivation to continue all the work already carried out. There is a plan that we try to stick with.
Reflecting & Evaluating						X	Qualitative feedback was carried out through consortium meetings, however there was no quantitative feedback. Progress monitoring reports will be applicable when implementing what was designed. It was important the moments of reflection on the whole process, to decide what changed and what needs to be improved. This is essential for suitability. Feedback and reflection were key for people to get involved and stay involved

CFIR Focus group

Next Adopter	ACSS PT	**Local Good Practice**	
Setting	National level with pilot implementation	**oGPs that you transfer from**	Basque Country
Date of the Meeting	12th April 2023	**Location**	Lisbon (Microsoft Teams)
Start time	10:00 AM (Lisbon time)	**End time**	12:20 AM (Lisbon time)

Participants			
	Name and surname	*Organization*	*Role*
1	Vanessa RIBEIRO	ACSS	MODERATOR
2	João SARDO BOLA	ACSS	ASSISTANT
3	Ana RAQUEL	FIGUEIRA DA FOZ HOSPITAL	HOSPITAL EXECUTIVE BOARD MEMBER
4	Adelaide BELO	ULS LITORAL ALENTEJANO (integrated care organization)	INTERNIST
5	Anabela RODRIGUES	ACES POVOA DO VARZIM/VILA DO CONDE (primary care provider)	PRIMARY CARE DOCTOR
6	Inês LOURENÇO	SHARED SERVICES OF THE MINISTRY OF HEALTH (SPMS)	PROJECT MANAGER
7	Inês TERRA	ACES POVOA DO VARZIM/VILA DO CONDE (primary care provider)	PRIMARY CARE DOCTOR
8	Elisa RIBEIRO	ACES POVOA DO VARZIM/VILA DO CONDE (primary care provider)	PRIMARY CARE DOCTOR

QUESTION		**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 11. Peer Pressure				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Peer pressure takes on a more "positive competition" role, as everyone wants to present the best possible project. I tis also relevant because it allows to learn from others experiences, including the flaws.	"we always have to foster positive competition"; "For me it took on a motivational role"; "Peer pressure is always good"	Everyone in the group attributes a positive effect to peer pressure
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Don't let early adopters loose focus	"I've always tried to convey the message that this project has a very positive impact on patients and that should be the focus." " the participation in JADECARE was very important, for the exchange of experiences between the various participants"	Some of the participants had coordination roles at the local level, therefore were the energizers of the key elements.
3.	If you started again the implementation process, what would you do differently?	The main factor to be changed that could represent an increase in value would be a different local level planning, in particular with regard to the planning of meetings and the availability of professionals in particular in the interconnection between hospital care and primary health care.	" had to shorten the working groups at times beacuse they were difficult to manage" "in addition to peers, we would involve the population and patients" "in an ideal world it would be very different"	Regarding the first expression, in one of the projects local working groups were carried out that were difficult to manage due to the large size.
CONSTRUCT 12. External policies & incentives				

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	It was not a relevant construct, because there were no external policies and incentives. This factor was reflected only in the emotional salary, since it allowed to do different things from the day-to-day work There is hope that the recovery and resilience plan can leverage the activities. The national health system is not organized to provide incentives to the implementetion of these innovative projects.	"For this project the salary was emotional"	The feeling that this issue was not relevant was homogeneous to all of those involved.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	There was no effect, since the profesisonals would not get any profit. However, it is necessary to demonstrate the results to the decision-makers which is in itself an incentive.	"we try to align strategies between providers [primary care and hospital care]"	[….]
3.	If you started again the implementation process, what would you do differently?	We try to align strategies between organizations (primary and hospital providers). Try to convey the idea that these projects always have added value for the lives of patients, trying to put pressure on decision-makers, in an attempt to promote the pratical implementation of the pathway in order to achieve health outcomes. "	"I hope that the Recovery and resilience plan can effectively allow the practical implementation of these projects"	[….]
CONSTRUCT 20. Organizational incentives & Rewards				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Incentives are non-existent, there is no possibility of granting financial incentives. It would have a positive efffect if it would be possible.	"All these projects are time consuming"	It is not fair for the professionals involved in the project, that give their own effort and time, not being reward somehow.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Since there are no incentives and rewards foreseen, personal commitment and the will to do more and better have always been put first.	[….]	[….]
3.	If you started again the implementation process, what would you do differently?	Try to leverage other kind of incentives, not necessarily financial ones, such as sponsorship for participation in conferences and presentation of projects.	"the chance to participate and share experiences"	[….]
CONSTRUCT 28. Self-efficacy				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	In all institutions it was the leaders strategy and in some cases the team´s strategy that enabled the implementation in the field, with a special role of the middle managers. It was key to know the groups taking advantage of the best of each one. The big challenge is trying to drag the late adopters.	"There's always a group of people who get ahead who are feeding the others" "Don't let early implementers loose focus"	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The selection of the professionals was based on their self efficacy skills.	“I challenged the right professionals [to enhance the positive effect]”	[….]
3.	If you started again the implementation process, what would you do differently?	[….]	[….]	[….]
CONSTRUCT 37. External Change Agents				

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	In the case of the Portuguese project, the role of the ACSS was highlighted, especially of Vanessa Ribeiro, as well as the existence of the project itself and its coordination. The ACSS´s guidance was proved to be of the utmost importance.	"the merit is yours [Vanessa Ribeiro] and the follow-up meetings were good to create the need to deliver results every month"	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	[….]	[….]	[….]
3.	If you started again the implementation process, what would you do differently?	It would have been interesting to foresee the involvement of patient associations or patients.	[….]	[….]

8.1.1.2 ARS Tuscany

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	9					x	Between the professionals of ARS and the professionals of reference for the District Zone (DZ) there was a process of co-design of the model to be implemented. This was fundamental for the definition and subsequent implementation of activities in a tailored manner aligned with both the needs and the actual resources of the context.
Evidence Strength & Quality	7		x				Our context has been trying for years to systematically implement the elements we have performed in the DZ, highlighting the pertinence and urgency of these actions. Although all the professionals shared the importance and usefulness of the theoretical background of these elements, there were no previous experiences available at the territorial level that would have provided strong evidence/data that the type of model we defined would have had a positive impact on the clinical practice of professionals and patients. Indeed, it was difficult to persuade professionals to experiment with this model and to invest their time for free in the planned activities. Consequently, this also had a negative impact on the possibility of seeing a clear relative advantage on the part of professionals
Relative Advantage	8		x				
Adaptability	8				x		The elements of our interest in the Basque OGP were fully adapted to the needs and resources in context and this increased the level of feasibility.
Trialability	8				x		The developed model was tested by a small group of professionals. This allowed us to modify, add or remove elements more easily during implementation so that we could achieve our objectives and understand in detail where improvement or intervention was needed.
Complexity	6		x				Although the planned actions were concentrated in a short period of time, they required a considerable amount of effort and time from the professionals. In addition, some steps of the model, due to some human and technological resource limitations, were somewhat tricky and complicated.
Design Quality & Packaging	5			x			The model was presented and assembled in as much detail and clarity as possible. However, some critical issues emerged due to the experimental nature of the model
Cost	7				x		No costs were foreseen for the implementation of the model.
II. Outer setting							

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Patient Needs & Resources	8			x			In accordance with the organization's strong focus on the patient, the intervention had as its main objective to improve the well-being and quality of life of the complex patient. However, direct patient involvement in the activities was not foreseen. For the success of the activities this did not have a major impact, however, whether the future patient involvement could improve the outcomes will be analyzed.
Cosmopolitanism	2			x			For our activities, there was no need for links with external organizations
Peer Pressure	5			x			There was no peer pressure since this was the first time in the Tuscany Region that this model and in particular the core element, i.e. multiple teleconsultation, had been tested. This dimension is instead leveraged to stimulate our new branching activities
External Policy & Incentives	9					x	Our model was built from the beginning on the recommendations and regional planning acts so as to foster greater adherence and involvement by professionals. Trying to respond to the needs of the Region, which reflect the needs of both patients and clinicians, was an important driving factor for us.
III. Inner setting							
Structural Characteristics	8					x	The 'decentralized' characteristics in the district organization were crucial for us. In fact, in our NAWG it was possible to include the coordinators and reference professional so as to foster a higher and more meaningful participation in the decision-making process. The involvement of the different units enabled a better understanding of the needs, resources and requirements of the context and professionals.
Networks & Communications	9					x	From the beginning, collaboration and cooperation between professionals was a strong point, thanks also to the already existing efficient coordination of professionals within the organization. This coordination helped to structure a stable team involved in the project. Communications, through emails, telephone contacts, online or in person meetings, sought to align all professionals on the activities, objectives and motivations of a specific action. In addition, conducting communication activities such as articles and webinars gave visibility to the model and strengthened professionals' engagement.
Culture	7				x		The culture of the importance of integrated care and teamwork, crucial aspects of our model, are present in both the organization and the professionals involved in the project. The presence of these values was a good starting point for us to encourage and support the participation of the professionals and their investment of time on the activities. However, although in most sectors this was a strength for us, in other areas, where these assumptions were not taken for granted, we encountered more difficulties in the involvement process.
Implementation Climate	6				x		The activities foreseen within the model, involving a change in the clinical routine of the professionals, encountered some resistance at the beginning. However, including the coordinators and leaders of the different sectors facilitated the participation of professionals
Tension for Change	7				x		The implementation context, thanks to the numerous projects and programs proposed over the years to address chronicity, proved to be fertile ground with a good level of tension of change that allowed for successful activities.
Compatibility	9				x		Thanks to the participation within the NAWG of the representatives for the different sectors involved in the activities, we tried to define a model that was functional and feasible for the professionals in their usual daily work. However, due to some limitations in terms of technological availability and time, some steps were difficult and unsustainable and that resulted in some management difficulties. This means that adapting the intervention method is crucial for successful outcomes.
Relative Priority	7				x		The involvement of the district management and the coordinators of the different sectors in our NAWG fostered the involvement of professionals in the foreseen activities

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Organizational Incentives & Rewards	8		x				Regarding the aspect of tangible incentives, we provided additional remuneration to one sector to facilitate certain activities. However, this did not ensure participation and did not increase the level of involvement of these professionals. On the contrary, it created misunderstandings and unease towards the other sectors.
Goals and Feedback	7				x		Within the dimension of the communication framework, professionals were constantly updated on the progress of activities and any critical issues so that they could discuss them together. This also increased the sense of ownership among professionals. However, the positive impact of this could have been higher if the process had been extended not only to NAWG professionals, but also to 'operational' professionals in the field.
Learning Climate	7				x		The efforts to foster positive teamwork with the NAWG and the aspects of adaptability and trialability were factors that facilitated a good learning climate, which in turn facilitated successful activities. However, as it was difficult to maintain this positive climate, the positive impact of this dimension was more attenuated.
Readiness for Implementation	6		x				There were no immediate and tangible indicators that supported the initiation and execution of activities. However, with the intention of involving professionals, it would have been useful to have objective data to support this.
Leadership Engagement	8					x	From the beginning, distributed leadership was fostered, where both the decision-making process and the objectives were shared with the representatives of the different sectors. This climate of engagement fostered a sense of ownership and importance of the project and consequently the smooth running of activities.
Available Resources	7		x				The lack of resources, especially technological resources and the lack of time of professionals, made difficult the organization and conduct of activities .
Access to Knowledge & Information	8				x		All professionals involved received training on the activities to be performed and this facilitated the sharing of objectives and the execution of actions in a coordinated manner.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	7				x		As reported for some previous constructs, this dimension had, for the most, a positive effect because a significant number of professionals developed a positive attitude toward the intervention. However, the difficulty of being a pilot project, experimental and quite time-consuming, dampened some of the professionals' enthusiasm.
Self-efficacy	6			x			The model was outlined by ensuring that the required activities were feasible and in line with the activities of the professionals. However, the dimension of self-efficacy was not investigated in detail, and it is assumed that this may not have had a negative impact.
Individual Stage of Change	5			x			The evaluation of the model's progress was done on a group rather than on an individual basis. Perhaps more focus on the individual would have added value
Individual Identification with Organization	6				x		Since the participation of professionals was on a voluntary basis, the positive perception of the organization fostered a climate of trust
Other Personal Attributes	-						
Process							
Planning	8					x	All activities were planned and designed together with the NAWG professionals. A fairly high level of planning was foreseen, which facilitated the reduction and anticipation, as far as possible, of organizational critical points.
Engaging	8					x	It was crucial for the success of the activities to thoughtfully involve the most appropriate professionals in the project.
Opinion Leaders	5			x			We did not involve professionals who could have been categorized as opinion leaders.
Formally Appointed Internal Implementation Leaders	8					x	It was crucial to involve the district leadership, coordinators and reference professionals of the different sectors in the NAWG for the success of the activities. The professionals within NAWG also played the role of Champions for their respective sectors.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Champions	8					x	
External Change Agents	8				x		The contribution of ARS professionals (external to the district) in facilitating the processes of planning and monitoring activities was a help and an added value for the professionals
Executing	8					x	Almost all planned activities were executed.
Reflecting & Evaluating	8				x		Within the framework of proper communication, it was important to provide and request feedback on the progress of activities so as to act promptly when necessary

CFIR Focus group

Next Adopter	ARS Tuscany	**Local Good Practice**	"Piana di Lucca" District Zone's approach to taking care of complex patients by integrating hospital and primary care
Setting	"Piana di Lucca" District Zone (Tuscany, IT)	**oGPs that you transfer from**	oGP Basque
Date of the Meeting	12/04/2023	**Location**	Online-GoToMeeting Platform
Start time	11:15	**End time**	13.00

Participants			
Name and surname		*Organization*	*Role*
1	Paolo Francesconi	ARS Tuscany	Moderator
2	Chiara Ferravante	ARS Tuscany	Assistant
3	Dario Grisillo	ARS Tuscany	GP and ARS Consultant
4	Marco Farnè	"Piana di Lucca" District Zone	Coordinator of Primary Care
5	Massimiliano Cortopassi	"Piana di Lucca" District Zone	Coordinator of Family and Community Nurses
6	Silvia Begliuomini	"Piana di Lucca" District Zone	GP and Coordinator of FTA "Capannori" (Functional Territorial Aggregation)
7	Fabrizia Vornoli	"Piana di Lucca" District Zone	Coordinator of Citizen Participation Committee

QUESTION		SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: RELATIVE ADVANTAGE				
1.1	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	-Health professionals are constantly overloaded and presenting them with a pilot project with just potential result had a strong impact on their involvement -In our context, medicine is often individualistic and little value is placed on cooperative work. It must be learnt that teamwork brings real benefit to both the professional and the patient.	-"In this situation of chronic fatigue where, unfortunately, bureaucracy often prevails instead of the clinic, it takes forward-looking minds to understand that the efforts of today are an investment for tomorrow. This must not be taken for granted." -"Many professionals wait for the system to change when actually the system needs to be changed from the inside."	On this point, there were interesting reflections on how each professional can 'conceive' the advantage, with what kind of indicators, and how they can be handled
1.2	How have you enhanced the positive effect or diminished the negative	- From the beginning, we shared and highlighted the importance of the project and the benefits, even though potential	-"In order to enhance this aspect we did our best, it is obvious, however, that being a pilot project we could not ask for a strong political mandate from the beginning."	-

	effect of this construct in your implementation process?			
1.3	If you started again the implementation process, what would you do differently?	-Fostering that the perception of advantage is also shared and supported by the Organization as much as possible -Considering that there may be more indicators to promote the motivation of professionals	-"The teamwork mindset must not be taken for granted, but should be taught gradually and constantly, it cannot be dropped as a solution from above."	-
CONSTRUCT 2: PATIENT NEEDS & RESOURCES				
2.1	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	-The concept of the "patient at the center" and improving their taking care were always the focus of the entire project	"Improving the care of the complex patient was the final goal of our project"	-
2.2	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	-Actually, the project showed how to fully respond to the concept of the "patient at the center" the team had to be personalized for the teleconsultation. Therefore, only the referring professionals of the patient should be involved, otherwise it remains a general approach	-"The concept of "the patient at the center" would have been more valued if the team had been composed of just the patient's referring specialists" -"The personalization of the team is crucial but at the same it is necessary finding a balance between what would be ideal and what is actually possible"	There were interesting reflections on these aspects highlighting pros and cons.
2.3	If you started again the implementation process, what would you do differently?	-Promoting a higher degree of patient involvement by introducing measures such as PREMS (Patient-Reported Experience Measures)	-"Reporting the experience of patients is an important indicator for getting better, for understanding if we are going in the right way, if there is something to change"	-
CONSTRUCT 3: EXTERNAL POLICY & INCENTIVES				
3.1	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	-Health policy and regional policy acts was key to foster motivation and give a strong context to the project	-"Health policy pressure in implementing our activities was crucial"	-
3.2	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Our model was built from the beginning on the recommendations and regional planning acts so as to foster greater adherence and involvement by professionals.	-"It was always emphasized that with our project we had the opportunity to respond to a long-standing need highlighted by health policies"	-
3.3	If you started again the implementation process, what would you do differently?	This aspect was thoroughly put to good use, hence no specific suggestions emerged.	- "Every effort was made to optimize this aspect"	- Involvement of trade union representatives was discussed, but did not emerge as a useful/feasible factor for the initial phase
CONSTRUCT 4: COMPATIBILITY				

4.1	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	-The adherence of the project to the values and needs of professionals was crucial to foster motivation	- “These things had been talked about for years, it was time to figure out how to do them and this project was the opportunity”	-
4.2	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	-The project's compatibility with important needs and workflows was considered from the beginning and emphasized throughout implementation	“The fact that we always wondered whether a specific action would have brought an added value to professionals was fundamental to the activities”	-
4.3	If you started again the implementation process, what would you do differently?	- Make more efforts on the technological side, better involving the Region's Digital Health Sector from the beginning	“Healthcare professionals are often overloaded, and some performed actions were tricky. Perhaps we could have put more effort into figuring out how to make them smoother, also with the help of technology."	-
CONSTRUCT 5: ORGANIZATIONAL INCENTIVES & REWARDS				
5.1	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	-Our incentive did not help the participation of GPs and at the same time displeased the professionals not involved - We were hasty in giving the incentive to increase the hours of the GP’s assistants, we did not precisely outline the activities and this led to a situation that was difficult to manage	“The incentive was not a determining factor in encouraging GPs to participate”	-
5.2	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	By providing the incentive at the beginning, there was no turning back even though it did not have the desired effect. Therefore, in order to diminish the negative effects, the fact and its (lack of) effect were also made known to other professionals	(No particular quotes to report)	-
5.3	If you started again the implementation process, what would you do differently?	Better analyze which activities could be delegated to the GP assistant in a feasible and sustainable way, so as to really free the healthcare professional from organizational/bureaucratic activities	“The health professional's working hours should be devoted to the clinic not to bureaucracy”	-

8.1.1.3 ASl Napoli

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	9				X		The need to improve the processes of integrated care of people with complex social and health needs is greatly felt by both the social and health sectors and both by the territory and by hospitals. The improvement is linked to the correct qualification of roles and functions of each actor in the process and to having IT tools to facilitate the connection.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Evidence Strength & Quality	8				X		The introduction of specific operating protocols with clear definition of roles and tasks as well as the introduction of new IT processes connecting the players required a change in the previous working methods of each, a change not always easily accepted.
Relative Advantage	8				X		Everyone highlighted the advantage of implementing the proposed solutions, solutions identified in a shared way at company level and in an experimental way with a local municipality. No alternative proposals emerged.
Adaptability	10					X	The products have been designed and developed by ASL operators to respond to local needs. As internal products, these can be easily adapted to any changing needs
Trialability	10					X	The products made have been tested on a small scale and in some cases modified following the testing to better respond to internal needs
Complexity	7				X		The changes introduced, in terms of new working methods (procedures, tools) were not perceived by all the actors as simple and this because it required a change in the previous working methods of each one, a change not always easily accepted, in relation to the individual propensity for change
Design Quality & Packaging	8				X		The products made were appreciated by the interested parties
Cost	10					X	The products were made by operators employed by the ASL. Therefore the costs are associated only with the working hours of the staff employed. There are no supply and/or investment costs
II. Outer setting							
Patient Needs & Resources	10					X	All the work carried out and the choice to join the Jadecare project is based precisely on the specific analysis of the complex social and health needs of the fragile population of reference and the search for ways to facilitate the satisfaction of needs
Cosmopolitanism	8				X		The project is part of a pre-existing system of good connections between the ASL and the Municipalities of the area. Link that needed improvements in the mode and tools of the link
Peer Pressure	6			X			There is no competitive pressure from other organizations, rather a mimetic pressure linked to the desire to replicate the interventions in other realities/organizations
External Policy & Incentives	8				X		The ASL need is linked to the dissemination and implementation of project interventions throughout the company territory, between health districts and municipalities and between hospitals and the territory. Therefore, once protocols, work tools and IT procedures have been defined, dissemination meetings have been held, meetings to detect any critical issues and identify corrective actions and implementation monitoring actions are in progress. These are meetings also aimed at the active participation of the various actors and the motivation for change
III. Inner setting							
Structural Characteristics	7				X		The ASL supports and sustains the process of organizational change required by the implementation of the interventions, through the ad hoc company work group which includes, in addition to the company Health Management, various Complex Operating Units belonging to the Territorial Care Department (including COU Socio-Health Integration) as well as the COU Computer Technologies, a representative of the Health Departments of the Hospitals and a representative of the Directors of the Health Districts
Networks & Communications	7				X		The planning actions intervened precisely on the improvement of the level of integration between the various internal company services involved in the processes of taking charge of people with complex social and health needs and the relative connection methods.
Culture	10					X	The initial context of the ASL was characterized by a high average age of the operators with little propensity to adapt to new working methods and tools. In the last two years, the retirement of a substantial part of the staff and the entry of young human resources, also related to the recruitment opportunities given by the

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							COVID19 pandemic, has made it possible to have operators with a greater propensity to change and, therefore, to an organizational culture that facilitates the implementation of integration and related connections. Such changes in the organizational culture have also been observed in the Municipalities
Implementation Climate	8				X		In addition to what has already been reported in the previous points, the implementation of the project interventions is also supported by the fact that this implementation has been included by the Company Management among the Budget and Performance objectives of all the COUs involved.
Tension for Change	7				X		Most of the stakeholders have perceived the need for change to improve the integrated responses to people with complex social and health needs, connected to the need to reduce the stress of individual services in addressing needs that are satisfied only through the correct connection between different services
Compatibility	7			X			The proposed changes were shared and welcomed positively even if reporting critical issues due to lack of human resources/professional profiles facilitating implementation
Relative Priority	8				X		Operators perceived the importance of implementing interventions within the organization
Organizational Incentives & Rewards	8				X		In addition to what has already been reported in the previous points, the implementation of the project interventions is also supported by the fact that this implementation has been included by the Company Management among the Budget and Performance objectives of all the COUs involved.
Goals and Feedback	8				X		The implementation objectives of the shared interventions of the project were communicated through protocols, work tools and IT procedures formalized through specific resolutions notified to all the services concerned, including the municipalities. In addition, dissemination meetings were held, meetings to detect any critical issues and identification of corrective actions and implementation monitoring actions are ongoing.
Learning Climate	8				X		In addition to the meetings referred to in the previous point, even those still in progress, support and consultancy activities are guaranteed for the players involved and the willingness to accept suggestions for improvement. Therefore, operators feel reassured in dealing with any critical issues that may arise
Readiness for Implementation	7				X		At the company level, an indicator of the organizational commitment to the implementation of interventions is given by the decision to include ad hoc objectives in the budget and performance evaluation forms. At the level of the individual services, some indicators are: significant attendance at organized meetings; no. requests for support in the management of new procedures; no. cases managed by applying the new procedures
Leadership Engagement	8				X		The management's commitment is given by the choice to create a specific corporate working group, to set ad hoc objectives in the budget and performance evaluation forms and to supply nurses and social workers to hospitals and health districts
Available Resources	7			X			The planning and implementation of the project interventions saw the involvement of internal services and operators already institutionally interested in these processes. This did not require additional costs, both for the design and processing/development of the products and for the training effects. Certainly these services were required to devote part of their working hours to organizational redesign and to accompanying operators in the implementation phase
Access to Knowledge & Information	8				X		Access to knowledge about operational protocols and the computerisation system was through the ASL's institutional channels (website, institutional email circuit, computer platform access credentials)
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	8				X		The lack of integrated intervention procedures led, among other things, to work stress for the operators who had to guarantee overall responses to social and health needs that could not be packaged independently within the individual service. Therefore, the attitude of the operators towards the intervention was positive because it introduced clarity of roles, responsibilities, connections and related work tools
Self-efficacy	8				X		The hiring of new human resources, the availability of nurses and social assistants in hospitals and health districts has increased confidence in the ability to implement processes
Individual Stage of Change	9					X	The procedures and working tools were designed in agreement with the various actors involved and tested with some services. Therefore, there has been active participation and involvement in the implementation since the early stages

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Individual Identification with Organization	8				X		There is a fair level of individual identification with the organization, even if not homogeneously in all corporate services.
Other Personal Attributes	8				X		Overcoming the self-referentiality of individual services is a determining factor for good networking. Surely the shared definition of protocols and integrated operating procedures, with clarity of roles and responsibilities, is a facilitating factor for reducing the levels of self-referentiality and increasing network work
V. Process							
Planning	9				X		Planning was guaranteed for the implementation of the project interventions. The following are the reference elements: the establishment of the company working group which has been given the task of defining integrated procedures/protocols for taking charge of people with complex social and health needs, with particular reference to integrated hospital-territory taking charge; the design and development of the IT platform also integrated with the social services of the municipalities and with the hospitals, the recruitment of nurses and social workers; the inclusion of ad hoc objectives in the budget sheets and for performance evaluation; the definition of a monitoring system
Engaging	8				X		The involvement was already guaranteed from the first phases of planning of the interventions. In addition, information and training meetings have been guaranteed through the ad hoc corporate working group and support and consultancy activities are guaranteed for the players involved
Opinion Leaders	8				X		The following are recognized as company opinion leaders: The company Medical Director, the members of the company working group, some in their capacity as expert opinion leaders and others in their capacity as peer opinion leaders
Formally Appointed Internal Implementation Leaders	8				X		The ASL has identified the ad hoc corporate working group to which it has entrusted the planning and implementation of the interventions. In addition to the company Health Department, the group includes various Complex Operating Units belonging to the Territorial Care Department (including the Social-Health Care Unit) as well as the IT Technology Unit, a representative of the Health Departments of the Hospitals and a representative of the of the health districts
Champions	7				X		The champions are identified in: Company Health Director; Director of the COU Social Health Integration; number 2 Directors of the Hospitals; number 3 Directors of Health Districts; COU Director of Home Care
External Change Agents	3			X			To date, no external agents of change are involved, except for the social services of the municipalities who are very interested in putting the integrated IT platform into operation to improve the levels of communication and coordination with the Health Districts
Executing	8				X		The initial planning had some delays and changes also due to the impact of the COVID19 epidemic. The modified one is mainly respected
Reflecting & Evaluating	9					X	The products/interventions envisaged by the project have all been designed, elaborated/developed and disseminated. The current and future commitment of the ASL is in the total and homogeneous implementation of what is produced throughout the ASL territory

8.1.1.4 AUTH

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	[9]			x		x	[since personal data are involved in the process, the perception of key stakeholders on the source of the intervention was very important and it determined if the data would become available to us]

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Evidence Strength & Quality	[9]					x	[The Stakeholder perception is a key contributing factor of whether the implementation will eventually be sustainable to the local society through their support]
Relative Advantage	[5]		x				[The perception of stakeholder that other interventions can also be similarly effective is an issue. There are other promising evidences that could influence their prioritization]
Adaptability	[7]				x		[The intervention can be adapted to the local reality however there are serious obstacles to overcome, data scarcity, Electronic Patient Health record keeping, lack of enculturation and leadership]
Trialability	[8]				x		[Unfortunately, the lack of available data do not allow to conduct classification of patients at this level. However, smaller scale clustering of patient is feasible for the beginning. For the empowerment, the wide piloting is an option. In the context of the project small scale feasibility study was conducted]
Complexity	[9]					x	[Very difficult since prior the implementation there are steps to be taken in order to foster relevant stakeholders awareness and the necessity as well as design algorithms to obtain accurate data as possible]
Design Quality & Packaging	[8]				x		[The intervention was presented very well but nit at the implementation that was of classification did not have the recognition as there was not enough time and resource to transform current perception and train for Electronic Health records]
Cost	[3]			x			[the needed resources for this intervention were covered by AUTH]
II. Outer setting							
Patient Needs & Resources	[10]					x	[Patient empowerment is the main tool for increasing patients' knowledge and skills. Barriers were discussed and certain measures were taken]
Cosmopolitanism	[9]					x	[AUTH overall approach is focused on networking with society and other organization through Living Labs and other research institutes]
Peer Pressure	[2]	x					[There was not pressure from any peer or organization with competing interests]
External Policy & Incentives	[10]					x	[The implementation of the interventions proposed in Jadecare require policy and legislative changes at the national level. It is positive that the governmental priorities are in this line]
III. Inner setting							
Structural Characteristics	[10]					x	[The Lab is the appropriate organization for the implementation of the proposed interventions since it conceptualizes the activities in a holistic integrative way, looking at the patient QoL, family, society but also policies and legislations]
Networks & Communications	[10]					x	[The internal communication was excellent throughout the project implementation]
Culture	[10]					x	[The norms and values are perfectly aligned with Jadecare project principles and interventions]
Implementation Climate	[1]	x					[Unfortunately, none of those will happen. All participants were at a voluntary basis, and they will not have any reward or support for their participation]

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Tension for Change	[8]					x	[It is starting to be clear that the change is inextricable linked with progress and that there is a necessity to upgrade our current practices]
Compatibility	[7]		x			++	[Within the organization there is compatibility, however in Greece there is great risk of the existing workflow and the changes towards electronic health records, since the values and norms are not yet mature enough]
Relative Priority	[9]					x	[Yes, all individuals are aware of the necessity of change towards digitalization of health care and common perception of the importance of the implementation within the organization]
Organizational Incentives & Rewards	[7]				x		[As a public institution there are pre-defined processes involved, however, there is a rewarding environment through incentives]
Goals and Feedback	[7]				x		[Goals are communicated clearly, and feedback is provided]
Learning Climate	[8]					x	[Yes, since there is a chain of command and a hierarchy where everyone has the responsibilities and duties, there is a freedom to express their opinion, test new concepts, suggest new proposals]
Readiness for Implementation	[9]					x	[It is an important component the commitment to the tasks at hand and consistency and liability]
Leadership Engagement	[9]					x	[Yes there is great commitment and accountability within the structure of the organization]
Available Resources	[4]		x				[Unfortunately, the level of available resources is inadequate for the effective implementation required to achieve such a great change]
Access to Knowledge & Information	[6]				x		[The knowledge is available to all through diverse means for the interventions made and dissemination events]
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	[10]					x	[At the Lab there is great awareness and familiarity with the proposed interventions, the problem is that the norm is not at this level and other healthcare organizations]
Self-efficacy	[1]	x					[all actions were on a collective basis. No individual beliefs involved]
Individual Stage of Change	[8]				x		[Yes there is enthusiastic leadership and promote change in the organization]
Individual Identification with Organization	[5]			x			[The commitment is an issue since the public entity make people insecure to be sceptical]
Other Personal Attributes	[10]					x	[In the Lab there is high level of motivation and learning style, there are organizations of seminars and professional Development workshops[]
V. Process							
Planning	[7]				**x**		[Yes, it is possible at some points to initiate a behaviour in advance or a method, but usually is according to the plan ahead]
Engaging	[7]				x		[Yes it is possible and could influence the implementation in the correct direction]

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Opinion Leaders	[6]				x		[Yes, it is possible that an individual could influence at certain degree with her beliefs, but the networking within the organization would not allow to influence the implementation of the intervention]
Formally Appointed Internal Implementation Leaders	[9]					x	[Yes, project manager and coordinator facilitated the smooth and effective implementation of the project activities]
Champions	[7]				x		[Yes, individuals within the marketing sector facilitated several dissemination activities of the implementation process]
External Change Agents	[7]			n	x		[Individuals or external experts who were affiliated did not influence the desirable direction]
Executing	[8]					x	Yes the implementation is according to the plan with only very minor changes
Reflecting & Evaluating	[9]					x	Yes both Quantitative and qualitative feedback was received regarding the implementation process and with appropriate debriefing

CFIR Focus Group

Next Adopter	AUTH Lab of Medical Physic & Digital Innovation	**Local Good Practice**	Greece's approach on patient classification and patient empowerment
Setting	Online meeting	**oGPs that you transfer from**	Basque Health Strategy in Ageing and Chronicity: Integrated Care Good Practice transfer and adoption
Date of the Meeting	16/06/2023	**Location**	Thessaloniki
Start time	10.00 am	**End time**	12.00 am.

Participants

	Name and surname	*Organization*	*Role*
1	Christina Plomariti	AUTH	Moderator
2	Fivos Papamalis	AUTH	Assistant
3	Panagiotis Bamidis	AUTH	Participant
4	Michalis Doumas	Ippokrateio General Hospital	Participant
5	Panagiotis Psomas	4th YPE	Participant
6	Smaranda Nafsika Ketseridou	AUTH	Participant
7	Konstantinos Imprialos	Ippokrateio General Hospital	Participant
8	Konstantinos Stavropoulos	Ippokrateio General Hospital	Participant

QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1 External Policy & Incentives			

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	This construct was of high importance to our implementation. This was not obvious from the beginning, but it was made clear when we tried to integrate external data and sources to our implementation and faced barriers concerning the existence of digital data in Greece	The external policies and situation posed a barrier for our work. Hospitals do not collect data in an electronic format Everything is in print Externally, hospitals are underfunded and there is a huge lack of resources	if there is a lack of resources, human resource training, if there is knowledge, if there are negative beliefs towards electronic health, you tell us about the electronic health record, about stratification, let's not we enter because it is on the second level, that is, it is the result, you understand. The reply for a participant was "all of the above".
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	During the dissemination events we highlighted the positive steps made and the steps that could bring difference at the local practice	There were many individuals who participated that focus on the positive elements of the JADECARE and wish that they had this system s in Greece as well. Also, in regard to their beliefs if the digitalization would help the NHS, the participant replied "the belief in most people is positive, but it becomes negative because there is no manpower and time to be able to implement this thing"	N/A
3.	If you started again the implementation process, what would you do differently?	We would be more aware of the deficiencies in order to be more realistic with the goals but also with the plans made. Also, we would integrate Policy makers more in order to see how in regards to the rest of the other EU countries we need to upgrade our digital health system	involving stakeholders from the beginning	[….]
CONSTRUCT 2 Patient Needs & Resources				
4.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Since we implemented a patient empowerment feature, the needs of the patients along with the resources they possess and use was considered very relevant in order to best deliver to them our services and achieve major acceptance	From the doctors' point: Many participants were interested to see what exactly is patient empowerment and they were very interested to participate. Specifically one participant mention "I wish I had the chance to speak up when I was mistreated by the health care personal. It was important moment to feel that nobody stays behind"	
5.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Through the activities we also raised the awareness of both health care personnel and the patient of the importance of the empowerment in the therapeutic progress. To change from the passive recipients of care to active agents in their treatment plan	The Director of one of the clinics responded "the Patient Empowerment… I was impressed… because to tell the truth ….I thought there wouldn't be… neither a particularly positive predisposition… nor very strong desire… to participate in such a project… and I thought they would do it just for my sake. But I was also impressed with the young doctors… my colleagues… and especially the nursing staff…to participate and to engage in this prosses	
6.	If you started again the implementation process, what would you do differently?	We would integrate more patients in this process and make some outreach events or in hospitals/ health care settings to increase their awareness more	Even a participant from the healthcare personnel at some point raised the issue of " more informative material would help us to better reach the patients and introduce our solutions to them"	
CONSTRUCT 3 Structural Characteristics				

	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The structural characteristics of the organizations involved was perceived of high importance. The fact that the involved staff has a high level of indeendence and that we were not consumed of “burocracy” facilitated the quick design and deployment of our solutions	We had the support of our superiors form the beginning nobody blocked our efforts we were not required to design large reports or lose time in informative meetings. Everything just flew	
	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The positive effect was enhanced by the active involvement of all from the beginnings. Doctors, nurses, directors were all present and would all follow all procedures	Our director was the first to want to try the solutions I asked our nurses to participate and relied on their opinion solely to come to the conclusion	
	If you started again the implementation process, what would you do differently?	Regarding the structural component, we would not change anything		
CONSTRUCT 4 - Knowledge & Beliefs about the Intervention				
	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	It is clear that through the JADECARE we healthcare personnel need and believe in new and innovative interventions. In our case is instrumental to have motivated staff that are willing to participate and engage in a new intervention such as the JADECARE project.	During our FGD this was confirmed by all participants. They all expressed their willingness to engage in new interventions that will help the health system to become more effective. Now even more that they have learned that the Digital enable care to provide more advantages than the traditional system and that personalized care is more effective and is tailored to the true needs of each individual. There were comment such as “I would like to participate again in a similar project” or “I wish we go towards digitalization of health in the country “	
	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The positive effect of this dimension is evident through the active involvement of the health care personnel from the bottom up to top down- from social workers and nurses to program planners and directors.	An important comment provided by a participant was that “ the problem with us the old timers doctors If we hadn't contacted you... we wouldn't have taken any of these actions. Zero, I can tell you for sure. And my feeling is that... though any other clinic you go to... if there isn't... basic opposition from the Director... who will say... don't bother with this kind of nonsense... here we don't have time to do the important things. I feel this has change throughout the communication and the activites made in this project”	
	If you started again the implementation process, what would you do differently?	We would provide more informative material about the available evidence of the digital care and personalized health system around the world and try to involve more hospitals and healthcare personnel.	The above-mentioned comment is indicative of the beliefs of the old fashion doctors and thus raising awareness and increasing their knowledge of the advantages and empirical support of digital care of major importance	
CONSTRUCT 5 - Other Personal Attributes				

	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The last construct is very much related to the above as they are in the same dimension and refers to the personal attributes of the health care personnel. This is very important and highly relevant since if the health care personnel do not understand the necessity of the digitalization of health, then none of the advantages provided in digital care will be available in Greece.	It is true even the participants at the FGD admitted that they had neutral or even negative attitude about digitalization of care. Some even expressed that "at the end digitalization will take the jobs of the doctors" and this open a window of opportunity that the digital care is a tool and always be a tool for the doctor to make her/his job more easily and effectively	MISSING
	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Certainly, JADECARE facilitated positively the change of the belief system and attitudes that some health care personal had against digitalization of care. However, this is only a small fraction of the whole NHS system in Greece and therefore more effort is needed.	The majority have changed beliefs about the digitalization of healthcare but there is a lot of work remain in Greece since the prevalence was only a small section. We need multiplier events.	MISSING
	If you started again the implementation process, what would you do differently?	If we would start again, we would assess the personal beliefs and attitudes of healthcare personnel at every level (directors, doctors, nurses etc.) before and after the project and assess the potential changes. This would be a valuable indicator and for our implementation of JADECARE and for future projects.	As already discussed above the participants admitted that especially the older doctors have certain beliefs that are not so positive towards engaging in digital projects and may see it as waste of time that could be spent more effectively. This attitude at least from those participated in JADECARE started to change as they had the opportunity to learn the empirical evidence for the advantages of digital care and experience their own some of the benefits with the VR.	MISSING

8.1.1.5 CCUH

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	4			X			Good practice from another country with a different health system
Evidence Strength & Quality	9					X	Involving all key stakeholders (incl. internal) from very beginning
Relative Advantage	5				X		A direct possible relative advantage of integrated care wasn't visible for every stakeholder
Adaptability	6				X		Adaptable but data access and funding issues need to be addressed
Trialability	9					X	It's really important to start with specific actions and interventions on a small scale that bring quick wins and later upscale and implement it on a larger scale
Complexity	8				X		
Design Quality & Packaging	8		X				Complex intervention with many components and difficult to assemble in the transfer
Cost	8				X		

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
II. Outer setting							
Patient Needs & Resources	10				X		Empowering patients is one of the main goals of the intervention
Cosmopolitanism	9					X	National level project
Peer Pressure	5			X			No pressure, voluntary implementation
External Policy & Incentives	9					X	On national level
III. Inner setting							
Structural Characteristics	4			X			Maturity in health innovation
Networks & Communications	8				X		Communication within the NAWG was up-to-date and responsive and as such significantly contributed to the success of the implementation.
Culture	4			X			This factor did not significantly affect the success of the intervention, as we always operate in accordance with the standard culture and values
Implementation Climate	6		X				NAWG does not have the final say in implementing the intervention, decision-makers at higher levels do, but they can also decide differently than the NAWG suggests
Tension for Change	9					X	There was common understanding that changes are needed, eg.because of lack of doctors
Compatibility	4		X				Alignment of values but not of work processes
Relative Priority	7				X		Integrated care and digitalisation are priorities on the political level in Latvia but for different health care providers there are also other priorities that more important or more urgent
Organizational Incentives & Rewards	7				X		It is very important for every involved party to build up a suitable incentive system
Goals and Feedback	8				X		Consensus on project objectives for active stakeholders
Learning Climate	8					X	Climate of collaboration and partnership
Readiness for Implementation	8				X		Deliberations (TSD), Jadecare) and political support by Alexandre Feltz. Setting up the project team has taken time and has changed. No or little visibility by the Mayor, the President or the Directorate General]
Leadership Engagement	7				X		
Available Resources	8				X		
Access to Knowledge & Information	7				X		
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	10					X	Motivation of a few key individuals helped the project to emerge and maintain the implementation target despite the obstacles
Self-efficacy	5			X			We believe that the entire NAWG group performed their work adequately and correctly
Individual Stage of Change	7				X		All individuals at NAWG are ready for change
Individual Identification with Organization	2		X				

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Other Personal Attributes	2		X				
V. Process							
Planning	7				X		Good planning is very important to the success of the implementation
Engaging	9					X	We changed the members of the team many times to achieve the best results, because selecting the right people to participate in the NAWG is critical
Opinion Leaders	9				X		For us it was important to find leader of digitalisation in each department but not all department has it
Formally Appointed Internal Implementation Leaders	8				X		The coordinator plays an important role in the implementation of the project and a good coordinator (project manager) can have a strong positive influence on the implementation.
Champions	9					X	For us it was important to find champions for digitalisation in the hospital
External Change Agents	7				X		
Executing	4			X			
Reflecting & Evaluating	8				X		

CFIR Focus group

Next Adopter	CUH	**Local Good Practice**	Development of digital eligible ecosystem for children' s healthcare as national level pilot project
Setting	Latvia	**oGPs that you transfer from**	THE DANISH ROADMAP
Date of the Meeting	30.5.2023	**Location**	On-site
Start time	10:00	**End time**	11:30

Participants

	Name and surname	*Organization*	*Role*
1	Ieva Lejniece	CUH	Moderator, Project manager
2	Guna Esenberga	CUH	Assist, Senior IT project manager
3	Linda Putniņa	CUH	Senior project manager
4	Iluta Riekstiņa	CUH	Member of the board of the hospital

	QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: External Policy & Incentives Evidence Strength & Quality				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Our practice outcomes are aligned to the health strategies at national health policy level as our project will become a part of larger schemes of health system transformation, such as Digital health strategy until 2029.		
2.	How have you enhanced the positive effect or diminished the negative effect	With engaging ministries and president in the project from beginning and getting support		We have also involved general practitioners now as they also are using

	of this construct in your implementation process?			our portal (as our national level e-healthcare system isn't functional)
3.	If you started again the implementation process, what would you do differently?	We would also involve primary care at an earlier stage and inform the ministries more about the status of the project, so they are more involved in the project.		
CONSTRUCT 2: Complexity				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Not all physicians were ready to involve in development of digitalization despite we had great examples to use. And we wasted some time working only with digitalisation experts. We had also difficulties to find a developer with common understanding about result needed so we needed to change them few times to find the one.	It's also important not to forget about externals experts in case it's needed	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We were ready to adjust and correct mistakes as this was first experience for us – eg.we were ready to changed IT developer companies as many times as needed to get the best result. The same with establishing team.		
3.	If you started again the implementation process, what would you do differently?	We would engage physicians and patients from beginning and also external experts. We started our project by establishing working group of internal digitalisation experts and their thought were different from "real" users.		
CONSTRUCT 3: Patient needs & resources				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	As patients are one part of main users it's very important to involve them in the process of user experience.	We involved patients (or their parents) by testing solutions Empowering patients is one of the main goals of the intervention	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We included parent board and also teenagers who can use solutions individually in in the NAWG. All products of the project/implementation were also given for review and commenting.	We have different design of patient portal for parents (who use	
3.	If you started again the implementation process, what would you do differently?	We would involve patients earlier and obtain the opinions of them more often		
CONSTRUCT 4: Evidence Strength & Quality				
1.	Please, describe the specific reasons for the consideration of the construct as	We engaged main users (physicians, patients) when developed the telemedicine strategy and developed implementation plan to	We were working on planning our digital ecosystem and Jadecare came in perfect moment with great and very useful Good practise. It supported to design implement our project especially considering that we started JA in	

	highly relevant in your implementation process.	be sure that strategy and plans are not only in good quality but also will be implemented in life	pandemic when the need for digital products were very high and solutions needed to develop quickly	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We also compared other models and solutions, but Danish model was closer to our needs. We also involved main users in comparison process and quality assessment	Project tools like SWOT, PDSA, etc. was also very useful	
3.	If you started again the implementation process, what would you do differently?	We would engage physicians and patients from beginning. We started our project by establishing working group of digitalisation experts and their thought were different from "real" users.		Involving all key stakeholders (incl. internal) from very beginning
CONSTRUCT 5: Engaging				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	We changed the members of the team many times to achieve the best results, because selecting the right people to participate in the NAWG is critical and project was successful because of valuable team members		
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We expand our team with physicians, patients, family doctors		
3.	If you started again the implementation process, what would you do differently?	We would involve main users in the team and project much earlier – physicians, patients, primary care		

8.1.1.6 CIPH

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
VI. Characteristics of the intervention							
Intervention Source	7					X	The idea was based on an external need, but internally developed. The internal development motivates the stakeholders and gives them a sense of autonomy.
Evidence Strength & Quality	9					X	The stakeholders deem the quality and validity of this evidence as very important since the concept of evidence-based interventions and proof of effectiveness and sustainability are important and well known to the stakeholders.
Relative Advantage	5			X			In this project, the perception of advantages of the planned intervention versus an alternative one was not discussed thoroughly and, therefore, this doesn't carry a lot of weight. Alternative solutions were not a popular topic since all resources were limited.
Adaptability	7					X	This carries relevance for the stakeholders because it helped the stakeholders to be more motivated and open when working on the intervention. This gave the stakeholders a feeling of freedom, independence and that sustainability can be achieved.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Trialability	7				X		This ability is relevant to the stakeholders, although it has not been used as part of this project.
Complexity	10		X				The stakeholders perceive complexity of implementation as the most relevant since rise in complexity means more resources need to be involved and resources are always the main limiting factor. In this project, complexity was the thing to tackle since there was no funds for a standalone website/online portal but the stakeholders had to make do with the basic resources they had.
Design Quality & Packaging	9				X		This construct bears great significance for the intervention implemented in Croatia. The way that a web-based source will be presented and how accessible will it actually be is paramount.
Cost	10	X					The cost of implementing an intervention is always the very important, regardless of setting or nature of project in the Croatian system. Costs are always limited and redefining costs within a project is mostly rigid, thus hindering optimisation of implementation efforts.
VII. Outer setting							
Patient Needs & Resources	10					X	Catering to the known patient needs is probably the most important construct in the implementation of the idea chosen in Croatia. The intervention chosen matches the patient needs and this is well known from experience. The choice of intervention, the adaptation process and the implementation were done by the Croatian Institute of Public Health, where prioritizing patient needs on a big scale is part of the work culture.
Cosmopolitanism	8					X	The chance to exchange knowledge and experience with good practice leaders who have these good practices in place and work on them actively is extremely helpful.
Peer Pressure	3				X		Peer pressure is not very pronounced in the field of public health interventions in Croatia. The Croatian institute of public health rather cooperates with potential competing organizations. In Croatian these would be mainly patient advocacy groups. This cooperation is always positively welcomed. JADECARE-sourced intervention peer pressure was not recognized as part of this project.
External Policy & Incentives	8					X	Political/governmental directive/incentive (direct or indirect) definitely increases motivation in a setting like the Croatian one. We are in agreement with the fact that a possibility of public reporting also motivates implementation a great deal.
VIII. Inner setting							
Structural Characteristics	7					X	The Croatian Institute of Public Health is the primary and dominating organization in the field of public health. All of the expertise referring to public health interventions, as well as implementation science is concentrated in the organization. Various partners outside of the CIPH are also part of this project. They provide their expertise in various field of the project, so as to make the outputs of the project as effective and as sustainable as possible.
Networks & Communications	7					X	Teamwork and effective communication within the next adopters circle are considered important in all aspects of the project, including successful
Culture	8					X	The way of thinking and organizational culture of the CIPH is public heath oriented and population-need centred. In implementation of public health interventions and good practices referring to health, this is an important aspect.
Implementation Climate	5				X		The implementation climate is not as important as political incentive/push.
Tension for Change	5				X		The tension for change is not as important as political incentive.
Compatibility	8				X		Compatibility is important as it, in part, insures motivation.
Relative Priority	9				X		The perception of importance influences implementation greatly.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Organizational Incentives & Rewards	7				X		Extrinsic incentives are perceived as important as they, in part, insure motivation.
Goals and Feedback	9					X	This is deemed very important as it also motivates workers and gives them a clear perspective.
Learning Climate	9					X	This is deemed very important as it also motivates workers and gives them a clear perspective.
Readiness for Implementation	7					X	Tangible and immediate indicators of organizational commitment to its decision to implement interventions are considered relevant
Leadership Engagement	9					X	Seeing the involvement and accountability of the managers with the implementation motivates all stakeholders working on the project.
Available Resources	10					X	Every project in which the stakeholders are involved in is seen through the lens of available resources first.
Access to Knowledge & Information	7						Is of access to knowledge about the intervention is important, but not paramount.
IX. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	5			X			Individuals attitudes are not very relevant as implementation activities are seen as everyday/routine work.
Self-efficacy	5			X			Individual belief in their own capacity is not incredibly important as the effort are team work efforts and tasks are distributed based on knowledge and expertise
Individual Stage of Change	5			X			Implementation of interventions and sustained use is seen as routine task at the workplace.
Individual Identification with Organization	6				X		This construct can be a source of motivation for some.
Other Personal Attributes	6					X	These are deemed important, as for any other project.
X. Process							
Planning	10					X	In the work setting of the stakeholders, planning is greatly appreciated and sought.
Engaging	8					X	The team members tasked with implementing an intervention need to be well selected
Opinion Leaders	7				X		The effect of opinion leaders with respect to implementing interventions is important in the setting.
Formally Appointed Internal Implementation Leaders	8				X		This is deemed as important in implementation processes.
Champions	7				X		These are perceived in the same was as opinion leaders are.
External Change Agents	6			X			External change agents are rare, so their real-life effect is hard to measure.
Executing	9					X	This is a great motivator.
Reflecting & Evaluating	8				X		Also provides motivations and perspective.

CFIR Focus Group

Next Adopter	CIPH	Local Good Practice	1. Croatian approach on an Integrated Healthcare Sector- The Digital Health Centre 2. Croatian approach on an Integrated Healthcare Sector – New media use in GP-patient communication and disease management materials
Setting	Croatia	oGPs that you transfer from	THE BASQUE INTEGRATED CARE APPROACH ORIGINAL GOOD PRACTICE – CORE FETURE 1 – Deployment of a School of health
Date of the Meeting	5.6.2023.	**Location**	Croatian Institute of Public Health
Start time	10:00 AM	**End time**	11:30 AM

Participants			
Name and surname		*Organization*	*Role*
1	Iva Stupar	CIPH	Moderator
2	Ivana Andrijašević	CIPH	Assistant
3	Ivana Brkić Biloš	CIPH	Participant
4	Petra Čukelj	CIPH	Participant
5	Tanja Lelas	CIPH	Participant
6	Tamara Radošević	CIPH	Participant
7	Gordan Sarajlić	CIPH	Participant

QUESTION		**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: COMPLEXITY				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Complexity means more resources need to be involved which implies better planning of activities. It is a construct that needs to be seriously thought-out. An intervention that was can be considered rather complex was chosen by the next adopters.	''The more complex the implementation is, the more resources are needed.''	The participants agreed.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	There were no funds for a standalone website so we had to make it with the basic resources we had.	''We managed to make a pretty good product, taking into account the resources we had.''	The participants felt proud of the accomplishment they have made despite facing substantial obstacles.
3.	If you started again the implementation process, what would you do differently?	Focusing on one thing at the time with more detailed planning in advance.	''Better timeline of activities would be useful.''	The participants agreed.
CONSTRUCT 2: PATIENTS NEEDS AND RESOURCES				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	''For some time we lacked a perspective on the target group – we don't have new research on patients' needs and patients' perspective, so we worked based on the findings we had at the time.''	The participants did not fully agree regarding statement about lack of a perspective on the target group. They discussed it and concluded that a clear perspective existed, but the initial idea itself was perhaps too ambitious.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	''I would really like to emphasize that, in spite of all, we managed to collaborate and deliver a product we are proud of.''		Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.

3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	''Due to COVID-19 we were not able to reach as many patients as we wanted.'' ''General practitioners were too busy with COVID-19 and unavailable most of the time.''	Participants expressed their dissatisfaction that COVID 19 delayed the implementation process and made initial plans difficult to achieve.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face
CONSTRUCT 3: AVAILABLE RESOURCES				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Available resources are crucial for making effective decisions and setting realistic expectations.	''It's such a great idea, but to realise it in its full potential, I think we would need to work solely on that for a month or so, which we couldn't manage to do with all the other tasks.''	All participants felt they could have done better if more resources were available.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	When we encountered challenges, we stuck to the initial idea of creating a unique place for patients - that was our motivation for moving further.	''Our initial idea of creating a website for patients was stalled because of COVID 19, but we had to focus on the future and what we will do later to make it better.''	
3.	If you started again the implementation process, what would you do differently?	Maybe start with a less ambitious idea and develop it along the way, following the state of available resources.	''You always want to do something big, but the reality dictates a different course.''	The participants nevertheless concluded that they were able to successfully achieve their activities and that they are proud of the work they have done.
CONSTRUCT 4: INDIVIDUAL IDENTIFICATION WITH ORGANIZATION				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Since our personal values and beliefs resonate with the mission of the organization we work for (general improvement of different aspects of public health), that was a great source of motivation in the implementation process.	''Since we work in public health, our approach was aligned with the mission of the implementation process. I think that would be different, maybe lacking, if we worked somewhere else, for example in an exclusively research-oriented institution. That is our strength.''	This construct seemed to confuse participants, and many were unsure how to respond. One participant took the initiative in responding to this question.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The motivation of the team regarding the implementation process was high from the beginning as there was a great amount of trust in the potential of the work that was being done.	''It was our mission to design a place that patients, especially those who have more than one chronic disease, can access and get reliable information. We wanted to make things easier for them.''	The participants enthusiastically agreed.
3.	If you started again the implementation process, what would you do differently?	Getting more feedback from the patients and patients' organizations as, when the workload was high, the motivation tended to lessen.	''It is crucial to remind yourself why you started the implementation process in the first place.''	
CONSTRUCT 5: PLANNING				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Planning is crucial in the implementation process. We worked best within the circumstances and with resources we had. Planning the work and sticking to it was sometimes hard due to the enhanced workload (COVID-19).	''Part of our team was unavailable due to working on tasks related to COVID-19 for the better part of the implementation process.''	Participants chimed in with examples of the obstacles that made the implementation process challenging.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Communication within the team as well as formal requirements regarding reporting our progress within the implementation process is what helped us the most.	''If it hadn't been for the reminders, it would have been much harder to keep track of the implementation process.''	

3.	If you started again the implementation process, what would you do differently?	We would aim to have clearer vision and better focus regarding our work – take on smaller scope of the work but do it with more dedication and make an internal implementation plan that the team can get back to and regularly check how the implementation process is going.	''Sometimes the extent of what we were doing seemed as if it could be a bit too much.''	Participants agreed. One participant emphasized the quality and amount of work that was done during the implementation process.

8.1.1.7 CSCJA&FPS

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	3			X			There is no evidence that the construct has influenced implementation.
Evidence Strength & Quality	7				X		Quality and validity of the intervention has been considered for its adoption. In the current context, it is perceived as very promising to adopt the proposed approach (proactive follow-up of complex chronic patients at home, facilitated by ICT tools) to address the current challenge (to improve not only home care/monitoring but also the use of available system resources) in an effective and efficient way.
Relative Advantage	8				X		The use of technology as a means of ensuring integrated and continuous care for this population, in order to improve their quality of life, is a commitment for the present and the future, which is established as one of the best alternatives to achieve the proposed objective. In the current context, the proposed approach is seen as very promising, as patients feel safer as they are followed proactively, episodes of decompensation at home are reduced, they can stay longer and with better quality of life at home, and the health system optimises the use of resources
Adaptability	8				X		Learning from what has proved to be effective and useful, while allowing it to be adapted to a new territory, is an important value of this project. Both the oGP and the local GP are designed to be applicable to different types of pathologies/situations.
Trialability	7				X		The possibility of carrying out pilot experiences before scaling up interventions in our environment proves to be a fundamental activity, given the large extension and diversity of our region. Andalusia has the size/population of a medium-sized country, which in addition to the intensive use of a corporate eHR system at all levels of care, allows for the implementation of pilots that support for subsequent scaled-up.
Complexity	9		X				The activity that is being carried out in JADECARE is part of the path that is already being developed in the Andalusian Public Health System. The proposed good practice implies the integration of a new technological development into pre-existing corporate systems, which requires a great effort in the previous design and the need for intensive testing prior to launch.
Design Quality & Packaging	8			X			There is no evidence that the construct has influenced implementation.
Cost	9				X		The proposed intervention is costly and requires external financial support. This necessitated a tendering process. In addition, entity awarded the contract had not previously worked with the Andalusian Public Health System. All this has delayed the initial deadlines and made communication between the parties more difficult.
II. Outer setting							
Patient Needs & Resources	9					X	The citizens' assessment of their needs and expectations plays a very important role in the planning of the Regional Ministry of Health and Consumer Affairs and the Andalusian Health Service, which are included in the interventions carried out. The SSPA's humanisation strategy is a

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							good example of this, as it is one of the dimensions of the quality of care. The population is well characterized and prioritized thanks to the Andalusian population health database (BPS) and the existence of a corporate eHR (Diraya) accessible from all levels of care. The target population is difficult to manage since it is a multifactorial problem (older people plus complex chronic conditions, etc.) but ICTs can help to monitor them (although they are usually victims of the digital divide).
Cosmopolitanism	7				X		For the development of a part of the JADECARE joint action in Andalusia, interconnection with other public institutions (specifically with the Regional Ministry responsible for social services) would be necessary in order to provide appropriate social and healthcare to those who need it simultaneously and synergistically. Beyond participation in the JADECARE Joint Action, there is no evidence that the construct has influenced implementation.
Peer Pressure	5			X			There is no evidence that the construct has influenced the implementation beyond considering the trends/outcomes of other healthcare systems/organizations in addressing the selected problem, since the pilot is limited.
External Policy & Incentives	4			X			There is no evidence that the construct has influenced implementation.
III. Inner setting							
Structural Characteristics	8				X		The Andalusian Public Health System is a mature and structured system that favours the implementation/adoption of this type of good practice.
Networks & Communications	9					X	The Andalusian Public Health System is a mature and structured system that favours the implementation/adoption of this type of good practice
Culture	8				X		There are: • Common policies/strategies for the whole territory (including a specific line on proactive follow-up of chronic patients and home care). • Common indicators for the whole system in the programme contract. • Centralised awareness/dissemination activities.
Implementation Climate	8				X		We are not starting from scratch since citizens have been assuming changes in terms of their relationships and use of technology. However, a communication effort towards all the stakeholders (healthcare professionals and citizens) will be necessary. Difficulties in integrating new solutions hampered uptake by healthcare professionals.
Tension for Change	6			X			The construct does not seem to have an excessive relevance and influence on the achievement of the project objectives.
Compatibility	8			X			The impulse and the leadership provided by of the organization, as well as its and commitment to the good practice, is slowed down by delays in integrating IT solution.
Relative Priority	8				X		The current situation (ageing population and increasing number of complex chronic patients) is perceived as a priority, so the System is receptive to piloting/adopting promising initiatives. The management centres responsible for the implementation of the new activities have included in their roadmaps the needed changes to implement the interventions included in the project, within a more global framework of changes within the Organization.
Organizational Incentives & Rewards	6				X		The Programme Contract of the Andalusian Health Service (a document that reflects the objectives and priorities of the Organisation and is freely accessible to the entire population) includes indicators for healthcare professionals linked to the main components of local good practice.
Goals and Feedback	7				X		Communication and adequate information of all the actors is a fundamental element to help achieve the objectives set (not only for the implementation of the measures, but also for their usefulness and necessity).

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							The healthcare professionals' performance indicators linked to the main components of good Andalusian practice are published in the Programme Contract.
Learning Climate	7				X		Teamwork (in which all actors involved contribute on equal terms, but adapted to their profile and level of management) will help to implement the activities. Working groups are overloaded (not only healthcare professionals, but also the ICT professionals).
Readiness for Implementation	8				X		Knowing from the beginning of the project what is expected and how to measure the activities carried out is a necessary support to carry out the intervention adapted to the objectives set. Prior to the intervention, follow-up indicators and milestones were defined to facilitate the monitoring and control of the implementation
Leadership Engagement	8				X		Those responsible for the Organization support this initiative and encourage its use/application as a strategy to address the global challenge we are facing. Health planning and the tools to carry it out require the commitment and leadership of managers to facilitate its implementation, especially if the objectives are framed in a comprehensive planning and a global project rather than in isolation. It also has relevance and influence in the transmission to the groups of professionals in charge of the final implementation of the interventions
Available Resources	9					X	In a context of fewer resources than needed to develop the interventions, this element is of paramount importance to achieve the expected results. There is a budget from the central government (Red.Es Project) that allows the development and implementation of the proposed IT solution. Efforts are being made in the field of awareness/training of health professionals in the field of good practice. It is important to mention that healthcare professionals are recovering from the COVID- 19 pandemic overload.
Access to Knowledge & Information	9					X	Access to the information that justifies the intervention, as well as the participation of health professionals in awareness- raising/training activities favours the adoption of the intervention in routine clinical practice. Ensuring that all the professionals involved have knowledge and accessible information, as well as the ability to provide feedback on those aspects that can identify areas for improvement in the intervention, is a guarantee for the success of the intervention.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	7				X		Healthcare professionals' knowledge and beliefs about the topic will promote/hamper their willingness to adopt the good practice and therefore influence implementation results. Although it may slow down the implementation, the relevance and influence in achieving the project's objectives is limitated, since it deals with the strategic planning of the organisation. Adequate communication and information help to overcome resistance to change
Self-efficacy	6			X			There is no evidence that the construct has influenced implementation.
Individual Stage of Change	6			X			Healthcare professionals generally identify with the Organization's objectives.
Individual Identification with Organization	5			X			There is no evidence that the construct has influenced implementation.
Other Personal Attributes	4			X			There is no evidence that the construct has influenced implementation.
V. Process							
Planning	8				X		Implementation has been planned in advance, setting objectives and monitoring indicators.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Engaging	8				X		The Organisation's commitment, combined with awareness-raising and training activities, makes it easier for more healthcare professionals to join. Healthcare professionals are generally aligned with the Organization's plans and strategies.
Opinion Leaders	5			X			There is no evidence that the construct has influenced implementation.
Formally Appointed Internal Implementation Leaders	9				X		The personal commitment of those responsible for implementing the good practice makes it more dynamic. The capacity of this internal leadership is essential to ensure that all the professionals involved develop the intervention designed in an appropriate way, to create an optimal working climate and, therefore, to achieve the success of the project.
Champions	6			X			There is no evidence that the construct has influenced implementation
External Change Agents	4			X			There is no evidence that the construct has influenced implementation.
Executing	8			X			Despite a correct planning of the interventions, unforeseen circumstances may occur that can hinder the development of the project, forcing the search for alternatives to its execution without distorting the objective of the project. Due to the problems that arose during the integration of the platform for the proactive follow-up of chronic patients with the pre- existing corporate systems, all the deadlines initially set for this component (LCF1) have been delayed and are therefore outside the implementation period set in the JADECARE joint action.
Reflecting & Evaluating	8			X			Continuous follow-up and monitoring of the activities to be carried out allows us to make the necessary changes to improve the project, with the participation of all those involved. Due to the problems that arose during the integration of the platform for the proactive follow-up of chronic patients with the pre- existing corporate systems, all the deadlines initially set for this component (LCF1) have been delayed and are therefore outside the implementation period set in the JADECARE joint action, including data gathering and outcome assessment.

CFIR Focus Group

Next Adopter	Regional Ministry of Health and Consumer Affairs of Andalusia (CSCJA)	**Local Good Practice**	Improving healthcare at home for complex chronic patients (CCPs), including proactive follow-up, in Andalusia
Setting	Andalusian Health Service (SAS), in particular, at primary healthcare level.	**oGPs that you transfer from**	The Andalusian LGP is based on the components Tele-COPD (CF1) of the Danish good practice
Date of the Meeting	15-05-2023	**Location**	Main premises of the Andalusian Health Service, Seville, Spain
Start time	12:00	**End time**	14:00

Participants			
Name and surname		*Organization*	*Role*
1	Ana M Carriazo	Regional Ministry of Health and Consumer Affairs of Andalusia	Moderator
2	Rafael Rodríguez-Acuña	Andalusian Public Foundation Progress and Health	Assistant
3	Carmen Lama	Regional Ministry of Health and Consumer Affairs of Andalusia	Deputy Director of Strategies, Plans and Processes
4	Víctor Ortega	Andalusian Health Service	Head of the ICT Development and Projects
5	Susana Rodríguez	Andalusian Health Service	Technician of the Andalusian Care Strategy

QUESTION		SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Patient Needs & Resources				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Putting the patient at the centre of the system. To anticipate to the complex chronic patients' needs/requests.	Based on the typology of patients who use the system most and therefore need it most, their needs have been identified. If we know who complex chronic patients are, what they need and what we need to do, we can anticipate what they will ask of us. Putting the patient at the centre of the system. Without really knowing what the needs of the population are, it is unlikely that we will be able to give them an answer that they will accept.	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Andalusia faces a rapid increase in their population living with chronic conditions, which puts a high pressure on our healthcare system. Multimorbidity has become in one of the most important challenges for healthcare system that must be tackled. The acceptance of digital systems as an alternative to the classical approach is increasing and has been strengthened as a result of the COVID pandemic.	The current positive juncture has been exploited "as the group of chronic complex patients tends to grow due to the configuration and demographic changes we are now in". We have taken advantage of the empowering moment we are in "acceptance of digital systems by people (of all ages and in all conditions) is increasing". The results are directly tangible for the patient: fewer emergency episodes, fewer inpatient episodes (patients feel better and avoid decompensation). Being proactive has allowed us to counteract the bad press about face-to-face consultations.	[….]
3.	If you started again the implementation process, what would you do differently?	Carry out patients/healthcare professional's analysis of expectations and demands in advance. Increase the involvement of healthcare professionals who would participate in the pilot from the outset.	I think what would be done differently is to add the expectations and demands part. Starting from the participation of the patient, even increasing the participation of other professionals who, at the end of the day, are going to use, are going to be responsible for, are going to be the protagonists of the interventions. When it comes down to it, it is very important to be able to rely more on both professionals and patients (who will be the ones using it when we get to the actual implementation of all the modules, home devices and so on).	[….]
CONSTRUCT 2: Available Resources				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	Without adequate human and material resources, no implementation project can be undertaken. GP's schedules are very tight, so careful planning is needed to address new activities in routine practice.	It can be very clear what needs to be done, but if there are no resources you cannot do it. So, it is fundamental. Proactivity is difficult to schedule so space and time must be allocated in order to carry it out. In other words, you cannot ask a health care professional to be proactive with an identified patient with a specific need at a specific time, if he has his agenda full and is overloaded.	[….]
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	Previous developments have led to the convergence of the availability of resources for implementation, ICT development, information systems and evaluation from many different backgrounds.	The resources available and programmed during the JADECARE project, such as funding from the Red.es programme or the proposal already included in the roadmap for the development of the teleconsultation service, have had a very positive impact. The use of the available resources in a new modular platform will enable new advances in the future, allowing adaptation to changing needs and facilitating proactivity.	[….]

3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	Improve the dissemination of the new tools being developed and their potential among professionals. Increase the topics of the training to be carried out. Better adapt the agendas of professionals to new practices. Develop more agile evaluation systems.	Promote from the beginning that the organisation gives the necessary time and space to do what we are all committed to doing. Relying on the professionals so that they can see that there is a response to the issues they identify, and advise them on where they have to move forward.	[….]
CONSTRUCT 3: Formally Appointed Internal Implementation Leaders				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Having the formal support and participation of the organisation's leaders in these types of projects is essential to ensure that they are fully deployed in spite of the difficulties that may arise. Having the support of those responsible for the Andalusian Plans and Strategies linked to chronicity has been very important.	A project of this depth, if you do not have the clear and serious drive of the leaders of the organisation and the certainty that they will continue to drive it despite the difficulties that arise, this type of project usually fails.	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Having the support of leaders at different levels minimises the inherent risks of internal changes that may occur as a result of political changes in the government. The involvement of local project leaders has had a synergetic effect on the deployment of the pilot throughout the territory. Include objectives linked to the deployment of the project in the programme contract.	Despite the difficulties at the beginning of the project, we were fortunate in the end that vertical and horizontal leadership converged.	[….]
3.	If you started again the implementation process, what would you do differently?	Try to ensure that the support gained at different levels of the System would have been achieved from the beginning of the project. Designate and include representatives of the different professional profiles necessary for the deployment of the pilot from the outset.	What would have changed at the beginning is that the convergence would have been planned rather than coincident along the way, i.e. it could have been planned and the leaders would have been aligned from the beginning. To include more different professional profiles who may not have such a constant and continuous role, but who will be needed at some point, and if they are not there from the beginning, it is difficult to get them 100% involved.	[….]
CONSTRUCT 4: Access to Knowledge & Information				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Having access to the knowledge and information generated in the original environment is very important when assessing/justifying whether to adopt a new approach. The practice includes activities that have to be done and that, thanks to the digital solution, will be done more easily.	Professionals have to know the project in detail (have to have access to the information and the previous knowledge), what improvements it implies and they must also be trained in what is new. Being able to do day-to-day tasks more easily encourages professionals to adopt new approaches.	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Taking advantage of other training needs, it has been used to disseminate and train in the new approach to multimorbidity. Promote that the new approach is put into practice using tools included in the corporate ICT systems.	They made use of training strategies from other projects. Being able to do day-to-day tasks more easily encourages professionals to adopt new approaches.	[….]
3.	If you started again the implementation process, what would you do differently?	To have developed from the outset a more effective strategy for access to knowledge and information. Have a group of facilitators that allow the transmission of knowledge, since information between equals flows more easily.	The information and dissemination processes of the project among the professionals were done a bit out of time. The project has been implemented into the real practice of professionals very gradually and linked to other strategies that were already on the table.	[….]

			In general, we have a problem with information and training because there are no specific resources for it, but the same people who are on one side we have to be on the other.	
CONSTRUCT 5: Networks & Communications				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Although considered very important for the system as a whole, networking has not yet been deployed effectively within the organisation. Our healthcare system forms a very large organisation, making it difficult for information to flow from where it originates at all levels. There is resistance to adopting the proposed guidelines from other levels, as there is a belief that local contexts are not known.	In fact, we are not using the potential it has at all. I think we are still “in our nappies” when it comes to the use of communication networks in public health. There is a feeling that "they're coming to tell me what to do, and they don't know what my problem is".	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The involvement of local project leaders who have promoted networking and mutual learning. To take advantage of the hierarchy of the system to focus on the topics that must be tackled and the approach to be followed.	If it hadn't been for the idea of implementing through a network based on local leaders, I don't think it would have happened. The decision of inclusion in the "programme contract" is an element that allows you to communicate.	[….]
3.	If you started again the implementation process, what would you do differently?	Develop a feedback system to inform healthcare professionals and patients about the results and impact assessment to. Boost the use of social media or corporate social media (for professionals only) to exchange the knowledge/news among the stakeholders. Agree and define the minimum required knowledge in each field/topic to be known by each professional profile.	The management of the people in a team in the field in which they work is very important: professionals cannot be without sufficient knowledge to carry out their tasks. This project has so far only been carried out by professionals, but we have not used the networks to disseminate what is being done, what we are trying to achieve, which population we need to insist on (why and for what purpose). The professional does not just want to be a participant. He also wants to participate. When you are a participant and you feel like a participant, you will do it.	[….]

8.1.1.8 EUSTRAS

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	2					X	Good practice from another country with a different health system.
Evidence Strength & Quality	9					X	Initial TSD actors convinced of the interest and importance of the method but difficulties in convincing a second level (doctors, health professionals)
Relative Advantage	8				X		Tried and tested territorial approach ….]

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Adaptability	6					X	Adaptable but data access and funding issues need to be addressed (e.g., via contract with health insurance in Germany
Trialability	4					X	[Current test identifies difficulties and transformations to be implemented but does not provide sufficient evidence for scaling up ….] Possibility of testing in an already large area: 3 districts of Strasbourg Lack of case and care management Study with the CPAM on the financial impact
Complexity	8						The method was initiated in the context of a territorial innovation project that aims to be "disruptive"
Design Quality & Packaging	8		X				Complex intervention with many components and difficult to assemble in the transfer
Cost	8	X					Attractive shared savings model but difficult to implement in a French funding system. High initial cost of support in a context of lack of sustainable funding
II. Outer setting							
Patient Needs & Resources	10				X		[…Lack of individualised data that limits the measurement of needs and barriers and prioritisation.]
Cosmopolitanism	10					X	[The mobilisation of health professionals as well as the health insurance and the regional health agency are critical for the realisation of the transfer of good practice
Peer Pressure	1			X			Approach is pioneered in the territory .]
External Policy & Incentives	10					X	[TIGA in the framework of the PIA and "ma santé 2022" which promotes a coordinated and territorial approach ….]
III. Inner setting							
Structural Characteristics	6				X		[Maturity in health innovation in the City and EMS ….]
Networks & Communications	6				X		[…Territorial Consensus on Health: City, EMS, HUS, Unistra, Region.]
Culture	6				X		[Territorial approach, general interest carried by the communities allows the City and the EMS to position themselves as trusted facilitators - with difficulties on this point for the liberal professions….]
Implementation Climate	6		X				Difficulty for actors to change framework: territorial approach vs. client or tool]
Tension for Change	8				X		[Sustainability of health financing, ageing population, development of chronic diseases, prevalence of diabetes in Alsace, insufficient prevention and crisis situation of the hospital, silos between city and hospital….]
Compatibility	8		X				[Alignment of values but not of work processes ….]
Relative Priority	7				X		[Carried forward by the EMS, the City and the GIP; insufficient engagement of the territory's free practicing physicians .]
Organizational Incentives & Rewards	3		X				[…No additional rewards planned; funding of posts to invest in the project.]
Goals and Feedback	8			X			Consensus on project objectives for active stakeholders
Learning Climate	8				X		[Climate of collaboration and partnership within the GIP and with the EMS project team….]

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Readiness for Implementation	8				X		Deliberations (TSD), Jadecare) and political support by Alexandre Feltz. Setting up the project team has taken time and has changed. No or little visibility by the Mayor, the President or the Directorate General]
Leadership Engagement	8				X		[…Commitment of DDEA and GIP directors + EMS and GIP managers. No or little visibility by the Mayor, the President or the General Management.]
Available Resources	8				X		[…Beaucoup de moyens consacrés par l'EMS, la Ville et le GIP. Question structurelle à régler du portage et du financement en continu sur la durée.]
Access to Knowledge & Information	8				X		[Integration in professional tasks (GIP) recent ….]
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	10					X	[Motivation of a few key individuals helped the project to emerge and maintain the implementation target despite the obstacles….]
Self-efficacy	3		X				Insufficient leadership in implementing the action plan
Individual Stage of Change	10					X	[…Essential lever for the dissemination of the method; depends on the capacity given by the organisation to scale up.]
Individual Identification with Organization	10		X				[As intervention brings about structural changes, the identification of the individual/organisation is very important, but organisational rigidities, particularly in large pyramidal organisations or atomised actors (e.g. free practicing physicians), mean that this necessary identification does not work well….]
Other Personal Attributes	10					X	[…Trial and error and co-construction.]
V. Process							
Planning	5			X			[…Trial and error and co-construction are more important.]
Engaging	10				X		Modest results for free practicing health professionals
Opinion Leaders	10				X		[…Important in mobilising actors and resources.]
Formally Appointed Internal Implementation Leaders	10				X		[…not the right operational level.]
Champions	10				X		needed for change management
External Change Agents	10				X		[…Initial training in Hamburg for several external change agents
Executing	4			X			More trial and error and co-construction.]
Reflecting & Evaluating	10			X			Not regular and structured enough for the secondary circle of actors (beyond the core group)

CFIR Focus Group

Next Adopter	EUSTRAS France	**Local Good Practice**	**Implement population based integrated care in 3 city quarters of Strasbourg**
Setting	TEAMS meeting	**oGPs that you transfer from**	OptiMedis
Date of the Meeting	16. 06. 2023]	**Location**	Teams meeting
Start time	10:15	**End time**	11:15

Participants			
	Name and surname	*Organization*	*Role*
1	Rémy Banuls.]	[EUSTRAS	Moderator
2	Manfred Zahorka	[OptiMedis)….]	Assistant
3	Corinne Bildstein	[GIP MSS]	[….]

	QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Evidence Strength & Quality				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The international evidence of the intervention was important to convince the initial actors on a conceptual level. However, it was difficult to convince the second level (doctors, health professionals) actors on the practical merits of the approach. Particularly the more public health-oriented population based approach was perceived as not too relevant for ambulatory care as usually doctors care for their own patients and not for populations.	There's a growing awareness in the medical community that we need to focus on prevention, because we're not very good at it. In France, medicine is very curative. Finally, there's also to see that the country right next door can convince the health insurance companies to invest in prevention because it saves them money. And people are less sick, which is quite a valuable thing	The evidence is an entry point for discussing new approaches but concrete entry points for organising change are needed.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Translating international evidence into local practice is challenging. Health professionals are busy working in practical situations, and they are not interested in translating concepts into operations. This has to come from a project team. Once practical solutions to existing problems are discussed, the actual partners become more interested	We don't have the same system in France with several health insurances, they are not independent organisations who could engage in contracts with private companies or others. Our doctors don't have the same infrastructure and staff. The approach needs translation and adaptation to the French system	Although it is obvious that prevention leads to better health, adapting an international best practice to a different context, like the one in France remains difficult. It is finally important to start with very concrete interventions and rebuild the model from there.
3.	If you started again the implementation process, what would you do differently?	The project started with a conceptual approach and tried to develop the concrete activities with its partners. Only later a more restricted team designed concrete actions (preventive care pathways), which became interested to local professionals. In hindsight, that process should have been reversed: to start with concrete actions and to rebuild/adapt the concept based on the concrete action	We could have built the implementation team differently. At the beginning, the GIP MSS team did not know concretely what was expected. Also, the public health approach initially used is usually far away from the working realities of health professionals.	
CONSTRUCT 2: External Policy & Incentives				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	TIGA in the framework of the PIA and "ma santé 2022" which promotes a coordinated and territorial approach. Aspects of population health are part of the national health strategy and is supported by ARS, for example the health professional networks (CPTS) and their health programs	There has been an evolution over time. The state is recognizing the importance of prevention. Today the health minister in France ins the Minister of Health and prevention. [….]	Prevention in health care became more important since around 2015 and has entered regional (regional health plan (PRS) of ARS) and local (local health contract CLS) plan of Strasbourg city. However, prevention is mainly understood as primary prevention, and dealing with

				chronic disease people to prevent disease aggravation (secondary and tertiary prevention) are new concepts
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	Most more integrated structures and the notion of population health are new. Many of the new forms of organising care are still more on paper than implemented in practice. We have initially tried to work with those structures and to jointly develop a population based/public health approach. However, for most actors this was new and not their daily business. After this initial step, we have moved from a more conceptual approach to concrete initiatives (e.g., a preventive care pathway), which created much more interest among the existing actors.	It is not the individuals, who are not interested. We have started with professionals, who's role is not to think in public health/populations terms. When we proposed this approach to health professionals, they said that it is not their task to be responsible for the entire city district but rather for their own patients	There is a gap in the understanding of population health/public health in current structures. Chronic care patients are not part of the current concepts. Case and care management is relatively new and mostly reserved for the most complex patients. The approach finally chosen is to start to introduce innovations to the existing thinking using the classic morbidity profiles and then, in a second step apply the new experience to a broader range of health conditions and make it a new standard.
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	One would have targeted different groups of professionals. Probably directly the multi- professional networks (CPTS). One could also start with a more concrete approach based on the interests of the specific groups of partners and develop the different elements of the concept step by step.	We would probably choose different partners, maybe directly the CPTS	The classis OptiMedis approach would be to create and institution, which owns the approach and then link to existing partners. In the absence of an institution, it is much more important to identify interested partners and start with their needs from the beginning.
CONSTRUCT 3: Knowledge & Beliefs about the Intervention				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Motivation of a few key individuals helped the project to emerge and maintain the implementation target despite the obstacles	There are some people who are very interested in the approach from the start. For example, the CPTS Strasbourg Nord, people from Pulsy. It is important to underline each time that the idea is not about creating new things but rather to align them better and facilitate exchange of information between the actors and also to help them increase their number of clients.	Population based integrated care can be perceived quite differently. For those, who have an idea on public health and a more patient centred approach, the idea is quite obvious, and people are interested on how to put this in place. Others are focussing much more on individual patient care and for them it is more difficult to link to the idea of population health.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The fact that we connect to an existing discussion helps a lot to develop further develop the idea of preventive care pathways. The preventive care pathway is an add on to that discussion. Preventing disease aggravation is a topic for quite many, who participate in this guideline discussion and the idea of a stronger integration of prevention is appealing	The process of a preventive care pathway for diabetes is linked to an existing discussion. People have already met on the topic of diabetes care, so it is not entirely new. We have some people who quite well understand these concepts and they are quite interested	The current intervention on preventive care pathways was the right thing to do at the right time. The preparatory work on data analysis and capturing the size of the problem is much appreciated information
3.	If you started again the implementation process, what would you do differently?	Possibly different choice of partners, and with a dedicated project team. Focus on concrete action, which are in line with partner's needs, with a direct benefit.	Start with a concrete aim and concrete interventions targeting the need of professionals with a "project" team rather than wanting to discuss conceptually with people who have enough other things to do.	One should separate the conceptual thinking from the actual implementation with partners. The OptiMedis approach foresees a local integrator group, which represents the concept and at the same time translates it in concrete action with the local partners- actions, which have an added value. A temporary project team could do the same thing, but would need to integrated sustainability questions from the beginning
CONSTRUCT 4: Reflecting & Evaluating				

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience.	We used evaluation tools to analyse an existing program and added some elements to look at economic impact of preventive care programs together with the CPAM. This was highly innovative, showed that we were capable of showing an impact and we could do this on a larger scale	Using data to analyse procedures and show impact was new. Discussing the data and trying to use them for change projects together with the actors (trainers, health educators) was also new. The collaboration with GIP MSS and the CPAM for matching data of program participants with the general population opened new fields of collaboration and of understanding the impact of prevention.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	There is quite some literature in France, which show the effect of preventive care on health. However, we mobilised local partners to proof with local routine data the impact of local interventions. At the same time this mobilised local actors to collaborate and showed, that it is feasible to show local impact.	The objective of the evaluation was not to provide scientific evidence but to use local routine data to proof effectiveness and show that it is possible with local data. We shared this experience in local and international forums	The small-scale evaluation exercises opened new fields of collaboration. It also underlined the importance of this work and the need to continue with better data.
3.	If you started again the implementation process, what would you do differently?	Within the JADECARE project data access (ARS and CPAM) happened from the start and at the feasibility stage. The idea of matching program data with health insurance data came later. The project has worked on accessing more comprehensive data bases (SNDS) for the last year, with considerable difficulties	GIP MSS should have used a more professional software at an earlier stage. Patient identifiers (no de SECU) should have also been collected more systematically	Data access for proofing project impact but also for generating business information for health professional networks is essential for steering the change process and define areas for investing in new activities. However, data access is complex
CONSTRUCT 5: Champions				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	needed for change management	People who are interested, who believe in the approach, who know how it could work and who are engaged in making it happen are essential. That is why a team is needed, which feels the responsibility, and is dedicated to the task. The team needs to have a clear role description of everyone.	A local champion of the concept, who carries the idea is essential. This local champion allocates the task to the team. It is much more difficult if not impossible to import the idea from outside and use an outside champion.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	During the Jadecare project we have succeeded to increase the number of champions. The interest of the champions will drive the project in the future. However, a dedicated team, who is entirely committed to the approach is still needed to satisfy the interest of the current and future champions and push the process forward.	It was initially difficult to understand the role GIP MSS collaborators should take. Initially, the project coordinator had all that knowledge, but when she left, we did not have her knowledge and did not immediately know how to take over	Championship and conceptual leadership were initially held only by the project coordinator, and it was difficult for others to see their role. Only when engaging in concrete action (preventive care pathways) other champions emerged. To some extent, potential champions existed from the beginning, but they did not fit entirely into the anticipated project setup.
3.	If you started again the implementation process, what would you do differently?	One would probably select a different set of partners where the concept fits better to their thinking. It would also be needed to identify a dedicated project team, which has sufficient time and resources and well-defined roles	One should start from the beginning with people who understand and value the concept with well-defined tasks and roles and the means to execute their task	OptiMedis uses an entrepreneurial approach to implement integrated care. The local team is exactly configured for that task and translates the concept into concrete action with the partners. There is still the task to find the local champions, but the existing team, who's sole purpose is to work on people's health makes this easier. The creation of a local NGO for that would have a similar

				effect. A project team could do that temporarily but would have to include sustainability measures from the start.

8.1.1.9 IDIVAL&SCS

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	10					x	The developed and tested interventions are the result of an internal desire of health care services enhancement. Patient and professional staff satisfaction surveys were carried out with good results.
Evidence Strength & Quality	10					x	After the intervention more patients than planned were evaluated under tele-psychogeriatrics program, more videos and materials than planned for the school of patients were developed. Nevertheless, the tele-rehabilitation program could not be started due to a delay with the informatics tools.
Relative Advantage	10					x	Health care providers and patients liked the pilot implementation. Nevertheless, the experience pointed out a lower number of tele-pyschogeriatrics consultations that could be effectively carried out. Most of the pathologies by themselves required face-to-face treatments. Regarding the rehab training and school of patients, these rates were higher.
Adaptability	10					x	The expectations regarding its implementation are very good, unfortunately, the delay with the informatics tool makes it appear as not easy to implement definitively.
Trialability	10					x	We count on the support of all the health care system in Cantabria. That warranties the possibility to test the intervention on a small scale (maybe bigger scales in the future) within the organization.
Complexity	10					x	The major difficulty for the tele-rehabilitation program is the lack of informatics tool. In the other hand, the tele-psychogeriatrics program was easier to implement than expected. Counting with the help of the health centres which hosts the target patients was quite easy to solve “technological problems” or “rejections” from elderly people. The implementation of the school of patients was also easy to carry out. Previous experiences in this scope favoured its implementation.
Design Quality & Packaging	10			x			Although we think that this aspect is very relevant, we couldn’t tackle correctly some tasks due to the delay on informatics tool. We chose an “n” because even when we consider the presentation of the intervention should has a positive influence in the construct, we just met this goal in some of the tasks.
Cost	10					x	Implementing tele-assistance will be very beneficial in terms of costs.
II. Outer setting							
Patient Needs & Resources	10					x	The most evident case is related with tele-psychogeriatrics program at which the “technological barrier” was successfully resolved involving health providers
Cosmopolitanism	8					x	Networking is always desirable and positive, but in this case is not very relevant as we can implement it by ourselves.
Peer Pressure	5			x			Competitive behaviour could be positive sometimes, but we are developing this program for own enhancement and growing. There is no peer pressure present within this implementation.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
External Policy & Incentives	5			x			We count on total support at regional level (Servicio Cántabro de Salud), but by this moment, we don't intend to transfer this implementation to country level.
III. Inner setting							
Structural Characteristics	10				x		Even when Hospital Marqués de Valdecilla is quite big, the Departments related with the project are very proactive and had not find any trouble for implementation permissions
Networks & Communications	10					x	Our Networks and Communication regarding this project have exhibited a good functioning procedures among the professionals and through the websites related.
Culture	10					x	Nowadays, SCS is working on the enhancement of its communication protocols, on the service provided, on the new technologies involvement. Thus, this project finds a good institutional culture to land.
Implementation Climate	10					x	The perception about the satisfaction of the changes derived from the project, not only by patients, but also by the involved professionals, is good. Nevertheless, we don't have evidence about the reception that could have the program if it is implemented as a general practice for the whole Departments that are participating.
Tension for Change	5			x			Both patients and healthcare professionals are very responsive to new initiatives. In this case, the proposed implementation attends to an enhancement. It is not the result of an intolerable situation that must be tackled.
Compatibility	5			x			The intervention was implemented gradually, in order to fit with the existing workflows and systems.
Relative Priority	5		x				The implementation of this project is not perceived as priority since the involved Departments have been working from long time ago with a more traditional approach and getting good results. This implementation leads into an enhancement. It does not intend to be a solution.
Organizational Incentives & Rewards	10	x					At every enterprise skilled and energetic employees are always appreciated. In this case these characteristics have allowed the involved team to participate in a project such like this, they were allowed to test these GPs at the hospital, and they received some help from the European Projects Management team, but they won't receive individual incentives.
Goals and Feedback	10		x				The goals were clearly communicated and achieved on 3 of the 5 LCF's. Unfortunately, for LFC 1 and 2, the delay on the informatics tool did not make possible to achieve the expected goals even when were clearly stated and communicated. Regarding the received feedback, it was positive in general terms.
Learning Climate	10				x		We consider all these aspects were achieved along the project.
Readiness for Implementation	10	x					It seems to be difficult to implement this GP in a short time because: 1. The tele-rehabilitation program couldn't be tested yet 2. The tele-psychogeriatrics program was successfully tested, but the obtained results pointed out the need of face-to-face consultation for most of the cases due to the suffered illnesses by themselves. It is not due to the implemented technology. 3. Just the school of patients could be implemented in a short period of time
Leadership Engagement	10					x	We consider it was correct. The worst impediment of the project advance was the delay on a subcontracted task. We are working on it, but we don't have a conclusive answer yet.
Available Resources	10		x				In this case, the major problems were related with the tele-psychogeriatrics program because finally we had less professionals involved and more evaluated patients than planned.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Access to Knowledge & Information	10					x	We are satisfied with this aspect. The information flow was correct at every stage.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	10					x	The satisfaction surveys were always positive.
Self-efficacy	10			x			As in every team, some professionals exhibited more self-confidence on their own capabilities to get good results than others. That's why we consider an "n" evaluation for this item.
Individual Stage of Change	8				x		We consider the team's mind is positive towards the proven practices.
Individual Identification with Organization	8				x		We consider the team's mind is positive towards the identification with the organization. As far as possible, the involved researchers received the required support to carry out this project.
Other Personal Attributes	8				x		As in every team, some professionals exhibited different abilities and attributes. In general terms, as a team, it worked correctly.
V. Process							
Planning	10					x	A good planning was carried out. It was also approved within the organization.
Engaging	10				x		The right professionals were detected, involved and engaged. Nevertheless, we could not reach all the professionals that we wanted to. Some of them finally could not participate on this project.
Opinion Leaders	5					x	We consider this aspect ok within our organisation. A respectful and encouraging work environment.
Formally Appointed Internal Implementation Leaders	10					x	IDIVAL has a defined structure which includes not only the health care professionals, but also the project management ones. From the very beginning of this project the leadership of each task was assigned. The obtained results from each one leadership were satisfactory.
Champions	5			x			Not required, nor identified.
External Change Agents	10					x	This project counted on the support of a health local actor (SCS) which allowed and favoured the implementation within the Cantabrian Hospitals.
Executing	10		x				In this case, the fidelity of implementation to planned courses of action, timeliness of task completion, and degree of engagement of key involved individuals were appropriated regarding the internal resources. Our worst difficulty was the external collaborator. Anyway, we recognize the importance of the executing construct.
Reflecting & Evaluating	10					x	The Plan – Do – Check-Act logic of continuous quality improvement was satisfactorily achieved.

CFIR Focus Group

Next Adopter	Instituto de Investigación Marqués de Valdecilla	**Local Good Practice**	[….]
Setting	Regional	**oGPs that you transfer from**	[….]
Date of the Meeting	April 20th, 2023	**Location**	LINUX Room at IDIVAL facilities
Start time	14:00	**End time**	16:00

Participants			
Name and surname		*Organization*	*Role*
1	María Luisa Sámano Celorio	IDIVAL	Moderator
2	Natalia Puente Fernández	IDIVAL	Assistant
3	Paloma González Álvarez	IDIVAL	Participant
4	María Lourdes López de Munain	SCS	Participant
5	Sonia López Medina	SCS	Participant
6	Verónica García Cernuda	SCS	Participant
7	Carlos Fernández Viadero	SCS	Participant

QUESTION		**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: Relative Advantage				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	• Solutions are more advantageous now. • Equity in virtual resources.	• "The advantage drives you to do that GP". • "The virtual question loses a lot of people along the way in the courses".	• Some degree of presence is necessary. It is difficult to do without face-to-face at the first Psychogeriatrics appointment. Also an informant must be established to indicate the patient's situation. • Increased sense of utility of virtual resources.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	• It is an opportunity, a seal of quality. • It is a challenge.	• "It is an addition to daily work" (overloaded professionals)	• At the hospital, there is no awareness on telephone consultation: interruptions occur, there are connection problems, etc.
3.	If you started again the implementation process, what would you do differently?	• I would not have used the Stanford online platform (patient school). • They would like to have better planning and to be involved in the project from the beginning. • There is a need for real improvement of the telemedicine tool.	• "It is very difficult to choose platforms and they cannot be modified. They are not mouldable, nor accessible" • "More time and more teamwork for the initial planning" • "Immediate solutions to those problems"	• Carry out the workshops through ZOOM. • The videos have worked very well, but the team should be more informed of the progress.
CONSTRUCT 2: Peer Pressure				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	• The pressure comes from society and from the hospital. • There is a real need for change • Adaptation to new technologies	• "The hospital establishes that new technologies must be incorporated" • "Four words: real need for change"	• All participants agreed that the need for change is real and that it is increasingly evident under pressure for this change to occur.
2.	Cooperation and communication within the team had a great impact on staying positive about	• A greater positive effect is observed in terms of collaboration, working as a team or having gone further.	• "There were resistances that have been broken" • "Service Motivation"	• Participants identify an increase in positive effects instead of a decrease in negative effects.

	implementation and maintaining the focus on the importance of the construct.			
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	• It has been a stimulus, at first there has been resistance, but then it has been a success (telerehabilitation). • The pressure has been the engine of incorporation into the project, but perhaps it was not his (patient school)	• "The digital skills in Cantabria are much worse than in other territories".	• Being involved from the very beginning in order to achieve better planning and understanding of the project to decide better.
CONSTRUCT 3: Tension for Change				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	• The pandemic has been the trigger for this change. • Incorporation of technology that can "replace" professionals. • The change to incorporate the patient in decision-making.	• "Technology can do certain things that the professional does"	• In general, the participants agree that the pandemic has provided an opportunity for change and opening up to digitization.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	• Change makes you do new things	• "Four words: real need for change" (repetititon. The participants agreed on this statement and was repeated several times throughout the FocusGroup)	• Participants identify an increase in positive effects instead of a decrease in negative effects.
3.	If you started again the implementation process, what would you do differently?	• One motivation is the promotion of self-care. • Patients become part of the change by getting involved in this project.	• "The forecast is that tele-rehabilitation will increase".	• More information to work teams of health professionals and patients in order to achieve a better and greater understanding of the project.
CONSTRUCT 4: Knowledge & Beliefs about the Intervention				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	• The vision of the system must be changed incorporating "tele-concept" as a day-to-day tool.	• "Fear perception from some professionals to be replaced" • "Participating patients became much more involved in their own recovery" • "It is necessary that the passive patient becomes an active patient"	• The implementation of this GP demonstrated how the information and the opportunity to share knowledge and beliefs have been beneficial for the organization. • Increasing demand for telecare is expected
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	• Professionals' belief that they are going to take away their work.	• "Overcoming the resistance of the professionals has been a problem at first". • "This way of work is not an alternative[1], it is a reinforcement". • [1]The word "alternative" must be interpreted in the sense of "substitution"	• A change of mind of some professionals who were not convinced at the beginning regarding the use of new technologies. • After overcoming the initial resistance of professionals who think they can be "replaced", the result has been very positive.
3.	If you started again the implementation process, what would you do differently?	• The first informative sessions need more reinforcement. • Subsequently, tutorials have been included in the platform with great	• Staff involvement is required from the start. • This leads a kind of "seguimiento de la masa"[2] • [2] In Spanish this means more involvement of the people, more tracking, a closer performance	• To improve communication channels to the patients and the professionals to avoid or overcome resistances as soon as possible.

		success. Then, it should have been included at the beginning.		
CONSTRUCT 5: Formally Appointed Internal Implementation Leaders				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	• Definitely, in this GP the success of the implementation has been directly linked to the leaders assigned for its implementation. • Between the 5 selected constructs, this one is the most important. The project goes ahead thanks to the will of the people who lead it.	• "Willfulness", "Commitment" (from the involved professionals, 100% dependent on the assigned human resources) • "Because you believe what you are doing is good, useful. You think it will contribute and it will remain" • (motivation of the leaders)	• The appointed implementation leaders have been correct in so far as they have demonstrated commitment and working capacity. • Designated leaders would be willing to take on new challenges (implementation of other GPs) even though they involve extra work.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	• A lot of loads, an added effort to the daily work.	• "It is a system planning problem". • "The lack of time. It has coincided at a time of greater demand for assistance and fewer professionals".	• Willingness of the professionals. • The stimulus that comes from learning new things.
3.	If you started again the implementation process, what would you do differently?	• Yes, they would get involved again. They would have liked to be there from the beginning. • Some of them feels the project as not own.	• "I believe it was not my project". This phrase must be interpreted in the context that this person was not involved from the very beginning of the project, and she could not select the GP to participate on. Maybe she could be more interested in other initiatives or projects.	• Participants want to make it again, to develop another project being involved from the very beginning and probably selecting better the objectives to tackle.

8.1.1.10 JFDPK

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	7				X		Still working on the primary care-hospital network building in regards to patient management
Evidence Strength & Quality	9					X	The general experiences and the research of the hospital supported the strength of the pieces of evidence
Relative Advantage	5				X		In local conditions, the perception is that an alternative solution can not reach as much success, as our solution
Adaptability	4			X			Still existing system errors are not allowing the full adaptation for the local needs, but negotiations have been placed about the issue
Trialability	6				X		After every steps the hospital workers giving feedbacks about the process
Complexity	9					X	The main difficulty is the centralized hungarian system, because it is not always a favorable environment for local innovative initatives
Design Quality & Packaging	6			X			Because of the complexity of the process, bundling and assembling was an important aspect at the planning times, so it can work well at the implementation time too

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Cost	2			X			Costs of the intervention and the implementation weren't so relevant, and influenced not so much the outcomes, thanks to there were some engaged persons whose time was the main cost. According to our implementation focus, we needed to change the processes, develop new, integrated patient pathways and tried to alter the stakeholders' mindset which is less expensive but - as we experienced -fairly hard.
II. Outer setting							
Patient Needs & Resources	8					X	The clinical problem is significant, with an exceptionally high number of non-traumatic lower limb amputations in Hungary.
Cosmopolitanism	8		X				Because of the complex clinical problem, the collaboration between many co-disciplines is desirable, but the network's capacity (its practical capacity) is lower than expected.
Peer Pressure	3			X			No one else in the hospital's care area is addressing the issue.
External Policy & Incentives	2	X					Can't really see the effort to change this problem.
III. Inner setting							
Structural Characteristics	7		X				Around 400,000 people live in the hospital's catchment area, and many of the patients concerned come from poor social and material conditions
Networks & Communications	7		X				There is room for improvement in terms of staff overwork, financial appreciation and a lack of staff, as effectiveness depends on the work done together
Culture	5			X			The significance is great, but they are not the main cause of a clinical problem, they could be improved
Implementation Climate	8	X					Often good work and successful implementation only comes with increased expectations, not rewards
Tension for Change	10	X					Change would require investment, and this is not supported because it does not pay off in the short term
Compatibility	7				X		We would like to improve the coordination of the patient journey, although the problem is largely decided in the prehospital phase and the lack of a socially supportive environment
Relative Priority	9				X		All of the individuals, from the different units, feel the importance of the problem and the necessity to find a solution
Organizational Incentives & Rewards	5		X				Good performance is often not rewarded well
Goals and Feedback	8		X				Clear definition of objectives and feedback is needed, but this is less than desired
Learning Climate	10	X					All this would be very important and an essential part of long-term planning, but the least tangible part of it is its implementation in everyday life
Readiness for Implementation	8	X					There is no will above the level of everyday participants to implement the necessary changes
Leadership Engagement	8		X				Progress is easier with greater leadership support
Available Resources	10		X				With more training and closer monitoring and facilitation of progress, less energy is wasted. The material distinction between actual and compensatory work is important
Access to Knowledge & Information	6			X			Incorporating knowledge into work processes is important, and this can be improved by bringing together representatives from different areas (more communication), but there were also more significant difficulties

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	6				X		The healthcare workers all know the importance of the intervention. The patient's sensitization is an important point in the process
Self-efficacy	10				X		If we're talking about the project's Hungarian use-case members-
Individual Stage of Change	8				X		
Individual Identification with Organization	5		X				Lot of staff change occurred during the project
Other Personal Attributes	10		X				Capacity and motivation issues arose amongst health care providers
V. Process							
Planning	9				X		N- the pre-planning was carried out by other co-workers who gave the role to others Lot of factors came up during the execution of the project which was not considered at the planning phase
Engaging	2		X				This part of the implementation has not been carried out due to the fact that it is a social problem in the first hand
Opinion Leaders	8					X	The opinion leaders support the intervention, because they understood the importance of the care of diabetes patients
Formally Appointed Internal Implementation Leaders	9				X		Internal implementation leaders are really devoted to the project, although the external support is not the highest
Champions	9					X	This kind of participation of the hospital in the project is dominantly thanks to them.
External Change Agents	8					X	The support of the primary care and general practitioners is crucial to the system change
Executing	10		X				From some aspects, the implementation went in a different way than we planned, but these bottlenecks pointed out the importance of further intervention points, where we can improve the quality of the diabetes care
Reflecting & Evaluating	10					X	Evaluation is a key factor not only in the project but also at the national level, as learning from past mistakes and evaluating what has been working fine.

CFIR Focus Group

Next Adopter	National Directorate General for Hospitals (OKFŐ), Jahn Ferenc South Pest Hospital	**Local Good Practice**	Jahn Ferenc South Pest Hospital
Setting	Local	**oGPs that you transfer from**	Catalan open Innovation Hub
Date of the Meeting	28 April 2023	**Location**	Budapest Csili Művelődési Központ
Start time	13.00	**End time**	15.30.
Participants			

Name and surname		*Organization*	*Role*
1	Gergely Mikesy Dr.	National Directorate General for Hospitals (OKFŐ)	Moderator
2	Éva Kárpáti Gray	National Directorate General for Hospitals (OKFŐ)	Assistant
3	Dóra Tóth	Health Services Management Training Centre (EMK) of SU	Project Manager
4	József Takács Dr.	Jahn Ferenc South Pest Hospital and Clinic (JFDPK)	Head of the Internal Department
5	Annamária Noszek Dr.	Jahn Ferenc South Pest Hospital and Clinic (JFDPK)	Diabetitian
6	Vilmos Keszthelyi	Jahn Ferenc South Pest Hospital and Clinic (JFDPK)	Project Manager (hospital)
7	Anikó Pusztai Dr.	family doctor (Leader of 12th district GP's)	Stakeholder

QUESTION		**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: XX				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	It was important to adapt the LGP based on the national specific needs and to transform it in a way to achieve the potential best way of implementation		One of the crucial point for us to have a good support from the OGP to help us to define the best possible way to transform the good practice to our local needs with the intention to accomplish the best way of implementation as possible.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Regarding the construction of our national health system, the goal was to find the supportive environment for the LGP and communicate it both internally and externally.	"Stakeholder involvement at national level should be further expanded both in clinical and primary care we need to seek for more collaborations to facilitate deliver more targeted, personalized high-quality healthcare to the population"	" I do agree that stakeholder involvement is key and should be encouraged at national level both in clinical and primary care. We should initiate &look for more co-operating partners to enhance delivery of more targeted, personalized high-quality healthcare to our citizens"
3.	If you started again the implementation process, what would you do differently?	During the planning phase of the LGP in the action plan we should have considered timing better (give more time for different tasks especially when the task involved external individuals too)	"We are all aware that certain tasks can be complicated. Not everyone agrees on everything, but a more intelligent outcome-based delivery of personalized care is necessary to meet citizens' needs, with a coordinated approach. This requires organisational changes and the introduction of new forms of care & services"	At the early stage of the project, we should have evaluated the risk factors better, as well as considered the political environment, the bottlenecks which are mainly connected.

8.1.1.11 LOMBARDIA

CFIR Survey

CONSTRUCT	**RELEVANCE**	**INFLUENCE**					**REASONING**
		--	**-**	**n**	**+**	**++**	
I. Characteristics of the intervention							
Intervention Source	N/A						Not applicable to the organizational setting in which the intervention has been implemented.
Evidence Strength & Quality	9				X		The totality of the professionals and almost all the patients who filled-in the satisfaction questionnaires, at the end of the LGP's activities, declared that receiving medical support through telemedicine has been somehow-to-very much helpful in the treatment pathway. In addition, among the feedback collected from the professionals, it emerged that telemedicine:

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							makes the services more accessible to patients (both in terms of "geographical distance" and time), allowing visits to be carried out with greater flexibility. It ensures greater continuity of care. It is useful for the prompt management of patients' crises or in emergency situations.
Relative Advantage	N/A						Not applicable to the organizational setting in which the intervention has been implemented. Indeed, the focus was on investigating the effects of introducing telemedicine practices, regardless of the specific type of solution (e.g., platform vs other digital tools) being tested.
Adaptability	8				X		It is crucial to design interventions that can be refined, adapted, or tailored to the local context, if needed. Looking at the LGP, the above was particularly important because the intervention was implemented in three different ASSTs (Territorial Social and Health Authorities) covering different territories and, for each ASST, two different disciplines (i.e., rehabilitation departments and psychiatry departments). During the implementation phase, some factors emerged which made it necessary to refine the intervention compared to what was initially planned. In this context, the "ability" of the practice to be readjusted and the fact that the focus of the intervention was goal-oriented (without strictly identifying a specific type of digital solution to be used) proved useful for the pilot to meet the local needs of the various departments without negatively influencing the achievement of the objectives. For example, the different ASSTs used different tools to carry out online visits and this has not hindered the implementation. Furthermore, thinking about the specific experience with the LGP, it would be important, when designing the interventions, to make them flexible enough to be adapted to different levels of IT readiness – in terms of both equipment and skills - of the structures implementing them.
Trialability	9					X	In some cases, remote visits were already performed by some of the six ASSTs' Departments involved in the pilot, following the pandemic period, or carried out privately by some of the professionals. Nevertheless, the implementation of the LGP allowed to adopt this practice in a systematic manner and to offer a more structured service to patients (also considering in a formal way some aspects, such as privacy-related issues); in other cases, the intervention represented the first experience with telemedicine within some Departments which, thanks to the LGP, would be able to offer this kind of service to patients. Having tested the practice in the pilot's context also allowed the professionals to assess its feasibility and usefulness. Analysing the satisfaction questionnaires filled in by the professionals at the end of the implementation phase, almost all professionals would wish for further development of telemedicine practices and their application by other professionals. In addition, the fact that the practice was implemented as a mix of both online and in-presence visits, makes it possible to 'reverse course', i.e., to return to a fully in-presence treatment if requested by the patient or if deemed necessary by the professional.
Complexity	8		X				Complexity was investigated first and foremost from a technical point of view. When asked how challenging the training was in terms of time spent to be autonomous in using the platform/app, the majority of professionals (8/10) reported that it was "quite demanding"; when asked if they had to dedicate time to train or support the patients in using the app, half of the respondents answered that they spent "quite a lot" of time on it, whereas the others affirmed to have dedicated little to no time to train the patients. During interviews conducted at the end of the implementation phase, one professional stated that further technical training on how to use the platform/app would have been needed. In addition, the IT equipment and network connection were not always adequate in the majority of the six departments of the ASSTs participating to the pilot. The above increased the complexity related to the intervention but did not significantly hinder its implementation. Concerning other implementation-related aspects, several preliminary meetings were held within the NAWG to discuss and solve any issues encountered by the six departments of the three health hubs (ASSTs) before the start of the implementation phase, e.g., privacy-related issues.
Design Quality & Packaging	3			X			The focus was on providing patients with a structured service that includes telemedicine visits, regardless of the specific tool to be used. Indeed, to achieve the practice's objectives, different tools have been used by different departments of the ASSTs involved in the pilot. Concerning 'quality', the majority of the patients was satisfied with the experience from a technical point of view (e.g., ability to see and hear the professional well through the screen; ease of connecting online; ability to understand the requests given by the professionals). On the other hand, professionals were less satisfied with the above-mentioned aspects, also in relation to the fact that sometimes online interactions do not allow them to fully

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							observe certain traits of the patients' body language. Moreover, professionals often experienced connection problems, lack of adequate IT infrastructure, or difficulties in managing the platform's functionalities.
Cost	0						Not relevant given the organizational setting in which the intervention has been implemented. Indeed, the digital tools used were either already available to the ASSTs or integrated with some additional functionalities.
II. Outer setting							
Patient Needs & Resources	10				X		Overall, patients' needs were already known to the organisation (in most cases, the patients who were proposed to participate in the pilot were already receiving treatments) and were relevant in structuring the practice (the ASSTs compared the needs of each patient with inclusion and exclusion criteria to decide if they were in the position to participate in the LGP). In some cases, preparatory interviews were held with patients to decide their inclusion in or exclusion from the LGP. Even though the patients had different health conditions and needs, a common line was adopted by prioritising the work on specific areas. The implementation of the practice gave the possibility to structure a service that some ASSTs already started offering during the COVID-19 pandemic, while also meeting patients' needs (e.g., in terms of informed consent, devices, rooms, modus operandi, forms and legitimacy)
Cosmopolitanism	3			X			· Some departments of the ASSTs involved in the pilot do not collaborate with other external organisations and have not developed a network focused on the specific topics covered by the pilot. Other departments of the ASSTs involved in the pilot built an extensive network and collaborate with numerous other external structures; however, this was not relevant to the implementation of the LGP. Other departments of the ASSTs involved in the pilot do collaborate with external organizations and projects with similar aims of the LGP implemented
Peer Pressure	0						There is no evidence of similar pilots carried out by other organisations (e.g., by other ASSTs – "Territorial Social and Health Authorities") in the same territory and at the same time span of the JADECARE pilot
External Policy & Incentives	0						These factors were not relevant in the implementation of the LGP
III. Inner setting							
Structural Characteristics	0						Over the last 3-5 years, the ATS ('Agency for Health Protection') Valpadana, which includes the three ASSTs participating in the pilot, has taken part in approximately 4 projects; JADECARE is the first trial in which all the three ASSTs have participated actively in the same way. However, the driving reasons for the ATS and the ASSTs to participate in a pilot are usually mainly related to the topic covered by the project and the motivation of the personnel involved in it; there were no structural characteristics of particular relevance or influence for the implementation of the JADECARE practice.
Networks & Communications	8				X		There are networks and communications between the ATS and the ASSTs as well as within the ASSTs and they are widening and improving also thanks to projects like JADECARE.
Culture	0						In the ASSTs that participated in the pilot, procedures concerning telemedicine, which were developed due to the COVID-19 emergency situation, were already existing and in use; however, to date, these procedures have not been officially formalised at ATS Valpadana ('Agency for Health Protection', which includes the three ASSTs) level.
Implementation Climate	7				X		There were some initial difficulties in engaging the ASSTs, but this was probably due to a high turnover of staff involved/who should have been involved in the project; having overcome this obstacle, stable working groups were established, and the following interactions were positive.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Tension for Change	5				X		Overall, the patients' needs were already known to the professionals and were relevant in the way the practice was structured and implemented. In some cases, implementing the practice was crucial because some patients moved to other cities, while others were unable to leave their houses; for them, without the telemedicine, it would have been necessary to interrupt the treatment pathway. Some professionals stated that they started with telemedicine visits because of an explicit request from some patients.
Compatibility	6			X			During a series of interviews conducted with the various departments of the ASSTs that participated in the pilot, the following evidence emerged: Some professionals stated that they had no previous experience - at department level - of tele-rehabilitation, but that their ASST already had an internal protocol on telemedicine. Moreover, having an information system already in use internally for data collection and visits management was important and fundamental to be able to start the implementation of the practice. Some professionals declared that they were aware of and already followed ministerial guidelines for the implementation of telemedicine as well as guidelines of the Order of Psychologists, and that this was relevant for the implementation of practice. Some professionals explained that the need for telemedicine had already arisen during the COVID-19 pandemic, but that with JADECARE the service has been provided to patients in a more structured way (e.g., with appropriate privacy documents, with the possibility of a shared access to data). In addition, before JADECARE, they received training on a technical tool, as part of an internal initiative, which proved to be relevant also in the context of the JADECARE pilot.
Relative Priority	8				X		The professionals involved in the pilot were asked to share their feedback and perceptions on the practice, through satisfaction questionnaires and interviews. When asked if they would have wished for further development of telemedicine and its application by other professionals, 6 out of 10 respondents “very much agreed” and 3 “fairly agreed”; when asked if they would have been willing to conduct further online telemedicine visits, 7 out of 10 respondents “very much agreed” and 2 “fairly agreed”. Finally, when asked if they thought that providing telemedicine visits was helpful in the patients' care pathway, 6 out of 10 respondents “very much agreed” and 4 “fairly agreed”. In addition, some professionals specified that the implementation of the LGP helped to ensure greater continuity of patients’ care.
Organizational Incentives & Rewards	N/A						Not applicable to the organizational setting in which the intervention has been implemented.
Goals and Feedback	8					X	A series of meetings within NAWG members has been organized before and during the implementation of the LGP. A high degree of participation and involvement in the meetings (including representatives of Lombardy Region, directors, and physicians of the involved ASSTs, and IT technicians) was observed, especially in preparation of the implementation phase. Meetings held prior to the start of the implementation phase were particularly valuable opportunities to share the main aims and goals of the LGP to the various actors involved, get their feedback, address difficulties, if any, and adjust the pilot actions to be as aligned as possible to pilot’s aims and goals.
Learning Climate	5				X		Overall, the professionals collaborated well and were highly involved in the practice. Not all the ASSTs foreseen structured moments of discussions within the professionals, or they did so only at the beginning of the implementation phase. However, there were several ‘informal’ opportunities to exchange views on the activities carried out and on the progress of the practice, both within professionals involved in the pilot and within the NAWG. These concerned both the technical tools to be used as well as the evaluation and usefulness of the practice implemented.
Readiness for Implementation	8				X		· A tangible indicator in this respect has been the presence, in two out of the three ASSTs, of a digital platform already in use and suitable for telemedicine practices, which was integrated with new functionalities for the implementation of the LGP. Another indicator is the fact that the ASSTs have immediately drawn up a protocol to organise the recruitment of patients according to certain objectives as well as inclusion and exclusion criteria.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Leadership Engagement	7				X		Leaders and managers of the ASSTs were highly involved in the implementation of the practice, especially concerning preliminary discussions on data protection issues (with the involvement of Data Protection Officers) as well as on the drafting phase of an internal agreement framing the involvement of the NAWG in the JADECARE's activities.
Available Resources	7			X			· Two out of the three ASSTs that participated in the pilot already had a platform in use internally, which was eventually integrated with additional functionalities for the implementation of the LGP; one of the two platforms was used also by the third ASST which was not equipped with a similar digital tool. Nevertheless, in most of the ASSTs' departments which took part in the pilot the resources, in terms of IT and network infrastructure, were not always sufficient or adequate. The professionals who participated in the pilot received training on the platform to be used and in some cases provided support to patients in dealing with the digital tools: 80% of the professionals who responded to the satisfaction survey reported that the training, in terms of time needed to be autonomous in the use of the tool, was "quite demanding", while the remainder stated that it was "not very demanding"; Considering the support that the professionals provided to the patients in using the digital tool, half of the respondents stated that they spent "quite some time" on this, 4 out of 10 respondents reported that they had to spend "little time" on supporting patients, while for one professional there was no need for patients' support.
Access to Knowledge & Information	8					X	The professionals involved in the implementation had access to the information on the LGP (e.g., through regular NAWG meetings, relevant documents…). They also had both expert knowledge on how to incorporate the intervention into their daily work and technical knowledge, gained also through the technical trainings they attended prior to the start of the trial.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	8				X		In most cases, the professionals involved in the pilot already had experience with telemedicine, due to the COVID-19 pandemic where this was the only way to continue with patients' treatment, while others privately adopted this modality; therefore, overall, both professionals and patients already had some experience with the online visits. However, the implementation of the LGP made it possible to use more systematic tools and to offer a more structured service to patients. One of the ASSTs involved in the pilot had no previous experience as organization with telemedicine in rehabilitation services; nevertheless, this was not an obstacle, but stimulated the ASST and the professionals, who would even like to promote the practice also in different contexts. Overall, the professionals collaborated well and were highly involved in the practice. Training on the methodological practice to be followed, including, for example, differences from the "face-to-face meetings"; how to manage the online interactions with patients; how to conduct the initial meeting with patients; privacy policy; necessary organisational steps to be followed, etc., especially for professionals without previous experience with telemedicine.
Self-efficacy	4			X			Some ASSTs did not feel ready, from an infrastructural point of view, to start with the pilot, e.g., due to the lack of an adequate network infrastructure or IT equipment. On the other hand, most of the professionals felt ready to start implementing the LGP, also because some of them were already carrying out telemedicine visits (e.g., from the COVID-19 pandemic). However, some further training needs emerged, e.g.: Technical training: need for practical training on how to use the technical tools (i.e., the platform) Clinical training: it is important to consider that in the professionals-patients interaction online a new element is introduced, namely the technical tool.
Individual Stage of Change	N/A						Not applicable to the organizational setting in which the intervention has been implemented.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Individual Identification with Organization	0						This construct was neither relevant nor influenced the implementation of the Local Good Practice
Other Personal Attributes	0						No other personal attributes were relevant in the implementation of the Local Good Practice
V. Process							
Planning	6				X		Certainly, the fact that the main features of the intervention, including roles and tasks of the actors involved, were known in advance and planned according to precise and structured schemes, was important for the implementation of the practice. However, it did not have high relevance for the successful implementation of the LGP, as deviations were necessary because of unexpected needs of both NAWG members and patients. These adjustments, even though they were not known in advance and planned according to precise schemes and methods, did not negatively influence the practice and, in some cases, they even helped to improve it.
Engaging	0						Given the organizational setting in which the intervention has been implemented, this construct was neither relevant nor influenced the implementation of the LGP
Opinion Leaders	0						Given the organizational setting in which the intervention has been implemented, this construct was neither relevant nor influenced the implementation of the LGP
Formally Appointed Internal Implementation Leaders	0						Given the organizational setting in which the intervention has been implemented, this construct was neither relevant nor influenced the implementation of the LGP
Champions	0						Given the organizational setting in which the intervention has been implemented, this construct was neither relevant nor influenced the implementation of the LGP
External Change Agents	0						Not applicable to the organizational setting in which the intervention has been implemented.
Executing	6				X		Notwithstanding a pilot implementation plan has been detailed and developed in advance, and the NAWG tried to follow the plan as closely as possible, deviations from the plan were necessary. However, these deviations did not affect negatively the LGP. Indeed, in some cases, interventions to adapt the designed pilot to new needs and unplanned issues that came up within the NAWG were needed; in other cases, deviations occurred because of patients' obligations, and adjustments to the planned intervention allowed them to better their experience within the LGP.
Reflecting & Evaluating	10					X	Satisfaction questionnaires for both patients and professionals, asking for their feedback and opinions on their experience with the LGP, have been collected and proved to be useful means to reflect on the implemented intervention as well as to draw conclusions about best practices and elements to be improved. Moreover, the feedback collected during the regular meetings organized within NAWG members allowed Lombardy Region and the ASSTs to address encountered difficulties or potential issues (thanks to the sharing of experiences among the different professionals) as well as to make the needed adjustments to the intervention so to improve the patients' and professionals' experience and reach the pilot's goals.

CFIR Focus Group

Next Adopter	Lombardy Region	**Local Good Practice**	Lombardy Digital Roadmap Towards an Integrated Health Care Sector
Setting	Regional	**oGPs that you transfer from**	The Danish Digital Roadmap Towards an Integrated Health Care Sector oGP
Date of the Meeting	April 3rd, 2023	**Location**	ASST Cremona "Telepsichiatria"

Start time	10:30	**End time**	11:30
Participants			
Name and surname		*Organization*	*Role*
1	Gianluca Carletti	ARIA/Lombardy Region	Moderator
2	Mara Mondani	Lombardy Region	Assistant
3	Nicolò Bondioli	Lombardy Region	NAWG
4	Salvatore Speciale	ATS Valpadana	Assistant
5	Nicole Genovese	ARIA/Lombardy Region	Assistant
6	Francesco Caruso	ASST Cremona	NAWG - Professional
7	Fabio Stefanoni	ASST Cremona	NAWG - Professional

Date of the Meeting	April 4th, 2023	**Location**	ASST Mantova – "Telepsichiatria"
Start time	09:00	**End time**	10:00
Participants			
Name and surname		*Organization*	*Role*
1	Gianluca Carletti	ARIA/Lombardy Region	Moderator
2	Nicolò Bondioli	Lombardy Region	Assistant
3	Salvatore Speciale	ATS Valpadana	Assistant
4	Elisa Schenone	ARIA/Lombardy Region	NAWG
5	Anna Cranchi	ASST Mantova	NAWG - Professional
6	Monica Coghi	ASST Mantova	NAWG - Professional
7	2 Professionals	ASST Mantova	NAWG - Professionals

Date of the Meeting	April 4th, 2023	**Location**	ASST Mantova – "Telepsichiatria Castiglione delle Stiviere"
Start time	13:00	**End time**	14:00
Participants			
Name and surname		*Organization*	*Role*
1	Gianluca Carletti	ARIA/Lombardy Region	Moderator
2	Nicolò Bondioli	Lombardy Region	Assistant
3	Salvatore Speciale	ATS Valpadana	Assistant
4	Elisa Schenone	ARIA/Lombardy Region	Assistant
5	Nicole Genovese	ARIA/Lombardy Region	NAWG
6	Patrizia Antonella Ruggiu	ASST Mantova	NAWG - Professional

	2 Professionals	ASST Mantova	NAWG - Professionals

Date of the Meeting	April 4th, 2023	**Location**	ASST Mantova – "Teleriabilitazione"
Start time	15:00	**End time**	16:00
Participants			
Name and surname		*Organization*	*Role*
1	Gianluca Carletti	ARIA/Lombardy Region	Moderator
2	Nicolò Bondioli	Lombardy Region	Assistant
3	Salvatore Speciale	ATS Valpadana	Assistant
4	Filippo Scagliarini	ATS Valpadana	NAWG
5	Elisa Schenone	ARIA/Lombardy Region	Assistant
6	Alessia Sempreboni	ASST Mantova	NAWG - Professional
7	Anna Cranchi	ASST Mantova	NAWG - Professional
	3 Professionals		NAWG - Professionals

Date of the Meeting	April 17th, 2023	**Location**	ASST Crema – "Telepsichiatria" and "Teleriabilitazione"
Start time	11:00	**End time**	12:00
Participants			
Name and surname		*Organization*	*Role*
1	Gianluca Carletti	ARIA/Lombardy Region	Moderator
2	Nicolò Bondioli	Lombardy Region	Assistant
3	Salvatore Speciale	ATS Valpadana	Assistant
4	Elisa Schenone	ARIA/Lombardy Region	Assistant
5	Nicole Genovese	ARIA/Lombardy Region	NAWG
6	Cinzia Sacchelli	ASST Crema	NAWG - Professional
7	Diego Maltagliati	ASST Crema	NAWG - Director
	14 Professionals	ASST Crema	NAWG - Professionals

Date of the Meeting	April 17th, 2023	**Location**	ASST Cremona – "Teleriabilitazione"
Start time	15:00	**End time**	16:00
Participants			
Name and surname		*Organization*	*Role*
1	Gianluca Carletti	ARIA/Lombardy Region	Moderator

2	Nicolò Bondioli	Lombardy Region	Assistant
3	Salvatore Speciale	ATS Valpadana	Assistant
4	Nicole Genovese	ARIA/Lombardy Region	Assistant
5	Nadia Poli	ASST Cremona	NAWG - Professional

Date of the Meeting	May 4th, 2023	**Location**	Online
Start time	11:00	**End time**	11:30
Participants			
Name and surname		*Organization*	*Role*
1	Nicole Genovese	ARIA/Lombardy Region	Moderator
2	Elisa Schenone	ARIA/Lombardy Region	Assistant
3	Nicolò Bondioli	Lombardy Region	NAWG
3	Salvatore Speciale	ATS Valpadana	NAWG

QUESTION		**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: Patient Needs & resuurces				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The ASSTs (Territorial Social and Health Authorities) compared the needs of patients with a set of identified inclusion and exclusion criteria and, only if patients' needs and resources matched the inclusion criteria, they were in the position to participate in the LGP. In some cases, preparatory interviews were held with patients to decide their inclusion in or exclusion from the LGP. Thus, for the ASSTs, patients' needs were highly relevant, and were considered when structuring the implementation of the practice. In some cases, the practice was initiated because of explicit requests from patients.	• *"The phase of choosing the patients to be included in the trial is crucial. Preparatory interviews were carried out to decide who was able to participate and who was not, based on strict inclusion and exclusion criteria identified by the ASST".* • *"The needs of the patients were well known to the organization; we enrolled patients who were already being treated at the ASST and who matched the inclusion criteria".*	The ASSTs (Territorial Social and Health Authorities) compared the needs of patients with a set of identified inclusion and exclusion criteria and, only if patients' needs and resources matched the inclusion criteria, they were in the position to participate in the LGP. In some cases, preparatory interviews were held with patients to decide their inclusion in or exclusion from the LGP. Thus, for the ASSTs, patients' needs were highly relevant, and were considered when structuring the implementation of the practice. In some cases, the practice was initiated because of explicit requests from patients.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	One of the ASSTs participating in the practice affirmed that, where patients had different health conditions and needs, in order to exploit the benefits of the practice in the better way possible, professionals decided to adopt "a common line" within patients, prioritising the work on specific common areas. Moreover, JADECARE allowed the participating ASSTs to offer telemedicine services in a more structured way also considering some important aspects for patients (e.g., in	*"This pilot was an opportunity to offer to patients a service that we were already providing following the COVID-19 pandemic period, in a more structured manner in terms of informed consent, devices, rooms, modus operandi, design and legitimacy".*	One of the ASSTs participating in the practice affirmed that, where patients had different health conditions and needs, in order to exploit the benefits of the practice in the better way possible, professionals decided to adopt "a common line" within patients, prioritising the work on specific common areas. Moreover, JADECARE allowed the participating ASSTs to offer telemedicine services in a more structured way also considering some important aspects for patients (e.g., in terms of informed consent, forms, devices, rooms, modus operandi)

		terms of informed consent, forms, devices, rooms, modus operandi)		
3.	If you started again the implementation process, what would you do differently?	A proper preliminary work is essential to transform an informal proposal into a formal and structured offer to patients; this concerns both the use of tools and the organisation and procedures to be followed in the relationship with the patient (e.g., the initial meeting and the steps to follow with the patient, the privacy policy etc.). There are differences between online and face-to-face visits and support, which require different methodological practices that have to be defined and studied beforehand.	*"There was no specific training on how to manage the relationship with the patient online, but it would have been useful; there are differences with face-to-face visits, online I cannot read the body language fully and this poses limitations that could perhaps be managed and resolved thanks to specific knowledge".*	A proper preliminary work is essential to transform an informal proposal into a formal and structured offer to patients; this concerns both the use of tools and the organisation and procedures to be followed in the relationship with the patient (e.g., the initial meeting and the steps to follow with the patient, the privacy policy etc.). There are differences between online and face-to-face visits and support, which require different methodological practices that have to be defined and studied beforehand.
CONSTRUCT 2: Reflecting & Evaluating				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	(1) satisfaction questionnaires for both patients and professionals, asking for their feedback on their experience with the LGP as well as (2) meetings organized within NAWG members were used to reflect on the actions put in place and evaluate the implementation of the practice. These proved to be useful and highly relevant to reflect on the implemented actions - and make adjustments if needed - as well as to draw conclusions about best practices and elements to be improved.	• *"We had internal discussions among professionals, also involving other more sceptical colleagues; we exchanged opinions, we should consider that the practice implies a change in our work habits".* *"We collaborated well, we discussed on the end-of-trial reports and on the satisfaction questionnaires; we also had structured meetings before implementing the practices on the use of the platform".*	No other remarks.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	The regular meetings organized within NAWG members were particularly valuable as the feedback collected and the issues discussed allowed Lombardy Region and the ASSTs to address encountered or potential difficulties, thanks to the sharing of experiences among the different professionals, and to adjust the intervention if needed, so as to improve the pilot.	*"Having regular meetings within the NAWG allowed us to have relevant guidance from Lombardy Region and also to learn from the experience of the other ASST's involved in the pilot".*	No other remarks.
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	Some aspects (e.g., privacy issues) should be considered with more attention prior to implementing the intervention and experts in the relevant fields (e.g., privacy, IT tools) should be involved as early as possible, in order to avoid overload of activities once the implementation starts. Also, it would have been beneficial to conduct in advance a more in-depth analysis of the available resources, e.g., in terms of IT equipment and infrastructure, personnel, rooms inside the ASSTs.	• *"The start of the implementation phase was challenging due to the number of meetings that were needed in order to address different questions at different levels e.g., administrative, technical and clinical issues, which, however, were difficult to understand and overlapped with the other activities".* *"We believe that for a future continuation of the practice it may be useful to build intervention settings within the different departments taking into account the resources objectively available and the therapeutic objectives".*	No other remarks.
CONSTRUCT 3: Evidence Strength & Quality				

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Satisfaction questionnaires were collected from both professionals and patients involved in the pilot to gather evidence. The insights received were valuable and relevant for the practice first and foremost insofar as almost all the patients who filled-in the satisfaction questionnaire declared that receiving clinical support through telemedicine is somehow-to-very much helpful in their treatment pathway; the same was reported by all the professionals providing feedback on the usefulness of the practice for the involved patients. Considering this assumption, it was possible to identify the main strengths of the practice, which will in turn guide the potential implementation and/or replication of the practice beyond the end of the JADECRE Project.	• *"One of the elements we appreciate is the possibility of being able to follow patients who moved for professional or personal reasons, even abroad!"* • *"Telemedicine ensures greater continuity of care and strengthens the therapeutic alliance between the patient and the physician".* • *"One of the positive elements granted by the practice is the ease of access to the service from the patients' point of view".*	To mention a few strengths of the practice, it emerged that the telemedicine: • makes the services more accessible to patients (e.g., in terms of "geographical distance", "time", "more flexibility"). • ensures greater continuity of care. • is useful for the prompt management of patients' crises or in emergency situations.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The feedback collected through the satisfaction questionnaires was then further discussed both internally by the ASSTs and within the NAWG and made it possible to identify the strengths of the practice, the areas for improvement, and some "pillars" on which to build, for the ASSTs' departments concerned, the potential continuation and/or replication of the practice beyond the end of the JADEARE Project.	*"It might be useful to add another level of feedback collection, e.g., to try to have, alongside the physician's objective assessment of the improvement (or non-improvement) of the patient's health condition, also a subjective assessment of the patients themselves as to whether their condition has improved".*	No other remarks.
3.	If you started again the implementation process, what would you do differently?	Some of the professionals stated that it would have been beneficial to start the intervention with a more solid base from both a technical and training point of view; on this latter point, it would have been useful to have specific methodological training targeted on the practice to be implemented. Indeed, it is important to consider that in the online professionals-patients interaction a new element is introduced, namely the technical tool. Thus, it would have been important to do further preliminary research on previous studies in this regard, or to know whether others are already investigating this type of interaction between the professionals and the patients and to have further relevant material as a reference.	*"It is necessary to do further research and receive training, for example, on psychotherapy visits done online: which are the advantages and the disadvantages, if there are any specific indications, which are the areas of intervention, how to build the settings…"*	No other remarks.
CONSTRUCT 4: Trialability				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The trialability of the intervention has been highly relevant insofar as allowed to test the practice in a specific and well-defined context and assess its feasibility and usefulness prior to a potential implementation on a larger scale, thus understanding strengths, needs, and areas to be improved. Moreover, having implemented the intervention as a mix	• *"In general, the practice works and has the same therapeutic value for the patient, but it should be considered that not all patients can take part in it, for example, for their clinical conditions, and that the online visits complement in-presence visits and do not replace them; these are still different things".*	This construct has been further investigated also considering the satisfaction questionnaires filled in by the professionals involved in the pilot and it emerged that, after the JADECARE experience, almost all of them would wish for further development of telemedicine practices and their application by other professionals.

		of both online and in-presence visits, makes it possible to 'reverse course' at any time, i.e., to return to a fully in-presence treatment if requested by the patient or if deemed necessary by the professional.	*"We believe that, if appropriately valorised and methodologically supported, this practice can be a winning modality even in the initial therapeutic phases, as well as a valid support for chronic patients and their families".*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	In some cases, televisits were already performed by some of the professionals involved in the pilot, carried out privately or following the COVID-19 pandemic period. Nevertheless, testing the intervention in the context of JADECARE allowed them (and the departments of the ASSTs they belong to) to adopt this practice in a systematic manner and to offer a more structured service to patients. In other cases, testing the intervention in the context of JADECARE allowed the professionals (and the departments of the ASSTs they belong to) with no previous experience to be able offer this kind of service to patients.	• *"Online visits were already performed following the COVID-19 pandemic, but the pilot allowed us to offer to patients a more structured service, complemented with the provision of general online support when needed".* • *"As ASST, we had no previous experience with telerehabilitation. However, this was not an obstacle, and JADECARE represented a stimulus for the organization and the professionals, even though they had not participated in this kind of interventions before".*	No other remarks.
3.	If you started again the implementation process, what would you do differently?	There is the need for a more practical training on how to use the technical tools (i.e., the platform) and further work on the technological aspects is also needed, a proper IT equipment must be in place. Indeed, the IT tools and software used were not always adequate to the service the ASSTs planned to offer. The IT platform used for the practice should be improved, e.g., by making it more user friendly or by integrating it with tools for managing both clinical records and reports as well as televisits. Further methodological and clinical training for professionals is also needed, especially for those without previous experience with telemedicine.	• *"Due to the lack of sufficient IT equipment and of user-friendly software, some professionals had to use their own personal tools (e.g., private mobile phones) or simplified platforms (e.g., WhatsApp)".* • *"It is necessary to provide professionals with practical courses on how to use the platform and to streamline the procedure, making the tools and platforms simpler and more intuitive".*	No other remarks.
CONSTRUCT 5: Adaptability				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Planning an "adaptable" intervention, i.e., piloting activities that can be adjusted and tailored to the local environment and background, was particularly important for the LGP as it was implemented in three different ASSTs covering different territories and, for each ASST, two different disciplines (i.e., rehabilitation departments and psychiatry departments).	N/A	No other remarks.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	One of the three ASSTs participating to the pilot was not equipped with a digital tool suitable for the implementation of the practice; nevertheless, the ASST adopted the platform which was used by one of the other two ASST's for carrying out the pilot's activities.	*"Different digital tools were used in combination to implement the practice: a platform for tracking patients' progresses, Microsoft Teams for video calls, and an additional programme was used for storing the data of chronic patients".*	As an example, the different ASSTs used different digital tools to carry out online visits and this did not negatively influence the implementation.

		During the implementation phase, there was the need to readjust the intervention compared to what originally planned; its adaptability, combined with a goal-oriented approach (e.g., focusing on the results regardless of the specific type of digital solution to be used) allowed the NAWG to meet the local needs of the various ASSTs' departments without negatively influencing the achievement of the objectives.		
3.	If you started again the implementation process, what would you do differently?	Considering the technical aspects, when designing an intervention, it is of the outmost importance to make it flexible enough to be adapted to different levels of IT readiness of the implementing organization – both in terms of equipment and skills. In this sense, it would have been better to carefully analyse the actual availability of IT infrastructure within the ASSTs, to choose simpler and more user-friendly digital tools as well as platforms that could be integrated with other digital tools for managing data from both clinical records and reports as well as televisits.	• *"The potential difficulties with the devices should be considered in advance"*. *"The platform that we used was a very interesting digital tool to collect and visualize patients' data in the context of the pilot, but not suitable for integrating other data, e.g., by transcribing the patients' paper clinical records".*	No other remarks.

8.1.1.12 MARCHE

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	8				X		The external source of the tool implemented (the Catalan Adjusted Morbidity Group -AMG tool for population-based health risk assessment) may have been problematic because not context-specific. However, the great tool's adaptability and the valuable support provided by the oGP had a positive influence on the implementation. Indeed, the intervention followed the Catalan methodology/tools, adapted to the regional context.
Evidence Strength & Quality	8					X	The strong scientific evidence of the population-based health risk assessment tools and the AMG algorithm were relevant and positively influenced the implementation process. Moreover, the presence of population-based health risk assessment in national guidelines and laws (e.g. National Plan of Chronicity) enhanced the interest of the ARS Marche's top management.
Relative Advantage	9					X	Scientific evidence demonstrated the good performance, great adaptability and transferability of the AMG tool, compared to other population classification tools. These features and the fact that the tool is publicly-owned were very relevant and had a strong positive influence on our selection and implementation process.
Adaptability	10					X	The adaptability of the AMG tool to regional characteristics (e.g. its ability to work with our health data) was one of the most relevant and most influential factors for an effective and sustainable implementation.
Trialability	9					X	The possibility of preliminarily testing the algorithm in a sample of regional data was a very important step to assess its local applicability and favoured the interest of ARS Marche's management.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Complexity	7		X				The activities' complexity was perceived different based on the perspectives and roles of the professionals involved and the specific phases of the activity (data management/quality analysis, review/research for the construction of indicators, organization of meetings with experts/top positions in the ARS Marche). The great complexity of data analysis did not hinder implementation process, thanks to the good quality of regional health data, the presence of an expert statistician in our NAWG, and the valuable support provided by the oGP.
Design Quality & Packaging	7				X		The implementation was guided by the careful and clear design of the intervention (through reference documents such as templates, deliverables, etc...) and the availability of the oGP to answer to any question. In addition, ARS Marche effectively managed the various project's phases, to make the results of the stratification algorithm relevant and influential for healthcare programming, involving staff from various levels of the organization.
Cost	8		X				The publicly-owned character of the AMG tool was a criterion for choosing the algorithm, as opposed to other economically expensive population classification tools.
II. Outer setting							
Patient Needs & Resources	7			X			Patients' centrality was not immediately tangible in the implementation activity, but rather from a health planning perspective, in the medium-long term. For this reason, it didn't influence the implementation process.
Cosmopolitanism	7				X		ARS Marche's liaisons with other regional, national (e.g. ProMIS, Agenas, Ministry of Health), and European organizations allowed comparisons, feedback's reception and support.
Peer Pressure	6				X		The adoption by other Italian regions of population classification tools was a key element in the selection phase but not in the implementation process. Comparison with other regions was not perceived as competitive, but oriented to continuous improvement of service quality, strengthening interest and motivation of ARS Marche's top positions.
External Policy & Incentives	9				X		The implementation process (e.g. sensitivity and motivation toward the intervention) was fostered by the inclusion of the population-based health risk assessment in national initiatives and regulations (i.e. the National Chronicity Plan, the National Recovery and Resilience Plan-PNRR, and the Ministerial Decree N. 77/22 about new standards of community health and social care services), and the related regional fulfillments, as a goal to be achieved in the short-medium term.
III. Inner setting							
Structural Characteristics	7			X			ARS Marche's structural characteristics were relevant on effective implementation, and their influence were both positive and negative. On the one hand, this was positive thanks to its resources (expertise on health data and epidemiology IT system) and role (operative arm of the Health Department of the Region). On the other hand, the various organizational changes occurred during the JA hindered its full contribution in implementation; continuous discussion with top management was difficult due to these complex dynamics.
Networks & Communications	8				X		The good level of communication in the organization allowed discussion and sharing among the different components of ARS Marche, enabled the collection of information and consideration of different perspectives of the professionals involved (statisticians, clinicians, managers and political members), and contributed to an effective teamwork. In addition, the dissemination and awareness-raising activities towards project's results enhanced interest of different organizational levels of ARS Marche.
Culture	7				X		Organizational culture was relevant and positively influential in the effective implementation, in terms of managing roles and responsibilities within the organization, according to decentralization and flexibility. In addition, the cultural orientation toward innovation, change and human resource development was crucial.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Implementation Climate	8					X	The successful implementation in ARS Marche was facilitated by the NAWG's receptivity to innovation and its readiness to change, as well as the support (material and moral) received by ARS management, especially from the perspective of sustainability.
Tension for Change	5		X				The desire and orientation to change were relevant in the intervention design phase. As the project progressed, significant organizational changes occurred in ARS Marche and are still ongoing. Because of this, what was initially reputed as a priority, changed its connotation over time. Therefore, the relevance and influence related to this item is neutral. In any case, interest in the activity of population classification for health planning purposes, in response to national and regional mandates, has always been alive.
Compatibility	9					X	The degree of affinity between the intervention's characteristics and the NAWG's activities was crucial for the implementation process. In particular, the use of a step-by-step approach in achieving objectives and related actions (according to adequate timeframes and guided by the reference documents produced by oGP), allowed a gradual integration of the project activities into the NAWG's activity plans.
Relative Priority	6				X		Although the NAWG was composed by professionals with different profiles (statisticians, clinicians, and experts on organization/political dimensions), there was a common understanding about the relevance of the intervention and members' activities were well oriented towards the final goals.
Organizational Incentives & Rewards	5			X			Tangible incentives were very limited in ARS Marche; the not tangible ones (such as appreciation, and high involvement in challenging and professionally rewarding activities) were not perceived as relevant.
Goals and Feedback	8				X		Constant discussion and feedback among NAWG's members and between the latter and the various stakeholders, enabled alignment between regional priorities/strategies and the intervention, with positive consequences in the involvement and motivation of NAWG's members.
Learning Climate	7				X		The implementation process was supported by a good learning climate, in which the contributions of NAWG's members are endorsed and emphasized by the Project Manager, who valued and integrated the different competencies, thus allowing NAWG's professional growth. ARS Marche is aware that a co-creation environment is important for making organizational changes.
Readiness for Implementation	9					X	The organizational commitment to the matter (goal setting, development of innovative processes and strategies), and the organizational support to the practice (creation of a favourable climate, access to ad hoc resources) was crucial for the realization of the intervention.
Leadership Engagement	8				X		The direct involvement of managers/leaders in implementation enabled results' achievement. In details, the project manager leaded the NAWG toward the common goal (acting as a leader), made the necessary resources available and activated to solve any matters.
Available Resources	10					X	Implementation's success was strongly supported by the resources available. Financial resources made it possible to hire statistical and clinical staff dedicated to the project. Moreover availability of data and support provided by internal staff were also crucial.
Access to Knowledge & Information	9					X	The accessibility of information and knowledge necessary for the implementation influenced the project's feasibility, especially with regard to data management. In fact, willingness, interest, and concrete activation of managers and technicians to allow access to the data were crucial to results' achievement.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	9					X	The adoption of a proactive attitude by the NAWG, aimed at developing, improving and integrating knowledge and skills regarding the intervention, fostered implementation, influencing members' own motivation and abilities.
Self-efficacy	8					X	The degree of confidence that each NAWG member holds in his/ her own abilities, concurred in results' achievement. Even if self-efficacy depends on innate characteristics (i.e., individual predisposition and abilities), training courses and learning opportunities made available by ARS Marche, formally and informally were highly relevant and influential.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Individual Stage of Change	7				X		The involvement of young, enthusiastic, and willing-to-learn individuals in the NAWG positively influenced the implementation process, making NAWG motivated, cohesive, and determined to achieve the goals, even in difficult moments. In addition, the heterogeneous composition of the NAWG was functional not only in goal's pursuit, but also in the development of skills, strengthening members' involvement in the implementation.
Individual Identification with Organization	7				X		The sharing of strategies and values among the NAWG's members and the organization positively influenced the implementation process: in fact, a good level of internal consistency is a prerequisite for greater service orientation, commitment and, consequently, effective implementation.
Other Personal Attributes	8				X		Minor characteristics, such as the ability to adapt to complex situations, motivation to act, and individual predisposition for learning were relevant to effective implementation.
V. Process							
Planning	9					X	We consider the methodology as being a point of strength of JADECARE. The intervention's step-by-step approach, based on an optimal planning (definition of timelines-indicators-actors involved in the templates; level of detail and clarity of documents such as deliverables) guided the NAWG's members toward the results, allowing the definition and division of roles/responsibilities, optimal time management and monitoring, over time, of the different phases. In addition, activities such as reflection on key elements of the project (by means of reference documents) allowed the NAWG to identify potential gaps and additional actions needed to support the intervention.
Engaging	8				X		The involvement of the different stakeholders (e.g. top positions of ARS Marche; health data experts) in the project, at the most appropriate times and coherently with their respective interests/roles was fundamental to achieve results potentially useful in a regional programmatic/political sense.
Opinion Leaders	5			X			In the implementation process pursued by ARS Marche, opinion leaders were not considered relevant, as the process involved a small number of professionals, embedded in the organization, and already motivated to the implementation.
Formally Appointed Internal Implementation Leaders	10					X	The internal formal leader (project manager) of JADECARE as guide and effective contributor in the practice, enhanced the internal cohesion of the NAWG, boosting the NAWG members' motivation and interest, supporting them at tangible and informal levels (through involvement, recognition and gratification).
Champions	10					X	The implementation process faced some bureaucratic (staff recruitment, health data access), cultural (resistance to change), and political issues (turnover of top positions) and sometimes resistance (also due to workload). The presence, in the NAWG, of goal-oriented components (who took an ongoing interest in the progress of the work, through contacts with various components of ARS Marche) that early identified and alleviated the impact of hindering factors, was fundamental for the implementation process.
External Change Agents	7			X			The support provided to ARS Marche by nationally relevant institutions (such as Agenas, Ministry of Health) would allow greater visibility and political impact relevant for sustainability, and would provide tangible support during implementation.
Executing	9					X	Execution phase in ARS Marche has been conducted in line with what planned, even if some delays occurred due to the complexity of activities (data management). Execution phase is linked to the effectiveness of the implementation, and its quality was closely dependent on the quality of planning.
Reflecting & Evaluating	9					X	Continuous monitoring, discussion and feedback among the NAWG members were very relevant to results' achievement. Indeed, they allowed to reflect on the results achieved, address critical issues through a multiprofessional contribution, make appropriate changes and also leave space to the emotional component of individuals, finding in each other empathy, understanding, sharing, support and motivation.

CFIR Focus Group

Next Adopter	Regional Health Agency, Marche Region (Italy)	Local Good Practice	A stratification tool (Adjusted Morbidity Group-AMG) for the effective management of chronic diseases in the Marche region
Setting	Marche Region	oGPs that you transfer from	Catalan open innovation hub on ICT-supported integrated care services for chronic patients
Date of the Meeting	04/04/2023	**Location**	Regional Health Agency (ARS) Marche
Start time	09.30	**End time**	11.00

Participants			
	Name and surname	*Organization*	*Role*
1	Roberta Papa	ARS Marche	Moderator
2	Giulia Franceschini	ARS Marche	Assistant
3	Marco De Marco	ARS Marche	Head of Health Technology Assessment and Biomedical Technologies Unit
4	Francesco Balducci	ARS Marche	IT Expert/Statistician
5	Laura Romoli	ARS Marche	Administrative employee

	QUESTION	**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: Adaptability				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The tool's adaptability to the regional healthcare data allowed to: 1) effectively deal with the complexity of the project, that, thanks to its adaptability, was not perceived as an obstacle for the implementation; 2) conduct the pilot study in a timely manner. The adaptability is also a result of NAWG's work/commitment, which conducted data adaptation operations, to fit the algorithm's requirements.	"Without this [the adaptability], there would be no continuum [from the piloting to the implementation]." "The fact that in one week we were able to organise the preliminary test, with immediate feedback, certainly made things easier." "Adaptability can also be seen as necessity, because we still had to go through a process of adapting our data to fit into the form allowed by this box."	Despite the recognized adaptability of the tool, the complexity of data management was acknowledged and highlighted by all NAWG members.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Each member of the NAWG played a specific role to enhance the adaptability during the implementation process, such as through: 1) an in-depth preliminary study of the original good practice (oGP), local context and data structure; 2) the completion of the administrative procedures ensuring project operation and personnel recruitment; 3) the operational procedures to fit regional data into the algorithm's requirements, despite inconsistencies/missing data.	"It is just part of the work I have done, i.e. to implement this procedure to make the algorithm adoptable.... and make it adaptable over time, so not just once." "And what did the rest of the group do? It made it possible for this person [the data analyst] to be here and to be integrated into the context". "The study of systems, the study of data, certainly was an important initial part of then facilitating the inclusion and integration of this good practice within our context."	Adaptability not only as a tool characteristic, but as a "challenging-to-build" requisite for results' achievement.

3.	If you started again the implementation process, what would you do differently?	Implementing the process again, once the pandemic is over (and the reorganisation of the healthcare system completed), it would be easier to: 1) involve and raise the interest of the stakeholders (more interactions/collaborations would be possible); 2) speed up the personnel recruitment and, consequently, have additional time to perform the activities.	"Certainly, starting over, now that the pandemic situation is over, we will certainly find a much easier framework and, not so much a willingness to collaborate, but a lightness of mind and a different ability to face problems." "I would not change anything…except the fact that [in some moments] I found myself doing the work very quickly, perhaps faster than I would have been "comfortable with". That's it, but it's part of the game." "…I would like to build up, constitute the working group better and have the opportunity to involve more people who more or less directly or indirectly can benefit from this project."	Regarding data management, the most complex part of the project, covid-19 seems to have had no impact.
CONSTRUCT 2: Readiness for implementation				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	The readiness of the organization for implementation was crucial. In fact, the support/commitment of Marche Region, as well as the pressure on health data during the Covid-19 pandemic, enhanced the implementation process, for example through providing timely access to health data.	"That is, this project happened in the right place, at the right time and therefore it was implemented and supported". "I have seen this readiness which was actually not only useful but even essential for being within the deadlines and setting up such a complex project."	The Covid-19 pandemic seems to have fostered the use of health data for research, innovation, policy-making and regulatory activities (secondary use of health data).
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	Each NAWG member committed his/herself to the project, thus boosting the capacity of the organization to implement the project. The following strategies have proven to be successful: 1) fostering the political commitment in the project; 2) disseminating the results to top managers; 3) promoting awareness of the tool within the organization, sustaining activities to achieve the objectives.	"[…presenting/disseminating the project at different levels of the organisation has been useful] To arouse that interest, which is fundamental and without which the activity would be an end in itself." "An activity that ends up arousing interest and giving a purpose to what one does was important."[.....] "and also giving it a frame."	It is perceived that Marche selected the Catalan oGP thinking to the possibility of its use in the long term.
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	The involvement of more stakeholders and professionals, limited due to the Covid-19 pandemic, the overburdened personnel and the regional reorganization, would have been fruitful.	"Our group has been very small compared to other implementations, partly because of the nature of our process, and partly because we have not been able to effectively, …. due to the reorganization and the changes that have taken place, …to effectively trigger [the implementation process] a little bit more, as well as the interest from other professionals."	The NAGW perceived that most of the desired changes are linked to the impact of Covid-19 pandemic and ARS reorganization.
CONSTRUCT 3: Available resources				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The availability of financial, human, and technical resources has been vital for carrying out the project. Professionals (mainly) dedicated to the project, guided by a Leader, allowed to follow the different phases of the project in a timely manner; physical shared	"Available, economic resources that translated into human resources were crucial."	

		spaces, IT tools (on-line meetings, shared remote folders of project documentation) and official JADECARE documentation, allowed an optimal management of the work. The oGP's availability in following ARS Marche step-by-step, was also a relevant resource.	"Having the availability of people and means to manage all these aspects is fundamental, because otherwise everyone is taken up with 1000 other things and in the end, if it is not considered a priority, this goes to the bottom of the ladder. So "I don't have time", "I can't"[...]" "The fact that we set up this remote access to data or that we were very agile remotely, with calls, etc. This for me was an available, important resource, even more during the pandemic, but it was also a way of organizing work efficiently, quickly, which was an asset."	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We used efficiently the available resources by integrating the NAWG with professionals with a perfect mix of skills and competencies.	"And it is difficult now, today and even two years ago, to identify others [professionals] who could have carried out these activities with the same competence, attention, time, dedication and interest." "Bringing together the different skills and focusing them on the project areas was important."	The current intervention on preventive care pathways was the right thing to do at the right time. The preparatory work on data analysis and capturing the size of the problem is much appreciated information
3.	If you started again the implementation process, what would you do differently?	Investment in IT tools, such as a high-performance PC, would have facilitated data management.	"In the end, we made it without any problem. But if I really have to say something, if there had been a dedicated, high-performance computer, it would certainly have been convenient not only for me, then maybe also for those who were there."	The availability of a performant PC occurred at the end of the project only
CONSTRUCT 4: Formally Appointed Internal Implementation Leaders				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Formally Appointed Internal Implementation Leaders acted as guides toward the results. They assigned activities/tasks to NAWG's members and transmitted knowledge to them; moreover, they have been a point of reference in technical and organizational difficulties, thanks to their managerial and operational role.	"We were a heterogeneous group…the first thing, i.e. trying to make the most of the skills we all had and make them result-oriented…..This is what I feel it has been done in the group, to bring out the best and instil it towards the common goal." "If there is someone who brings you back on the right path, allows you to do things, to get to the goal, one goes nowhere, i.e., it always ends up on the list of 1000 things to do according to the various priorities everyone has." "[The role of the project manager] was very important…. because in such a complex project, I would not have been able to do my part, if I had had to follow so many other parts that we split up."	All participants described these figures through very positive terms and recognised the importance of the role.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The in-depth study of the oGP prior to the start of the project made the leader highly trained and ready for the role. This allowed the leader also to easily take/maintain control of the activities; stimulate the NAWG's members to work together, integrating their different competencies, motivating and empowering them. These aspects allowed every NAWG's member to perform their own activities and, at the same time, to learn and transmit knowledge to the others.	"But my effort was both to hold the threads of all the activities to be done, on the one hand integrating them into our daily work, and on the other hand trying to divide up the roles, but then really trying to create this integration and the transfer of skills and knowledge of each one to the others, so that they could both enrich themselves and grow the whole organisation."	

			"I knew that where we couldn't manage, there she was, who still managed to hold the reins of the situation, and that was important."	
3.	If you started again the implementation process, what would you do differently?	As highlighted before, the recruitment of dedicated professionals at the beginning of the project would have facilitated the work.	"If we had had the dedicated people earlier, of course everything would have been easier."	Participants acknowledged that the delay in recruiting dedicated figures was due to the difficulties related to the pandemic and internal organisational changes at ARS.
CONSTRUCT 5: Planning				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	A detailed plan of timings, roles and activities was necessary to achieve the results effectively and efficiently and to manage the technical and organizational complexity of the project. Tools such as guides and templates to be filled in the different phases of the project were somewhat demanding but necessary to objectively analyse the work done.	"So in such a complex project, … if you are well organised, you work better. It [planning] is really necessary." "It[methodology and tools] allowed us to assess well all the various stages of the process and gather a whole series of information that we might not have been able to see on our own, because sometimes you are immersed in your daily work […] you don't have the lucidity to say, ok now I'm going to stop, I'm going to look at where I've got to, what I have to do to get to the next step."	Planning construct summarizes what has emerged so far (as it related to adaptability, resource management, the role of leaders, and led to readiness for implementation)
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Optimal overall project planning was accompanied by good local planning, led by the project' leaders and oriented to meet the project deadlines, making changes when necessary. Moreover, the NAWG was proactive and ready to adapt the planning with the changes occurred during the project.	"And above all, realigning the plan each time on the basis of the various issues that occurred."	
3.	If you started again the implementation process, what would you do differently?	The Dashboard's elaboration should have been started earlier, because of its complexity.	"Behind the word 'dashboard' there can be a graph or something very complex, so in my opinion it requires some kind of new planning in itself…"	In the original plan, the dashboard should have been developed from existing tools already available at regional level. This was not possible due to internal and pandemic-related organisational difficulties, which redistributed priorities within the organisation.

8.1.1.13 RND

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	8					X	JadeCare has been very positive as an externally developed intervention. The reason is that the idea seemed exciting and new in a field where development is often difficult. In this way, intervention acted as a "battering ram" to get started
Evidence Strength & Quality	5		X				OGPs has been great examples, but there is little valid evidence from research etc., used to implement the project in the Region of North Denmark. However, the dialogue with the hospital's health professionals shows that they see great strength and quality in the solutions from Optimedis and Kronikgune.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Relative Advantage	1			X			OGPs has been good examples, but there are many other examples worldwide. Whether that "Risk stratification of group" is more effective than "AI at individual level" is unclear in our context. There is no evidence or comparative analysis from research, patients, etc., which solution that it is the most optimal model to choose for us.
Adaptability	6				X		It is very difficult to implement an entire system from one health system into another health system. This was initially a big challenge. But Mix'n'match method combined with a flexible approach has made it possible to adapt and implement sub-elements in the JadeCare project.
Trialability	9					X	JadeCare and the developed dashboard in RND have initially been a pilot project in Steno with a focus on later expansion to the rest of the health areas in the North Jutland region. Once the methods were known, it was the task of the innovation unit "Ideklinikken" to spread the solution to areas other than diabetes. This has resulted in a very flexible approach, where you can easily and quickly make adaptations and modifications in the pilot without having to involve the entire organization. (Fail fast and cheap)
Complexity	4		X				JadeCare and the European health areas are very complicated areas with different objectives, organizational forms, financing model, IT system and target groups. This is very difficult to learn from each other, but the focus on sub-areas (Data, Patient empowerment, etc.) has made it possible to learn from each other and then implement the models in a local setting.
Design Quality & Packaging	7				X		Intervention has been well designed and packaged. There have been ongoing adaptations and method development where necessary (in particular the development of "Mix'n'match" in the initial phases)
Cost	1			X			Costs have not been important for Steno and RND, as we have already been 100% financed by tax funds or funds from the Novo Nordisk Foundation.
II. Outer setting							
Patient Needs & Resources	5		x				Patient needs have not been very visible in the project, as the focus has primarily been on data and IT systems. But in the long term, data should be the basis for Region Nordjylland to be able to meet patient needs to an even greater extent.
Cosmopolitanism	7		x				The external focus has been important for the intervention in Region North Jutland. Risk stratification of patients etc. has to be carried out with many data sources. RND need data provided from partners. (Socio-economic data, salary, employment, marital status, etc.). Therefore, external networks are important. However, the Danish health clusters are a newer model which is being implemented, so participants had to be involved to a greater extent on an ad hoc basis. In order to adapt the model, there has been adhoc dialogue with: The Department for International Cooperation, The department for BI and analysis, "The Idea Clinic", The Department for Quality and the Working Environment (RND), Danish Center for Health Research, Telecare Nord, Department of Intersectoral Health, "The health profile", The practice unit (GPs), Psychiatry, Aalborg University, Institute for Public Health, Institute for Medicine and Health Technology, Center for general medicine, Aalborg municipality, and Frederikshavn Municipality.
Peer Pressure	3			X			There has been no Peer Pressure in the intervention. Instead, there has been a common and positive understanding and interest in collaboration with our external partners.
External Policy & Incentives	4				x		There are many national and regional strategies for data and digitization that have a natural connection with the JadeCare intervention. However, many of strategies have been at a strategic and visionary level and have not had much focus on project on an operational level.
III. Inner setting							
Structural Characteristics	3				x		In the North Jutland region, Intervention and JadeCare have been anchored in two project organizations (Steno and Ideklinikken). This has been beneficial in relation to the project management, but has, conversely, entailed a risk of getting too far away from the operating level.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Networks & Communications	2			x			There have been working groups of between 5-25 participants, so there has not been much need for communication tools.
Culture	9			x			Although the initial focus was on data and structures, in the long term it became more and more about culture. How do we shift focus: From individual patients TO population overview From daily management TO Data-driven organization From treatment TO prevention etc. Experience shows that developing and operating a data environment is only a small part. In the long term, the big task is to create a change in the culture of health professionals.
Implementation Climate	6	x					The climate for implementation during JadeCare was far from optimal. Although the healthcare staff were initially interested, the focus disappeared in connection with Covid19 and then long waiting times due to loss of capacity due to Covid19.
Tension for Change	5				x		The increasing number of diabetics and other chronic diseases gives a feeling of need for new thinking in the area.
Compatibility	2				x		Not much focus. RND is prepared to continuously incorporate new and incremental solutions.
Relative Priority	5				x		The project has had a high priority in the organization with dedicated resources and the participation of top management.
Organizational Incentives & Rewards	1			x			Such a reward system does not exist to a very high degree in the Danish healthcare system, so this focus has not been discussed.
Goals and Feedback	2			x			Not an important focus area for us.
Learning Climate	5				x		The organization has generally seen a very good working environment with room for new ideas and solutions. However, the working environment has been under pressure due to Covid19.
Readiness for Implementation	7	x					When the solutions went from Mockup to having to be implemented in our IT system, the project was affected by the whole region getting a new EHR. Working with this EHR meant that all tasks were downgraded. since it didn't make sense to develop on an outdated system. However, the reports were built when the new EHR had been implemented
Leadership Engagement	8					x	The managerial support for the project has been massive. both from middle managers and top management, there has been support for the ideas of working more data-driven.
Available Resources	5		x				Time and money have been allocated to the project. However, a data manager changed jobs during the project and it has been difficult to recruit qualified staff to take over this position. Even if the budget is present, it is uncertain that the public sector will be able to attract staff with a computer background.
Access to Knowledge & Information	6					x	The project has had good access to knowledge to support the project. For example: Knowledge from health professionals Knowledge from university (AAU) Knowledge from international experts.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	7				x		Health care law in Denmark has a high level of education in all key positions. Therefore, you are prepared to act professionally and implement new solutions.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Self-efficacy	3			x			Not relevant to the project
Individual Stage of Change	2			x			Not relevant to the project
Individual Identification with Organization	8				x		There is a high degree of identification with one's professional profession within the hospital.
Other Personal Attributes	1			x			Not relevant to the project
V. Process							
Planning	9					x	Planning tools are very important for the implementation to succeed and planning tools have also been an important focus in the JadeCare Project. Since Steno was established in 2017, we continuously need new methods and tools, whereby JadeCare has been an important learning for us.
Engaging	5				x		There has been a high degree of commitment throughout the project, which also makes implementation easier.
Opinion Leaders	1			x			Not relevant to the project
Formally Appointed Internal Implementation Leaders	8				x		The managerial support for the project has been massive. both from middle managers and top management, there has been big support to the implementation phase
Champions	1			x			Not relevant to the project
External Change Agents	1			x			Not relevant to the project
Executing	9				x		It is important that an organization can turn ideas into action, which has also been successful in the JadeCare project.
Reflecting & Evaluating	5			x			The PDSA tools are used both for reporting, but also continuously for evaluation and discussion in the Next Adopter Working Group(NAWG)

CFIR Focus Group

Next Adopter	n.a.	Local Good Practice	n.a.
Setting	n.a.	oGPs that you transfer from	n.a.
Date of the Meeting	n.a.	**Location**	n.a.
Start time	n.a.	**End time**	n.a.

Participants			
	Name and surname	*Organization*	*Role*
1	n.a.	n.a.	n.a.
2	n.a.	n.a.	n.a.
3	n.a.	n.a.	n.a.
4	n.a.	n.a.	n.a.
5	n.a.	n.a.	n.a.

	QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Intervention Source				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	It has been great to see the intervention and solutions from other countries. Although we are subject to the same GDPR rules, there is a big difference in their implementation of data projects in different EU Countries. In Denmark, we have a lot of focus on quality. Good to see another model from Germany that combines quality with economy.	*“We do a very similar data project and often encounter the same problems with not being able to get, for example, socio-economic data. Good thing we can learn from others countries”* *"Stepping completely out of your own context gives something special. It is very interesting to see other countries using their data – should we have performance measurements on doctors in Denmark"*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	It is good that we did not have to implement a complete IT system, but could also be inspired by parts. Mix'n'Match has also worked well.	*"Although Spain has an IT system to group the patients, it all depends a lot on the data quality. We must take this into account before trying in RND”*	
3.	If you started again the implementation process, what would you do differently?	Better process for selecting best practices. We would have more focus on clinicians and patients' attitudes towards data.	*"It has been a challenge to choose a best practice 5 years ago. Maybe it could be newer OGP”* *"We have been too close organize to ministries, etc. and too far away from the clinic. My dream was that the doctors could come on study trips"*	
CONSTRUCT 2: Trialability				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	RND has chosen a model where the solution is first developed in the area of diabetes and then spread to other areas in the rest of the region. So, it has been a kind of "bottom up" approach from the beginning.	*"It has almost been a bottom-up approach for RND, where Steno made the first models. But we have got good networks across the rest of the region, but unfortunately there are still many barriers to get socio economic data"*	
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	On the positive side, RND for networks has a place where other interested parties could follow the project on the sideline. On the negative side, it has been difficult to get it strategically anchored outside the diabetes area, but this is the downside of the bottom-up approach.	*"The network with other departments has meant that we have a good feeling of what has been going on elsewhere"*	
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	The project has been affected by both Covid19 and the replacement of the EHR system. Next time hopefully this won't happen.	*“We get a lot of data breaches when we get new systems. We changed in 2007 and again in 2022. It couldn't be worse timing for us than both the new EHR and Covid19"*	
CONSTRUCT 3: Culture				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Although the initial focus was on data and structures, in the long term it became more and more about culture. How do we shift focus from individual patients to population overview	*“Although medical science is very nature scientific, there has been little focus on the population approach in RND. We have learned a different way of working with data and create a new culture.”*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	In the Danish context, it is the politicians who have to worry about the economy. But JadeCare has made it possible to focus on smaller decentralize business areas with savings potential.	*“We introduce our clinicians to other data types with inspiration from Spain and Germany to make decisions. JadeCare is something other than research and evidence"*	

3.	If you started again the implementation process, what would you do differently?	A process where RND involves both politicians, patients and clinicians to a greater extent and runs a cultural process together with an external partner.	*"We must involve the health professionals and the patients much more. We may have some thoughts in the office, but they are the ones who have to carry a new culture"*	
CONSTRUCT 4: Leadership Engagement				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	There has been great support from the Steno management, where the management also has been part of NAWG. In addition, there has been a numbers meetings with the clinic management and the strategic top management.	*"It is difficult to get higher up the management level, since we have had a dialogue with all directors in the North Jutland region and put data and diabetes on the agenda"*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	A lot of work to get hold of the top management, but there is not immediately anyone who wants to have management responsibility for the work with population data.	*"We have planted Jadecare in the strategic action plan for the top management and the entire North Jutland Region"*	
3.	If you started again the implementation process, what would you do differently?	After the SWOT analysis, a broad working group was created, but some dropped out during the project (Reason new job and Covid19 pressure). Perhaps they could be retained better.	*"We started with a large internal steering committee, but some have gotten new Job. Other had difficulty finding time for it because of the new EHR"*	
CONSTRUCT 5: Planning				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	JadeCare has included a number of planning and analysis tools (CFIR, SWOT, PDSA, etc.), which we have learned to use and which can also be used in other contexts.	*"When you do projects, then you just have to fill in a number of forms. But we have learned alot from the process in JadeCare that we have been through"*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Together with the project management in JadeCare, we have continuously adapted the tools and, for example, Mix´n´Match has enabled a more flexible project process.	*"We have previously worked with EU projects, so we know that 10-20% must be set aside to work with planning tools"*	
3.	If you started again the implementation process, what would you do differently?	It has been good to focus on themes (for example data). Perhaps one should also focus on "Next practice" and not just "Best practice"	*"There are many different actors in JadeCare, so PDSA etc. provides a common understanding... Maybe the healthcare field is just too complicated for new projects like JadeCare"*	

8.1.1.14 SACYL

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	8				x		The project was developed internally by the GRS to respond with its implementation, in rural and urban areas, of technological solutions that make it possible to provide a broader and more efficient health care throughout the territory of Castilla y León, especially caring for people with chronic illnesses and dermatological patients.
Evidence Strength & Quality	8					x	The intervention is included in the "Castilla y León Chronic Patient Care Strategy (SACYL)" which aims to adapt the operation of the Castilla y León health system to the new reality of the growing demand for care derived from patients with diseases Chronicles.
Relative Advantage	9					x	The applicability and benefits of teledermatology and the care of chronic polypathological patients by telepresence have been identified and communicated through meetings with health professionals from both hospital care and primary care, and meetings with patient associations.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Adaptability	9					x	Adaptability was key in the implementation, carried out through the use of a methodology based on two cycles of improvement of the quality Plan-Do-Study-Act and a set of qualitative and quantitative methods to improve the adoption and the application.
Trialability	9					x	During the project execution period, pilot tests were carried out for both Local Core Features. The piloting of Teledermatology was carried out in all the health centers of the health area of Segovia, and the piloting of the telepresence project to respond to complex chronic patients, in the Care Continuity Unit (CCU) of the Zamora Care Complex with the North Benavente Health Center. Based on the evolution and results of these pilot tests, the project was extended to other health areas of Castilla y León.
Complexity	8					x	The project implied a technical and organizational change, it is a complex implementation due to the scope of the project, which will cover the entire territory of CyL, due to the number of steps it requires and also at the organizational level, it includes regulatory, technological, data protection... and you need to contact many agents of the parties involved, hospital internal medicine services (CCUs), dermatology service, health centers, legal advice, provincial management...
Design Quality & Packaging	7				x		The entire process was proposed and reviewed periodically for its best implementation within the Ministry, of the GRS, with the Services involved.
Cost	10					x	The regional health management has invested heavily in high-quality technology and economic support of the project.
II. Outer setting							
Patient Needs & Resources	10					x	The geographical dispersion in this Community is a barrier to the effective and efficient provision of health care. With the implementation of the project, the objective is that at the local level the patient can have a consultation with the specialist, who has a quick assessment, and that this consultation is decisive, without the need to travel.
Cosmopolitanism	10					x	Castilla y León works in collaboration with other external organizations: universities, research institutes, hospitals, residences and other regional, national and international health institutions. On the other hand, Sacyl's own network structure allows the connection of all health centers and hospitals, 342 centers among themselves, and with other external institutions such as residences.
Peer Pressure	7			x			The organization is always working on continuous improvement and the implementation of good practices seeking collaboration with other entities.
External Policy & Incentives	9					x	The IV Castillay León Health Plan and the Castilla y León Chronic Patient Care Strategy (SACYL) were key to the implementation of these practices in the medical care system.
III. Inner setting							
Structural Characteristics	9					x	The Regional Health Management of Castilla y León, SACYL, is the public service that manages public health services in the Spanish autonomous community of Castilla y León, belonging to the National Health System, established in 1986. The Decree 12/2022, of 5 May, establishes the organic structure of the Ministry of Health of Castilla y León, BOCYL of 6 May, and the Decree 16/2022, of May 5, establishes the organization and operation of the Management Regional Health (GRS), BOCYL of May 6. The Project has been directed by the Service for Organizational Innovation and Transformation of the Care Model (made up of seven people) of the General Directorate of Health Care of the GRS, and then by the Health Research and Innovation Service (made up of nine people) of the General Directorate of Health Planning of the Ministry of Health in collaboration with other Services of the GRS: Information and communication technologies (Expert and Decision-maker), Socio-Health Coordination Service (Expert and Decision-maker) and Department of the Health System (Expert). Management of Primary Care and Hospitals.
Networks & Communications	9					x	The Castilla y León healthcare system has an internal network to facilitate communication between healthcare professionals, as well as a public website and social networks. In addition to these tools, to monitor the project, regular face-to- face and online meetings are scheduled with the professionals to review the activities and resolve doubts or problems.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Culture	10					x	Values such as teamwork are essential for the development of the projects. Leadership is an important facilitator to promote the change of culture, as well as training.
Implementation Climate	9					x	At first, some resistance had to be overcome. We found different levels of motivation of the professionals, however, the commitment and knowledge of some of the professionals in the Project has revoked this situation of lack of motivation and initial training of other members. Regular meetings and contacts with professionals to detect their difficulties have been key to their involvement.
Tension for Change	9					x	The geographical dispersion in this Community is a barrier to the effective and efficient provision of health care. With the implementation of the project, any citizen of Castilla y León can benefit from this technology, especially the elderly, people with multiple pathologies and dermatological patients, mainly in rural areas. Health care is reinforced with the teledermatology and the telepresence, providing a quality service. Transferring the necessary information to the citizenship is essential for them to value and accept it.
Compatibility	8				x		In the implementation of telepresence and teledermatology it was vital to take into account the organization of the previous work and adjust it to establish the modifications that improved the use of these new practices. The implementation schedule was carefully prepared, adapting to existing workflows and periodically reviewed through the interaction with the parties involved in the project, health professionals, managers, patient associations…
Relative Priority	9					x	The telepresence project was designed to respond to the strategic lines of the IV Castilla y León Health Plan: specifically, the measures that support the advancement of telecare together with face-to- face care in the region.
Organizational Incentives & Rewards	6				x		Telepresence has been included in the Annual Management Plan that encourages care and research activity and the project has been submitted for recognition awards.
Goals and Feedback	8					x	Communication is established through agile multidisciplinary meetings: operational meetings, consensus and cooperation meetings between the parties involved: focus on common objectives and evaluation of the different alternatives to achieve them and then consensus meetings on the final documents. The leadership of the people who promote the project has been fundamental.
Learning Climate	10					x	First of all, those key people who had an impact on the project were selected, and all the health services and areas involved (care organization and human resources, among others) were involved. It is a multidisciplinary teamwork with a strategic vision, each professional profile and each leader contributing their work in their field to design and implement the project.
Readiness for Implementation	9					x	The Health Research and Innovation Service has led the project and has coordinated key people from the services involved with very diverse profiles: technicians, telecommunications engineers, computer scientists, legal professionals... and from different health areas. The implementation has been done on the consensus of objectives, development of processes, monitoring of progress and evaluation. In order to share the information, online and face- to-face meetings have been established, and through other digital media such as email.
Leadership Engagement	9					x	From the initial agreement of the management team of the Ministry of Health and the Regional Health Management (GRS) and contact with the managers and directors of each of the health areas and subsequent transfer of the agreement to the services involved.
Available Resources	9					x	The regional health management has invested from its budget in high-quality technology and financial support for the project, in addition to the dedication to the project of personnel from the Regional Health Service, project managers of the peripheral Health Departments (technical and functional), health professionals from the public health system of Castilla y León and health professionals from social and health residential centres. The training of professionals has been carried out through training before the installation of the technological and diagnostic devices, and once they

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							were already operational. Rooms and infrastructures in the health centres have also been made available for the development of the telepresence and teledermatology activities.
Access to Knowledge & Information	9					x	Fluid and regular communication has been maintained with the leaders and managers of each area, detecting new needs and training has been prepared in different formats for continuous training adapted to the needs as the project progressed. The training has been made available to the professionals through different means: videos on the health portal, which are publicly accessible to all citizens: (https://www.saludcastillayleon.es/profesionales/ es/teleatencion), infographics, presentation days, sending documentation by email...
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	9					x	The health professionals from the CCUs and dermatologists from the pilot centers have transmitted their experience, knowledge and enthusiasm to health professionals from other hospitals and primary care, so that they become familiar with and appreciate the advantages that the application of these new technologies can bring to the healthcare.
Self-efficacy	10					x	Different training sessions have been carried out aimed at training health professionals for the application of telepresence and teledermatology equipment. The tool allows professionals to carry out their care activity with the patients they care for, with a quality similar to that of other forms of care.
Individual Stage of Change	8				x		The training has been scheduled and delivered gradually through online and face-to-face training. An important part of the training has been based on cascade training through training of trainers. Professionals with more experience have transferred the necessary information and trained staff from their teams and professionals for their involvement in the project.
Individual Identification with Organization	9					x	It is an institutional project in which the professionals have been involved and collaborated. At first, some resistance to change was found, mainly related to the overload of work of health professionals and technicians in their participation in multiple projects.
Other Personal Attributes	9					x	The motivation and training of health professionals has been addressed through training with the participation of leaders in each area and in health centres. There were different levels of motivation and initial knowledge that have been taken into account when implementing the project. Competences have been developed through training. The professionals have taken into account the functional and geographical factors that influence the care of polypathological patients in rural areas, in order to provide a quality service. Values of commitment to all citizens, attention to diversity, empathy.
V. Process							
Planning	10					x	A solid project design is key to success, allowing it to continue after the project ends. To this end, we developed a formal plan for implementation. In the pre-implementation phase we carry out the planning of the application, where we prepare a detailed action plan broken down into the specific actions to be implemented. During the implementation, we have carried out the start up and operation of both practices based on the methodology of the PDSA cycle (Plan, Do, Study, Act). We planned the work in the first step: "PLAN" of the cycle and we established Key Performance Indicators (KPIs) to monitor the achievement of each of the actions.
Engaging	9					x	The leadership of the people who promote the project is a strong point for the implementation of a telemedicine project: leading people from both the central administration and peripheral management and the local teams themselves have taken part. Thus, a network of leaders was established that have made it possible to extend the project to the entire Autonomous Community. Managers have to push with enthusiasm and conviction, but care professionals have been the benchmarks in their own environments, with the staff of their teams.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Opinion Leaders	9					x	The Project has been actively promoted by the Service for Organizational Innovation and Transformation of the Care Model of the General Directorate of Health Care, and subsequently by the Health Research and Innovation Service of the General Directorate of Health Planning, Research and Innovation, with the involvement of the management teams of the health area managers and through a network of doctors and professionals in hospitals and primary care centres.
Formally Appointed Internal Implementation Leaders	9					x	In telemedicine, coordination with all the parties involved is important, as well as agreement on the objectives. For this purpose, follow-up meetings were established with managers and/or interlocutors assigned to the health services (Directors and Medical and Nursing Personnel of Management of Primary Care and Hospitals) and the management team of the peripheral managements and all the areas involved: regulations, material and technological equipment, information systems, Quality Service, Leaders of the care organization, data protection delegate, and human resources among others.
Champions	10					x	The care professionals (internal medicine doctors from the CCU of the Zamora Care Complex, dermatologists (Segovia Care Complex) and the primary care doctors who have directed the pilot tests of the Project have been key in the training and involvement of their team personnel and professionals from other centres, making possible the extension of the project to other health areas.
External Change Agents	8					x	Companies in the technology (ICT) and telecommunications sector, with which concept tests were carried out prior to decision-making. The intervention of patients and families through patient associations: it is very good that patients know about the project and can make their contributions.
Executing	9					x	The implementation of the actions was carried out according to the established plan of the PDSA cycle (Plan, Do, Study, Act). The approach used to monitor compliance with the planned actions and the schedule has been through Key Performance Indicators assigned to each established activity, previously defining a target value for each of the KPIs. The implementation has been carried out gradually, carrying out pilot tests for both practices. The teledermatology project was piloted in all the health centers in the Segovia health area and the piloting of the telepresence Project to respond to complex chronic patients in the Care Continuity Unit (CCU) of the Zamora Care Complex with the Benavente Health Center North.
Reflecting & Evaluating	9					x	The method used to evaluate the variations found was through compliance with the KPIs. We have considered both qualitative and quantitative variables. A qualitative analysis has allowed us to know the satisfaction of patients and health professionals and a quantitative one the study of variables such as the number of patients treated through teledermatology and telepresence, reduction of waiting lists, completed training for professionals...The variations found were reviewed in scheduled follow-up meetings with those responsible for the information of each of the KPIs and those responsible for the services involved.

CFIR Focus Group

Next Adopter	**SACYL**	**Local Good Practice**	**Teledermatology**
Setting	Regional level	**oGPs that you transfer from**	The Digital Roadmap towards an Integrated Healthcare Sector
Date of the Meeting	08 - May- 2023	**Location**	Online
Start time	16:00 h	**End time**	17:45 h

Participants			
Name and surname		*Organization*	*Role*
1	Dr. María Antonia Martín Delgado	SACYL, GRS	Moderator

2	Dr. V. Elena Ramos Macías	SACYL, GRS	Assistant
3	Ms. Cristina López Hernández	SACYL, GRS	Participant
4	Dr. Raixa N. Pérez Martín	SACYL, GRS	Participant
5	Dr. Anibal Blanco Domínguez	SACYL, Medina del Campo Urban Health Centre	Participant
6	Dr. Juan Jurado Moreno	SACYL, Medina del Campo Rural Health Centre	Participant
7	Dr. Beatriz Casado Verrier	SACYL, Segovia General Hospital	Participant
8	Dr. Luis Vicente Gonzálvez López	SACYL, Segovia Health Care Management	Participant

	QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Patient Needs & Resources				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	- The patient is essential. Avoid unnecessary trips. - A single photograph allows to diagnose the pathology, instead of several face-to-face consultations. It allows to quickly differentiate the banal pathology from the tumor. - In a single consultation, diagnosis and treatment are made quickly and efficiently. - Provide the patient with an efficient and fast service.	[00:21:23]: “First of all we work for the patient, for patient satisfaction. With this method we are avoiding patient displacements, consultations. We recently saw a melanoma, a malignant type on the scalp, simply with quality photos a week, he already had a face-to-face consultation and the next day he had surgery, all in record time”. [00:23:35]: “The vast majority of patients are very satisfied”. [00:24:03]: “I can tell you that now that I'm collecting the data, I'm delighted. First, because our fight was always over the early diagnosis of cancer. Second, do not saturate the queries with banal issues”. [00:28:24]: “The most important thing is the extremely high efficacy and efficiency of the practice.” [00:32:46]: "In rural areas they have been provided with a service that they had never had before, they are delighted." [00:38:23]: “The important thing is the resolution capacity it has, we are benefiting the patient thanks to early diagnosis.” [00:46:24]: "Take into account geographic dispersion, family distance (loneliness), economic distance."	All agreed on the rapidity of the diagnosis of cancer and that the waiting lists have decreased significantly.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	- Quick messaging would optimize the non-face-to-face consultation procedure (so that quick communication can be established in the event of an error: if the photo is not correct or the image has not been obtained...) - Very important to humanize and give proximity to the patient. - Providing more training for primary care physicians.	[00:18:51]: “"Good use of these tools: interesting to humanize and give proximity to the patient." [00:33:34]: “At times when there have been very few dermatologists, it was the way, but you have to follow this line because it is the fastest way to access.” [00:35:41]: "The tool loses value when there is a waiting list of more than a week" [00:48:53]: “The training of primary care physicians is being improved to prevent more referrals to hospital care. Training with the consultations themselves”.	
3.	If you started again the implementation process, what would you do differently?	- Improve the process of uploading photos to the EHR and have time in consultations - They propose that private mobile phones can also be used safely.	[00:09:30]: “Put means of transportation for health centers. Within the telemedicine projects, take into account patients who are far away and also those who, while in the city, have difficulties reaching the centers”.	They suggested several proposals for its optimization.

		- Use of fast messaging between Primary Care and Hospital Care. - In telemedicine projects, provide means of transport to travel to health centers.	[00:33:34]: “Regardless of the number of dermatologists in each area, teledermatology must be there because it is a form of quick access, and it is a form of filter.” [00:41:43]: “Not starting until there is an app that can automatically upload photos to the repository. It is slow and not very intuitive for Primary Care.” [00:42:47]: “It is limited to official mobile phones. It should be able to be implemented with private mobiles through a connection with the professional's Desktop”. [00:44:22]: "Quick messaging would optimize the non-face-to-face consultation procedure (so that quick communication can be established in the event of an error: if the photo is not correct or the image has not been obtained...)".	
CONSTRUCT 2: Implementation Climate				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	- At first you always have to overcome some resistance to change. It is very important that the project works quickly. - The involvement of professionals in the project is essential. Of leaders who promote and supervise it. - Works in collaboration between primary care professionals and hospitals.	[00:56:41]: “The better it works, the better the feedback between professionals and between patients”. [00:57:55]: "The ease of carrying it out is key, if it gets complicated, you can't." [00:59:05]: "We have reduced the distance between the hospital and Primary Care."	
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	- With leaders who have promoted the project and trained colleagues and other professionals. - The effectiveness of the practice has improved its acceptance and implementation.	[01:06:05]: “It shows where there has been leadership” [00:26:24]: “The System will not saturate it with trivial pathologies. Now more complex reasons for consultation arrive at the hospital”.	
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	- Leaders in all health centers that promote the project and carry out training. - A guide to referral criteria through non-face-to-face Interconsultation for all of Castilla y León. - Processes review.	[00:57:25]: “That there be a leader or 2 per Health Center who push the rest and do training”. [01:03:17]: "It is essential to prepare a document with clear instructions for referral (what photos to send): clinical and dermoscopic image." [00:59:27]: “The circuit is not well established. Sometimes it is sent to the dermatologist without a photo or more information.”	They shared the same vision: training is key to the involvement of professionals in the implementation of the practice.
CONSTRUCT 3: Self-efficacy				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	- The training of professionals is key to the application and use of the teledermatology equipment. - This tool allows professionals to develop their care activity with a quality similar to that of other forms of care.	[01:03:18]: “What has been done is relevant.” "The commitment of dermatology services is important; they have seen an opportunity with this tool and there has been a clear commitment."	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	- With training - Through continuous training in health centers. - Sharing information between professionals and between different health centers.	[01:03:40]: “Training, training and training, methods, review process planning." [01:03:55]: "Training has improved, sharing cases with colleagues in Primary Care and if you have any doubts, you can consult through remote consultation." [01:05:05]: “Share cases that we have, the most outstanding, important, those that can teach us, let's say from errors that not to do, what to do and how to do it. And we raise them in the ongoing training sessions”.	

			[00:43:54]: "Resident doctors and other professionals are being trained so that there is continuity"	
3.	If you started again the implementation process, what would you do differently?	- A mayor number of sessions, training workshops aimed at training professionals. - Greater dissemination of all available resources and improve communication channels between primary care centers, management and hospitals.	[00:52:58]: ""We need to provide more training for the use of mobile phones and dermatoscopes: training and training for the diagnostic process, mobile phones... Training planning." [00:43:54]: "Assess the option in saturated centers of training an assistant to take the photos." [01:06:29]: "A certain lack of communication has been observed between different levels: Health Center, management with professionals, between Primary Care and Hospital Care... there is a need to transmit more of what is available, there is a lack of dissemination"	
CONSTRUCT 4: Plannings				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	- Planning is key to the success of the Project: the provision and optimization of resources, the coordination of all the parties involved, the training of professionals...	[01:08:41]: "Planning is necessary because otherwise the resources are expenses." [01:08:41]: "Planning is key: the administration must plan and optimize the use of resources." [01:13:36]: "Here it has been projected well."	They agreed that the project was well planned.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	- Centralized purchase was made but the bidding process delayed the execution of the project at the beginning. - Periodic meetings with the different services involved have been key in the process of extending the project.	[01:13:36]: "The computer science did not reach the same level, the resources, when it improves, more professionals are hooked". [01:08:41]: "Slow implementation." [00:48:50]: "In teledermatology there are few devices: mobiles and dermatoscopes so that in rural areas they can take the devices and work fluently." [01:14:40]: "Centralized purchase: due to administrative contracting, the equipment acquisition period is extended. A large-scale purchase takes 6-8 months and must be budgeted for the previous year".	
3.	If you started again the implementation process, what would you do differently?	- Centralized purchase and buy the same type and model of dermatoscope for use. - Advance the training of professionals upon the arrival of the dermatoscopes. - Provide more dermatoscopes. - More communication between the different levels, managers, health centers, hospitals...	[01:08:41]: "Biggest enemy in Preimplementation: IT delays. Asynchronous in the speeds of each area. If it had been done at the same time, it would have been better." [01:15:56]: "There are dermatoscopes that are very difficult to use, it is better to make centralized purchases."	
CONSTRUCT 5: Champions				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	- The healthcare professionals and primary care physicians of the pilots have been key in training the personnel of their teams and of other centers. - Through the leaders it has been possible to extend the project to other health centers and areas.	[01:24:01]: "It is important that there is a reference in each of the teams. Conductive thread so that there are no problems in handling". [01:26:33]: "One of the successes is the leadership of the project by specialty. Teledermatology has worked very well in health centers and areas and the resolution capacity is improving. Recognize the work of Primary Care and Hospital Care professionals".	

2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	- With closer training between primary care and hospital care, holding workshops. - Improve coordination between dermatologists. - Facilitate communication.	[01:25:39]: “They began to lead 2 colleagues and now there are 4-5 leaders. The leader should not assume the work, but motivate the rest of the interested people”. [01:23:27]: "The quality of the image in which the person in charge of dermatology has gone to the training has improved a lot."	
3.	If you started again the implementation process, what would you do differently?	- The incorporation and training of more pediatricians. - More referral criteria courses are needed. - Improve communication between health centers, coordination with area service managers.	[01:20:27]: “There is a lack of pediatricians" [01:29:43]: “There is a lack of coordination between dermatologists: how do you make a report of an ICNP. The report must have a series of basic elements: clear diagnosis, treatment… Homogeneous requirements of the teledermatology report.” [01:35:47]: "General lines of action at the regional level and more operational commissions by areas". [01:36:03]: “You have to leave flexibility to the professionals, but there are issues such as continuity, structured information, which are fundamental. If the information is structured, it is much easier to share it.”	They remarked the importance of training in referral criteria through remote consultation and use of the dermatoscope.

Next Adopter	**SACYL**	**Local Good Practice**	**Telepresence**
Setting	Regional Level	**oGPs that you transfer from**	The Digital Roadmap towards an Integrated Healthcare Sector
Date of the Meeting	10 - May- 2023	**Location**	Online
Start time	14:00 h	**End time**	15:33 h

Participants			
	Name and surname	*Organization*	*Role*
1	Dr. María Antonia Martín Delgado	SACYL, GRS	Moderador
2	Dr. V. Elena Ramos Macías	SACYL, GRS	Assistant
3	Dr. Raixa N. Pérez Martín	SACYL, GRS	Moderador
4	Ms. Belén Alonso Fernández	SACYL, GRS	Participant
5	Mr. Francisco Javier Martín Morales	SACYL, Zamora Care Complex	Participant
6	Dr. Pablo García Carbó	SACYL, Zamora Care Complex	Participant
7	Dr. María Josefa Blanco González	SACYL, Benavente North Health Center	Participant
8	Mr. Jorge Pérez González	SACYL, GRS	Participant
	Dr. María Antonia Martín Delgado	SACYL, GRS	Moderador

QUESTION	**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: Patient Needs & Resources			

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	-Improve patient health care. -It allows quick consultation with the specialist and avoids displacements.	[00:05:03]: "The important thing is that it allows health care to be focused on the patient himself, on the patient's needs." [00:06:28]: "Patients accept it naturally" [00:10:37]: "Easy access for the patient to the specialist, long journeys are avoided and I also see that it is also very good for them, that they can count on their family doctor and the doctor specialist at the same time, and at the same time the specialist and the family doctor share information".	They agreed that patients are satisfied.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	-It has improved with the implementation in all health areas. -It is necessary to continue working on its dissemination so that its application is more widespread.	[00:04:07]: "It has been positive because they have tried to ensure that all the basic areas have this tool." [00:14:40]: "The tool does not make sense if it does not suit the needs of the patient. The tool adapts to the patient and not the other way around".	
3.	If you started again the implementation process, what would you do differently?	-Provide more information to patients and also with more informative campaigns at a general level. -Review the organization.	[00:04:35]: "Inform the patient" [00:11:33]: "I wouldn't change anything, because everything is very explained and the information reaches them. The patients are delighted." [00:11:33]: "A general outreach campaign, because we are talking about the patient who is informed because they already have an appointment. I mean that everyone knows this tool and can sue it, or even the patient with his family doctor." [00:15:51]: "Changing something for the patient: I wouldn't change it. Change at the organizational level: yes". [00:15:12]: "I think I lack visibility."	More work needs to be done on communication, bringing the practice closer to professionals and patients.
CONSTRUCT 2: Implementation Climate				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	-At first there has been some rejection, due to ignorance. Communication and training are basic for the acceptance and use of the practice. -Improvement of procedures.	[00:18:37]: "Having a good implementation climate is essential, professionals must be convinced that they can see patients. They cannot, if they have, turn off the equipment. Focus attention on the patient himself." [00:30:11]: "Fundamental implementation climate for the adoption of a new technology that generates fear and rejection as a technological barrier, along with the ignorance of what it could mean."	The importance of communication and professional training.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	As the implementation in health centers has progressed, the climate has been improving.	[00:17:48]: "It has improved over time because the number of inquiries has been increasing." [00:19:25]: "Over time it has improved compared to the beginning. As the colleagues from the health centers are testing it, progress can be seen: try it. They have recently started at the Toro center: the first consultations they have had have been delighted, patient and caregiver with poor mobility". [00:29:23]: "It is proven. The system works and is very efficient".	Positive assessment of its evolution from the beginning of the project.
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	-Improve communication between the different levels: peripheral management, professionals... -It is necessary to reach more directly to the professionals.	[00:17:48]: "To reach the professionals more directly and better explain the project, in an extensive way." [00:23:19]: "Communication, complete information does not reach all professionals. There is a communication problem."	It is essential to transmit the project, make it known.

			[00:30:11]: "There are many teams that are shut down, due to lack of communication and fear, they believe that it will replace them, they don't know how to use it and they see it more as a problem."	
CONSTRUCT 3: Self-efficacy				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Knowledge of the tool and training essential for professionals to feel adequately trained for their application.	[00:32:55]: "When the system is known, it is effective: the professionals who are next to the patient say it. Patients and family perceive it. The capabilities of the teams are very high". [00:35:04]: "It is a good tool: the fact of using it shows that it is a useful tool and we are effective when applying it." [00:34:54]: "When the professionals see that it has been effective, they feel capable of implementing it." [00:36:51]: "The information has not reached primary care professionals effectively, and that is where many of the problems have come from".	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	As the training has progressed, the number of consultations made through telepresence has increased. Its application has increased by involving other colleagues of the professionals who made consultations through telepresence.	[00:35:04]: "Training. Simple manuals were prepared, which also report on the use cases". [00:42:09]: "When the residents rotate I try to always have them with telepresence: so that they see that it is not science fiction and that it is useful, I am convinced that they are going to use it."	
3.	If you started again the implementation process, what would you do differently?	-Orientation of the training, reinforce it with the realization of workshops for its application. -Information sessions in the centres. -Procedures for organizing telepresence consultation agendas.	[00:33:48]: "Inform more. Ability to bring information to health professionals and training". [00:35:04]: "I wouldn't change anything, the manuals you've done, phenomenal, the problem is getting the final information to professionals and patients." [00:35:04]: "It is very important that it reaches the peripheral centers. Especially there, which is where the tool can be most useful". [00:39:47]: "Orientation of the training, it is not well oriented: breaking the fear of the technological barrier and incorporating this tool in the care activity: this is the most complex. The adoption of technology involves holding workshops that force you to use it: by areas…" [00:39:47]: "The complexity of coordinating agendas is a limiting factor." [00:38:37]: "Information days in the centers and also face-to-face sessions through teams or videoconference".	They agreed on the criteria to reinforce the training of professionals.
CONSTRUCT 4: Planning				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	A solid project design is key to success, and continue working on the actions that allow the practice to continue once the project ends: digital skills of professionals, guides...	[00:42:51]: "Planning influences the implementation process." [01:12:24]: "Continue working on the issue of digital skills of professionals, the issue of protocols and guides."	

2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	-Nurses or case managers in hospitals. -Management of the consultations agenda and necessary coordination.	[00:43:55]: "It is a tool that should grow exponentially. Changes in the schedule of telepresence to adapt it to the needs and coordination." [00:47:19]: "A nurse is needed, a telepresence-only case manager to manage all the hospital agendas." [00:48:11]: "In Primary Care planning is easier because there is a person in charge of telepresence at the Health Center to set the day and time."	
3.	If you started again the implementation process, what would you do differently?	-Dedicate specific rooms for telepresence consultations in health centres. -Incorporate health professionals to provide health care in telepresence consultations.	[00:45:02]: "It would be better to create a single telepresence query. Create the telepresence unit. With a team of people dedicated to it. Expand the offer of the telepresence agenda". [00:45:02]: "Incorporate new people." [00:49:44]: "It is very important to optimize the location of the device, that it be in an accessible, available and programmed place". [00:48:11]: "The protocols should be clearer so that the usefulness can be seen. What type of patient is the candidate for the consultation". [00:45:33]: "It can be used in many different specialties."	Telepresence specialization, with dedicated rooms and staff.
CONSTRUCT 5: Champions				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	It is essential to have leaders committed to the project to promote it. Leaders at all levels, health areas, hospitals, services involved...	[00:55:06]: "It is essential to have a good leader in each area who would have made the project their own and promote it throughout the basic area and transferred to hospitals. A leader in each of the services or units that would have committed to the project". [00:58:37]: "Leaders are essential. One point of failure is communication: the drive belt is important. Selection of leaders, they must be pampered, trained… they are the key"	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Transmitting the project to the professionals in the teams, in other centers... increasing participation.	[00:57:52]: "Convinced that the tool is very useful but it is difficult to convince the team". [00:56:57]: "The three of us are convinced that it works and that it is good (center of Zamora). And I think we've done everything we can and we're doing everything we can to keep it going." [01:10:17]: "Professionals are open to technology, the problem was the time of the pandemic: otherwise it is a perfect tool. It's going to work and it's going to make the job easier."	
3.	If you started again the implementation process, what would you do differently?	Increase communication for the diffusion and acceptance of the project at a general level. Expansion process supported by new projects: TSI.	[00:57:16]: "Fundamental that the information reaches each other." [00:55:36]: "There is an information transmission barrier that must be jumped." [01:07:14]: "Citizens don't know about this possibility of avoiding displacements..." [00:58:37]: "The concept of responsibility: not to confuse leadership with responsibility." [01:12:24]: "Give continuity with new projects. More participation."	

8.1.1.15 SELBM

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	6		X				If the interventions are externally developed this has created additional legal barriers that hinders local implementation
Evidence Strength & Quality	8				X		It is really important that the intervention is evidence based and also response to the local needs that has been identified by the professionals and patients
Relative Advantage	5			X			A direct possible relative advantage of integrated care was not visible for every stakeholder and if well it was partially compensated by the additional workload due to the new procedures that have to be implemented in the daily work
Adaptability	7		X				It was still not really clear how the integrated care best practices model could be implemented in the region. Due to the complexity of the Belgian health system and the fact that integrated care was based on foreign system that largely differ from the Belgian one.
Trialability	9					X	For the stakeholder it was really important to start with specific actions and interventions on a small scale that bring quick wins and later upscale and implement it on a larger scale
Complexity	9	X					Due to the complexity of the Belgian health system on the one hand and the complexity of implementing a new health paradigm like integrated care the stakeholder thought it will be really complex and a long term project that will take time.
Design Quality & Packaging	1			X			This construct had little to no relevance.
Cost	9				X		The stakeholder positively view that the Government of the German speaking Community want to invest in integrated care. But they also are aware that in initial phase the implementation will have high cost
II. Outer setting							
Patient Needs & Resources	5			X			In this phase of the project only a patient organisation was involved in the process, no patients survey was performed to assess their needs.
Cosmopolitanism	5			X			The stakeholders in the region are networking between each other on a regular basis and also due to the small size of the region they have also an intense collaboration with external stakeholder outside the region. But these patterns have not yet had significant influence on the implementation of the integrated care in the region
Peer Pressure	1			X			Not yet relevant.
External Policy & Incentives	7				X		All the strategies on federal and Community level are leaning towards integrated care but there is a need to find an integrated and coherent strategy that considers all the other ones
III. Inner setting							
Structural Characteristics	1			X			This construct has not yet had an impact on the initiative. The small size of the organization could have a relevance in the future implementation.
Networks & Communications	7				X		Due to the small size of the German speaking Community the stakeholder know each other very well and the informal network communication is very important in every project. But it is not specific to the integrated care initiative
Culture	1			X			This construct had no specific relevance

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Implementation Climate	5			X			There is common understanding that changes are needed but this- would also mean a further strain on the already scares human resources
Tension for Change	9					X	There is common understanding that changes are needed but this- would also mean a further strain on the already scares human resources
Compatibility	1			X			This construct has not had a significant relevance in the process
Relative Priority	5			X			Integrated care is a priority on the political level in Belgium but for different health care providers there are also other priorities that more important or more urgent
Organizational Incentives & Rewards	7			X			It is very important for every involved party to build up a suitable incentive system but currently it is not yet clear which shape it will have
Goals and Feedback	1			X			Since the field implementation has not yet happen. This construct is not yet relevant
Learning Climate	6				X		Due to the small size of the German speaking Community and its localisation near the border of Germany, Luxemburg and the Netherlands the stakeholder and politics are eager to learn from best practices in Belgium and abroad
Readiness for Implementation	1			X			This construct can not yet be evaluated due to the fact that the concrete interventions have not been implemented
Leadership Engagement	5			X			The representatives of the different organisations actively participated in the different meetings
Available Resources	9			X			The German speaking Community has committed to pre finance the implementation of integrated care. But the human resources in the health sector are really scare and it could a negative influence on the project
Access to Knowledge & Information	1			X			This construct is not yet relevant
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	1			X			This construct has not yet been relevant.
Self-efficacy	5			X			The capabilities to execute the implementation is closely link to availability of human resources
Individual Stage of Change	5			X			The relevance is low cause the interventions are still in an early phase
Individual Identification with Organization	1			X			/
Other Personal Attributes	1			X			/
V. Process							
Planning	1			X			The concrete implementation for plan for the different interventions will be developed and available by June. So the relevance of this construct is low.
Engaging	1			X			This construct has not yet have had a significant relevance

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Opinion Leaders	6				X		In the region it is important that the representatives of the main health organisations firstly the hospitals, GPs and the Ministry are backing the initiatives this has a positive effect on any project in the health sector
Formally Appointed Internal Implementation Leaders	8			X			Due the small size of the German speaking Community the project coordinators have always other tasks to do than only the project coordination and they are also working in an organisation that is an integral part of the project, so they know the health provider landscape very well and this can be positive but they also have a lot of other task to do, which can hinder the implementation
Champions	1			X			Not yet relevant in the frame of the project.
External Change Agents	10				X		OptiMedis has acted as an important external change agent in the region the feasibility sturdy which was performed could be the basis to implement integrated care in the region. It is also raised questions about how the model could be implement in the region and fits into the Belgian health system.
Executing	1			X			The concrete implementation plan is still in development and will be available in June
Reflecting & Evaluating	1			X			Not yet taken place on a regular basis and had a significant relevance

CFIR Focus Group

Next Adopter	Dienststelle für Selbstbestimmtes Leben	**Local Good Practice**	German speaking Community
Setting	[….]	**oGPs that you transfer from**	OptiMedis
Date of the Meeting	25 May	**Location**	Eupen
Start time	13:00	**End time**	15:00

Participants			
Name and surname		*Organization*	*Role*
1	Guillaume Paquay	Dienststelle für Selbstbestimmtes Leben	Moderator
2	Roger Erkens	Dienststelle für Selbstbestimmtes Leben	Assistant
3	Dr. Karl Vermöhlen	Hospital St.Vith	Doctor
4	Isabel Meyer	Hospital St.Vith	Direction Quality and Communication
5	Olivier Warland	Consulting and Therapy Centrum	Director
6	Björn Marx	Health insurance	Representative
7	Anja Boffenrath	Patient consulting organization	Social assistant
8	Kerstin Sack	Independent Psychologist	/
9	Marion Wengenroth	Ministry of German speaking Community	Healthcare expert
10	William Klubert	Sport federation	Sporthealth coordinator

QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS

CONSTRUCT 1: Trialabilty				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	For the stakeholder it was really important to start with specific actions and interventions on a small scale that bring quick wins and later upscale and implement it on a larger scale	"The integrated care has to take in account the specificity of the German speaking Community" "We need quick results due to the dramatic personal shortages particularly in the health and care sectors, we can't afford to participate in a process that has no quick results"	/
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The stakeholder defined the actions and care pathways which have priority in the region and should be implemented first	"We have no time to lose" "We need to care about our patients and work with them on the field"	/
3.	If you started again the implementation process, what would you do differently?	Start quicklier with concrete actions	"There is a lot we already knew beforehand. Now we need to do something, which is good for our services and our patients!"	/
CONSTRUCT 2: Complexity				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	Due to the complexity of the Belgian health system on the one hand and the complexity of implementing a new health paradigm like integrated care the stakeholder thought it will be really complex and a long term project that will take time.	"It is important to have a common motivation and that all involved parties have an added value" "It is important to take into account the specificity of the Belgian system and see what is feasible in the short term"	Due to the complexity of the Belgian health system on the one hand and the complexity of implementing a new health paradigm like integrated care the stakeholder thought it will be really complex and a long term project that will take time.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	It is important to keep close contact and exchange between the different political levels, mainly community and federal level and need to adapt to the political decision on federal level.	"The federal state is away from efficiency generation (shared saving). It is time to rethink."	It is important to keep close contact and exchange between the different political levels, mainly community and federal level and need to adapt to the political decision on federal level.
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	All parties want to get East Belgium integrated, but it is difficult to know all initiatives and political changes that are underway. It would have been better to get informed about different projects and initiatives before.	"Sometimes we don't know what the other service is doing even if we are small Community" "It is important to know about the projects of one another, so that we take them into account and do not do the same twice or do things that are not wanted or possible So we avoid losing time and resources"	All parties want to get East Belgium integrated, but it is difficult to know all initiatives and political changes that are underway. It would have been better to get informed about different projects and initiatives before.
CONSTRUCT 3: Cost				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Innovation needs to be financed and the stakeholder appreciate the support of the German speaking Community". Need to rethink use of healthcare due to cost evolution.	"…notes in this context that the ageing of society is accompanied by an increasing need for care. This in turn leads to rising costs and, against the backdrop of a shortage of skilled workers, to bottlenecks in care."	/
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The prevention and health promotion measures that should be implemented in the frame of integrated care could have a positive effect on the cost evolution and slow it down.	The increase in medical costs is considerable. If necessary, these could be slowed down by preventive measures or health promotion.	/

3.	If you started again the implementation process, what would you do differently?	The estimation of cost of the implementation is not known at this stage. It should be made sure that the action implemented will be cost-efficient	"From the point of view of a company, we have to make sure that the actions are cost-efficient and will be financed"	/
CONSTRUCT 4: Tension for change				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	There is common understanding that changes are needed but this would also mean a further strain on the already scares human resources	"People need to rethink. The attitude that getting involved in social insurance, opens up entitlement to benefits, similar to car insurance, needs to be worked on. The issue of overuse of health services also needs to be addressed, be it the consumption of medicines or paramedical services as an example." "…notes in this context that the ageing of society is accompanied by an increasing need for care. This in turn leads to rising costs and, against the backdrop of a shortage of skilled workers, to bottlenecks in care."	/
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	It does not need to be enhance there is a common understanding of the need of change, but the resources are key to achieve the change	"Skilled labor retention is a key factor" "The changes must also have positive effect on the work condition of the health care workers and patientcare"	/
3.	If you started again the implementation process, what would you do differently?	The common understand for change is there, so it is important to use this awareness and motivation in the right way.	"Take into account the scarcity of the available human resources and also focus on retention of skilled labour forces"	/
CONSTRUCT 5: Available resources				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The German speaking Community has committed to pre finance the implementation of integrated care. But the human resources in the health sector are scare and it could a negative influence on the project	"…notes in this context that the ageing of society is accompanied by an increasing need for care. This in turn leads to rising costs and, against the backdrop of a shortage of skilled workers, to bottlenecks in care."	/
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The prevention and health promotion measures that should be implemented in the frame of integrated care could have a positive effect on the number of patients treated and so also on the workload.	If necessary, these could be slowed down by preventive measures or health promotion. Innovation must be financed and have a positive effect on	/
3.	If you started again the implementation process, what would you do differently?	One of the main issues are the waiting lists caused by the scarcity of human resources and the rising number of patients. This issue should be a absolute priority.	"…access to mental health care is associated with waiting periods of 3 months caused by existing shortage of specialists."	/

8.1.1.16 SMS&FFIS

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Intervention Source	9				X		Concrete interventions have been designed by the participants themselves
Evidence Strength & Quality	9				X		It is based on the experience of clinicians in the best care for the population, as well as the analysis of existing evidence.
Relative Advantage	9					X	High motivation of the participants
Adaptability	9					X	It adapts to the environment and scope of professionals and coincides with their clinical practice.
Trialability	9				X		There is the possibility of testing it in Service and a motivated and experienced center, to detect possible imbalances and correct them before their extension to the rest
Complexity	8				X		Despite being a complex process, the participation of the parties in the design has made it possible to overcome the difficulties
Design Quality & Packaging	8				X		An integrating strategy is used for all parties involved in the process
Cost	10					X	Both technical and personal resources of the organization itself have been used
II. Outer setting							
Patient Needs & Resources	8				X		The patients participate actively in the process and feel like a protagonist and their participation is evaluated through a survey.
Cosmopolitanism	6				X		Due to its own characteristics and dealing with confidential clinical information, interconnection with other organizations is difficult.
Peer Pressure	7				X		The public health environment allows little competition between different sectors
External Policy & Incentives	7			X			The only incentive comes from the motivation of the participants
III. Inner setting							
Structural Characteristics	9					X	The organization has experience and maturity in providing services and also in a public environment
Networks & Communications	7				X		The public health system in Murcia has an internal network to facilitate communication between professionals, although it has required adaptation to the Project.
Culture	10					X	There is a consolidated public service culture among professionals
Implementation Climate	8				X		Resistance to change may be present, but institutional support and the motivation of professionals counteract this resistance.
Tension for Change	7				X		There is a perception of the professionals of the need for another way of doing things, more adapted to the circumstances of the patients.
Compatibility	8				X		It is necessary to integrate into the usual work of professionals, not being oblivious to the fact that this contemplates complications due to care overload
Relative Priority	7			X			Different ways of doing things, adapted to new needs and environments, is established as a felt need.
Organizational Incentives & Rewards	5			X			The SNS does not establish the possibility of incentives, apart from the recognition that professionals obtain
Goals and Feedback	8				X		The design of objectives and the fulfilment of them corresponds to the professionals themselves, which facilitates feedback

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Learning Climate	10					X	It has been prepared by consensus and based on the previous opinion of the professionals involved who have shown their needs, support and opinions of all members have been taken into account
Readiness for Implementation	7			X			Actions, circuits and processes have been defined, and computer platforms have also been adapted to carry them out
Leadership Engagement	10					X	Importance of leadership within the organization, as well as the support of the institution
Available Resources	8				X		It has had shared material and personal resources from the organization itself, which has meant a certain delay in its application and implementation.
Access to Knowledge & Information	9					X	Tools and circuits have been designed that allow access, as well as information sharing between professionals and participants .
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	8				X		Training strategies and knowledge of the tools as well as the intervention itself have been designed
Self-efficacy	9					X	The participating health professionals have the adequate capacities to carry out the Good Practice and guarantee its success.
Individual Stage of Change	9					X	The health professional involved has the necessary motivation and enthusiasm to carry out the changes that the set of interventions implies in their habitual practice, as well as learning and knowing the tools they have.
Individual Identification with Organization	9					X	The sanitarian professionals involved are part of the public institution that provides health services and this facilitates the interaction between them.
Other Personal Attributes	10					X	The health professionals involved have considerable advantages when working in a network, which facilitates the exchange of information, the development of an intervention established by themselves and a good practice that they consider can benefit their patients and improve their care .
V. Process							
Planning	9				X		Protocols and circuits have been developed to carry out the intervention, as well as facilitating computer adaptations
Engaging	10					X	The professionals with the greatest commitment to the Intervention and also to the Organization have been selected.
Opinion Leaders	10					X	Within the Organization, leaders have been selected who favour the implementation and support it and are experts in similar projects
Formally Appointed Internal Implementation Leaders	10					X	There is a core group of leaders capable of promoting change and being able to drag others to carry out the intervention and in whom the rest trust
Champions	10					X	There are experts in this matter within the organization itself and with experience
External Change Agents	6			X			The characteristics of the public health system make this situation difficult
Executing	8				X		Importance of the Execution of the Good Practice according to the plans established in its design and implementation
Reflecting & Evaluating	9				X		Continuous evaluation is essential in any Process to be carried out that allows guaranteeing its adequate development and fulfilment of objectives.

CFIR Focus Group

Next Adopter	SMS & FFIS	**Good Local Practice**	ONLINE PHYSICAL REHABILITATION
Setting	HOSPITAL MORALES MESEGUER-MURCIA	**oGPs transferring**	Digital Roadmap towards the integrated healthcare sector
Date of the Meeting	28.06.2023	**Place**	MORALES MESEGUER HOSPITAL-MURCIA-Training classroom
Start time	10:30 a.m.	**Ending**	12:30 p.m.

Participants			
Name and surname		*Organization*	*Role*
1	Mª DEL PILAR LOPEZ ACUÑA	Ffis	Coordinator and Moderator
2	ROSA FERNANDEZ TARAZAGA	Ffis	Assistant
3	PEDRO PEREZ LOPEZ	SMS	Principal investigator
4	JUAN VICENTE LOZANO GUADALAJARA	SMS	rehabilitative doctor
5	ENCARNA SEVILLE	SMS	rehabilitative doctor
6	ALBA PALAZON	SMS	rehabilitative doctor
7	FCO. JAVIER CECILIA CANALES	SMS	Physiotherapist
8	MARIA PELLICER ALONSO	SMS	Physiotherapist

QUESTION		**SUMMARY STATEMENT**	**QUOTES**	**OTHER REMARKS**
CONSTRUCT 1: Design quality and packaging				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	In General, the pilot has been accepted very positively, since the experience in the rehabilitation service shows the benefits that a project like this can offer.	-Responds to the patient's care needs with digital skills and low availability of time or travel. - It is very important to incorporate the remote rehabilitation tool into our therapeutic arsenal. *- Encouraging previous experiences.* -Agree on the procedures. *- It is through the evidence that allows for continuity and consistency in the development of the project, through previous references it allows us to obtain a prediction of future results.*	Being the first of the questions in the session, the participants take a while to get used to the dynamics of the focus group, despite having received the instructions on how it works, they are quickly redirected by the moderator.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The commitment of professionals and managers and the joint commitment, allows an optimistic attitude to the development and growth and implementation of the project according to the improvement processes detected.	*-The main intervention has been revitalizing the execution of program content and fostering group cohesion.* *-After some hesitant beginnings, I now believe that the tool already has shape and the*	The participants agree that they have positively strengthened the construct of Solidity and Quality of the Evidence. The implementation process.

			impression is that it will be useful in daily clinical practice. *-Contribution of experiences of all participating professionals and their opinion on the project.* *- Reduce individual variability.* *- Expectant attitude and the need to discover new forms of treatment.*	
3.	If you started again the implementation process, what would you do differently?	This topic denotes in the first sense the deficiencies that we initially perceived in the transmission of the best practice which resulted in significant delays in implementation and bottlenecks in obtaining the necessary resources for its development.	*-I would carry out a more detailed review of the days prior to the recording of the videos to optimize the time in them* *-It would change the type of pathology on which to carry out the piloting. It would use a more clearly hospital-based prescription process along with a health center-based one* *-Obtain more information on the Good Practice to be implemented* *- Review of forms and correction of errors* *- Present and highlight the evidence found*	This question leads to an interesting debate among the participants, always with a positive and constructive approach.
CONSTRUCT 2: Learning climate				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	This construct denotes the excellent collaboration that was achieved between managers and implementers, and the successful degree of commitment and work that has allowed us to achieve excellent results.	*-The learning climate has been highly collaborative, prioritizing the collective/group over individual roles* *-It is a stimulating process of development and learning of the healthcare team* *-Leadership and committed people who collaborate as a team* *- Promote new avenues of research on the processes attended* *- The essential learning climate to increase the initiative and formulation of proposals of creative ideas.*	The debate on this construct highlights the synergy between the participants and good multidisciplinary coordination.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	In this aspect, the need to have greater availability and time is the characteristic that becomes more relevant, and the union of the group and collaboration. The factor that favors the compensation of deficiencies.	*-Promoting group identity and achieving our work objective.* *-The lack of time is a very limiting factor to be able to develop the implementation of the tool.* *-Construction of project and procedures among all participants.* *- Evidence update available.* *- The climate has made participation possible, although the difficulty of finding times and spaces did not favor it.*	Although in general the participants see a positive effect in the implementation through this construct, they show some negative aspects. They show interesting aspects that can be improved from a very constructive point of view

3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	*In this aspect, the need for longer planning times for the organization of the agendas arises again, under the need to release the care workers so that they could work with more planning.*	*-Flexibility of execution times preparation review of the work.* *-I would try to increase the dedication time of the members in the process.* *-Development of tools and interoperability more agile and faster.* *- Review of evaluation methods.* *- It would enable consensus and meetings to contribute ideas and search for meetings, encouraging participation.*	This question generates an interesting brainstorm on the part of the participants, above all they stress the need to modify times, especially a longer implementation time.
CONSTRUCT 3: Leadership commitment				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	*In this construct, very positive and encouraging feedback was received, however, the need for greater corporate support is perceived.*	*-Having competent, decisive and collaborative leaders has been definitive and decisive.* *-The involvement of the organization's managers outside the development team has been scarce.* *-Adequate selection of leaders and managers of different levels of care.* *- Coordination of the professionals involved in the experience.* *- Commitment as an essential element for the correct development of the application and compliance with deadlines and activities.*	All the participants praise and appreciate the commitment of the project leaders and detect the need for greater institutional commitment.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	In this aspect, advantages are attributed to leadership that allowed the objectives to be achieved, although the need for greater involvement of the organization's management levels is also insisted on.	*-The leader has encouraged and accompanied the work of each member in their development and has united human labor and the product.* *-The feeling of little interest on the part of the health management puts a brake on the expectations of success of the process.* *-Coordination of participating professionals.* *- Ensure the use of the work tools developed.* *- It has had a positive effect for the implementation of the application.*	Disparity in the opinion of the participants who have contradictory feelings regarding the effect of the implementation process on the construct of Leadership Commitment. Opinions from within the team are positive, however they have not perceived the necessary institutional commitment.
3.	If you started again the implementation process, what would you do differently?	*The need to have greater support from managers to streamline processes has been very decisive in the development of the implementation*	*-Give more support to the leader.* *-It would ensure the commitment on the part of the management of the center and the SMS in procuring the necessary resources.* *-Involve higher management more in interoperability.* *- Previous piloting.* *- I would try to give more responsibility to the participants, generating greater involvement.*	The barriers encountered with respect to the construct of the Leadership Commitment are discussed. The deficiencies perceived at the level of deficiency in the support and operational support at the management level are evident to give agility to the pilot processes

CONSTRUCT 4: Commitment				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	At this point, the great commitment assumed by the professionals involved in the development of the pilot is described; however, there is concern that this interest be generalized among the greatest number of professionals, and that adequate dissemination be carried out.	*-I consider that the selection of professionals has been highly cared for, taking into account both the academic and experiential profiles as well as the empathic character of the members of the group* *-I think that the professionals involved in the tool are participating. The future commitment of all the therapeutic teams in the use of the tool is more doubtful.* *-Motivation of the professionals involved and enthusiasm for the development of the Process.* *- Ensure the participation of professionals.* *- The dissemination and training of the project is essential to ensure the greatest participation and reception among the participants and that they assume a leading role in its development.*	In this question there is an agreement of all the participants who refer that the Commitment construct is highly relevant in the project implementation process.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Delivery and commitment at the implementation level have been able to overcome the obstacles they have faced, but there is a perception that this does not happen in all instances, due to unforeseen changes in its structure.	*-The different members of the group with more than 20 years of work experience, love their work and have contributed their enthusiasm and a high capacity for commitment.* *-I think that the involvement of physiotherapy in primary care has been low for various reasons: personnel changes, care pressure.* *-Teamwork of different professionals* *- Hold those involved in the use of the tool accountable* *- It has been necessary to generate commitment and participation in order to sustain the project*	-The opinion of the participants is divided as to how they have potentiated the positive or negative effects of this construct
3.	If you started again the implementation process, what would you do differently?	*In general, the intention was expressed to involve a greater number of professionals in both development and implementation.* *And also the need for greater dissemination.*	*-I would request that the writing of the documents be more enjoyable* *-Would ensure the presence of PA physiotherapy in the process development group* *-Improve training in the use of tools* *- Make the model extensible to other professionals* *- It would have carried out more strategies aimed at dissemination and participation,*	There are various contributions on this point. Opinions invite us to continue working on dissemination and implementation involving a greater number of professionals.

			promoting the prominence of key figures and dedication.	
CONSTRUCT 5: Formally appointed internal implementation managers				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	There is general concern about the continuity of the project after so much work has been done. And they describe the need to involve implementers directly responsible for their deployment through a better distribution of time and incentives.	*-They have developed a great job dedicating and investing great hours of personal work.* *-Everyone is involved in the development of the process.* *-Incentive in terms of training and prestige that ensures sustainability over time.* *- Ensure the feasibility and execution of the project.* *- The responsibility of the project must have clearly defined people for the intervention and referents throughout the process.*	In this question the participants show different points of view when facing the answers. At this point, the need to have more resources is evident and to motivate the professionals involved with incentives, since the overload of work complicates the proper development of the implementation.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	This construct has gained importance since during the implementation attempt we faced many bottlenecks that were resolved thanks to a very collaborative team.	*-Trying to unlock problems and encouraging resolution* *-The development of the piloting of the application is due in large part to the involvement of internal managers* *-Participation of the professionals involved in present and future decision-making* *- Keep in mind the use of the assistance tool* *- It has positively influenced having clear and being able to go to the referents in the organization and implementation of the work dynamics*	Positive evaluation by all participants.
3.	If you started again the implementation process, what would you do differently?	*In general, a very positive assessment was given where the managers and implementers achieved a high level of motivation and collaboration, what was a general feeling was the need for more implementation time and improvements.*	*-Well, I would make more reflections of this type that make me value and increase respect for the work of my colleagues.* *-I think that in this aspect things have been done correctly. I would not change anything.* *-Have more time for its development and more professionals.* *- Try to involve more professionals from the team.* *I wouldn't change anything.*	The comments reflect a very positive perception with possibilities for improvement based mainly on the need for human resources that allow sufficient time for implementation.

8.1.1.17 UHO

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	8				X		We see JadeCare as an externally-facing opportunity. There is quite a strong conservatism within healthcare services in the Czech Republic. If there is to be change, it is advisable to have evidence of the realism of the new approach. We then pushed this from the inside out. In this way, the intervention acted as a gate opener to kick-start something new.
Evidence Strength & Quality	6				X		OGP were a great example and provided a great deal of information in a more general sense. However, what we perceive as a barrier is the lack of specific follow-up information on the study visits, the dialogue directly with the providers, which for example in WP 8 took place only during the thematic workshop. We also missed discussion with hospital staff or clients.
Relative Advantage	3			X			Within, for example, telepsychiatry, there are pressures to intervene much more deeply, to be more progressive, and to implement a much broader scope on the issue. However, if we already have experience within JC that even the "less ambitious" approach has not been easy to implement, the idea of bigger steps is somewhat misguided. It was the OGp that rather held us back to specific smaller goals at the beginning, which helped in feasibility.
Adaptability	6				X		It is very difficult to implement the whole system from one health system to another health system. I can't imagine it without the long-term stay of the OGp implementation team. It would also be dependent on completely different finances with regard to purchasing and paying for IT solutions etc. The mix'n'match method combined with a flexible approach helped to find a solution to adapt and implement the sub elements in the JadeCare project. And it was this that helped to really realise some of the elements and, more importantly, to kick-start change in other areas and "infect them with enthusiasm".
Trialability	10					X	The good practice was finally launched in a pilot test. For example, the pilot validation in telepsychiatry started other discussions and other pilots in seemingly different aspects, but with the same result - integrative approach, documentation sharing, collaboration, etc. The pilot testing resulted in adjustments and changes and collaboration between several actors. The pilot testing has also attracted the interest of several stakehoalders.
Complexity	4		X				Health services are very different at European level, different organisational forms, funding models, IT systems, but we believe that the aim and target groups are similar. Given the differences in systems and approaches and languages, it is challenging to learn from each other, but the focus on sub-areas makes it easier and allows for subsequent implementation of models in the local environment with a view to necessary changes in own systems to allow for example interoperability.
Design Quality & Packaging	6			X			Jadecare is quite a big project and it was not easy to manage so many partners and to have a system that makes the work as easy as possible and helps both OGps and NAs, but the leaders made it.
Cost	9					X	Cost and funding are of course important. Some elements are underfunded, some not at all. It was necessary to fund the entry process and also to find other resources, for example, when we needed to make a lot of adjustments and changes in IT systems.
II. Outer setting							
Patient Needs & Resources	5		x				On the one hand, the needs of the patients have not been reflected because the benefit to them has been more in facilitating communication between providers, but in the context of telepsychiatry, for example, it is quite clear that the new approach facilitates communication, and overall access to psychiatric care, in cases of compensated patients. However, it is difficult to engage these patients, who may be at risk of stigmatization, in communication with stakeholders. We do it for them.
Cosmopolitanism	7				x		It was important for the intervention in the region to conduct interventions, pilot validations, IT changes, etc. using many resources. Engaging partners, sharing data and expanding the network of active supporters, partners, etc. is very important, both at the policy level and collaboratively

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
							within the practice. Therefore, we have established close cooperation with the Olomouc Region (political representation), the aftercare hospital, but cooperation within the company, doctors, IT department, etc. was also necessary.
Peer Pressure	1		X				There was no peer or competitor pressure in the intervention.
External Policy & Incentives	6			x			There are many national more or less up-to-date strategies for data and digitalisation that have a natural link to the JadeCare intervention. However, many of the strategies have been at the strategic and visionary level and have not focused much on the project at the concrete level. National strategies often lacked linkages to systems change and funding.
III. Inner setting							
Structural Characteristics	3				x		Our hospital is rather a carrier of new approaches in the region and thanks to our connection to the university we can educate future doctors, inspire them to do their thesis on the topic, etc. The organisation is quite large (by local standards) it is difficult to push for change.
Networks & Communications	2			x			The working groups had between 5 and 12 participants, so there was little need for special communication tools.
Culture	9				x		Focusing on culture is very important, even if it is sometimes approached too pragmatically. There was a need to change the way we looked at new opportunities, to educate and talk to the service provider, to get support from within. Demonstrate efficiency and effectiveness and fight the old order. This is a never-ending process. Experience shows that developing and operating a data environment is only a small part of the change. Software alone will not change the process. In the long term, the big challenge is to create a change in the culture of healthcare professionals.
Implementation Climate	6			x			The climate for implementation during JadeCare was far from optimal. Health staff were initially uninterested and the experience with Covid did not bring extra change.19 Management support and pressure for change from above is needed.
Tension for Change	7				x		The growing number of seniors, the desire to increase the prestige of the hospital, the introduction of paperlessness, etc., raises the need for new thinking in this area. However, this thinking mainly concerns new doctors, younger enthusiasts. The management feels that change is needed and would be good, but they also have to address some existential problems, e.g. lack of medicines, protective equipment, etc. Then some things go by the wayside.
Compatibility	2				x		UHO is ready to continuously introduce new and progressive solutions. However, close cooperation with the Ministry and the regional administration is needed.
Relative Priority	5				x		The project has a high priority in the organisation. There are resources allocated in the organization to work together on the solution.
Organizational Incentives & Rewards	2			x			There is no specific reward system, but experience shows that incentives can be motivating and retain participation in the project.
Goals and Feedback	2			x			Routine communication is ongoing.
Learning Climate	5				x		The organisation generally has a very good working environment with room for new ideas and solutions. But sometimes it is hard to find resources and time.
Readiness for Implementation	7				X		Conservatism within the Czech Republic has already been mentioned several times and this brings with it a kind of natural resistance to innovation and its implementation. It is not that changes are not happening, but they are happening slowly.
Leadership Engagement	8				X		The managerial support for the project was great.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Available Resources	7				X		The project was able to raise money for its wider activities, and eventually attracted the expertise and interest of regional politicians. However, some positions are hard to get, the chronic shortage of e.g. child psychiatrists, IT seniors, etc.
Access to Knowledge & Information	6				X		The project has had good access to knowledge to support the project.
IV. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	7				x		Health law in the Czech Republic is not ambitious enough and insufficient in the sense of the electronicisation of healthcare. A lot of negotiation and persuasion is needed to implement new solutions.
Self-efficacy	3				X		Sometimes it happens that an individual "moves mountains".
Individual Stage of Change	2			X			Not relevant to the project
Individual Identification with Organization	3				x		Not relevant to the project
Other Personal Attributes	1			x			Not relevant to the project
V. Process							
Planning	9					x	Planning and communication tools, cooperation, are very important for successful implementation. The JadeCare project also deals with planning. The JadeCare project has been an important experience for us.
Engaging	8				x		There was a high level of engagement throughout the project, but this could have been extended to a larger number of people. The high level of engagement facilitates implementation. We are trying to increase it, for example by training future doctors.
Opinion Leaders	7				X		Approval of the chair and support from members of specialty group committees, etc. is needed. Therefore, this is quite a crucial topic.
Formally Appointed Internal Implementation Leaders	8				x		The managerial support for the project has been massive. both from middle managers and top management, there has been big support to the implementation phase
Champions	1			x			Not relevant to the project
External Change Agents	1			X			Not relevant to the project
Executing	8				X		It is important for an organisation to be able to think about the future and to implement ideas, new approaches and, moreover, within a certain timeframe so that there is a clear development.
Reflecting & Evaluating	6				X		The PDSA tools are well chosen with sufficient explanation and support from OGP. These are certainly lessons to carry with us in future interventions.

CFIR Focus Group

Next Adopter	n.a.	**Good Local Practice**	n.a.
Setting	n.a.	**oGPs transferring**	n.a.

Date of the Meeting	n.a.	**Place**	n.a.
Start time	n.a.	**Ending**	n.a.
Participants			
Name and surname	*Organization*	*Role*	
1 n.a.	n.a.	n.a.	

	QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Intervention source				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The important thing is where the source comes from, we didn't want to source from a private entity because we are not primarily interested in commercialization. It is about validating the practice according to the needs of the doctors in the hospital. For us, it also came from within the UHO, as a motivational source of physician involvement in the process.	*Where the initial appeal comes from is important and has a significant impact on whether staff are inclined to follow or stay with the original processes.* *Documentation is not at the level of digitization in our country as it is abroad.* *Jadecare has provided resources on how to motivate doctors.* *The implementation process has been simplified thanks to the source.*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Frequent communication, involvement in the process of developing a new practice from scratch as needed. Reflecting their needs (doctors, patients and paramedical staff).	*"We were listened to, I was involved in the process from the beginning, I felt that my needs were perceived and how I could improve my work with clients therefore I had no doubts about the chosen implementation."*	
3.	If you started again the implementation process, what would you do differently?	Map the time capabilities of the IT professionals who created the technical solution. Have the finances to create or purchase a technical solution. Have directly dedicated staff to the technical solution. Map the interest of physicians and medical staff - intrinsic motivation. Educate medical staff on innovations in medicine.	*"Educate medical staff on innovations in medicine."* *"Education is important. University involvement is appropriate."*	
CONSTRUCT 2: Trialability				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	Verification of effectiveness - time, sample of patients. It helps in adjusting the implementation of processes and their acceptance by the management.	*"A well-defined group of patients who can benefit is the hardest group to select. We have had other diagnoses where it didn't make sense to continue or had to be modified to make it work."* *"It is about effective planning not only of time but also of economic resources."*	
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	By developing applications for intervention and implementation in house according to the needs of health professionals.	*"It was helpful that support was in the hospital and doctors knew who to contact and could respond proactively."* *"It was good to see that it works abroad."*	
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	Creating a better campaign for patients, working with patient organisations.	*"I think by using the PDSA cycle it has been set up correctly and there is not much to change."*	
CONSTRUCT 3: Cost				

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The costs are not only related to the implementation of the new practice itself, but also to the preparation for it. Funding is also needed for equipment, not just motivation, software etc.	*"We have a Bismark model of health care reimbursement, so the motivation of patients and health insurers is difficult."* *"It's hard to convince an insurance company that it makes sense, that you can move some care online and increase accessibility."* *New procedures often bring with them more costs but should be cheaper in the long run.*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Communication with insurers, motivation for the creation of working procedures by insurance companies.	"Insurance companies should know what documentation they require."	
3.	If you started again the implementation process, what would you do differently?	Choose a different tactic to engage insurance companies. More active involvement of Mental Health Centers, which were undergoing transformation at the time of the implementation of telepsychiatry best practices. Involvement of patient organizations.	*"Aim for insurers to engage proactively and create their own guidelines for the implementation of new practices."* *"Insurance companies, thanks to the covid, had other concerns not clinging to how to report telemedicine as it should be done.* *There could have been malpractice..."*	
CONSTRUCT 4: Culture				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The standards and decrees of the hospital influence the possibilities of work in the hospital and its development. The participation of innovators in the organization is also part of the culture. According to the set culture, most people in the organization think, then it is possible to plan the implementation of change correctly.	*" Some regulations are taken as a standard that is unchangeable..."* *"The culture is such that change is first rejected."* *"Standards bind us, such as data sharing."* *"It is important to take inspiration from abroad, even though the systems may be different. A change of mindset is important."*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	It is important to involve top management and present progressive results.	*"Multidisciplinary is also important, so there is an interaction between teams (teams resistant to change vs. resistant to change)"* *"Digitalization is one of the strategic goals of the hospital."*	
3.	If you started again the implementation process, what would you do differently?	Better to communicate good practice and change. Sensitively set up information to hospital staff. Involvement of experts, interviews with admirers who adopt praxis on intranet. It is important to work with competences within the staff.	*"Maybe more getting information out (magazine, interviews)."* *"Experts are cautious. The older ones are not enthusiastic, but the younger ones have experience with it and will infect other doctors who would like to be involved but need to see it work."*	
CONSTRUCT 5: Planning				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Jadecare has included a number of planning and analytical tools that we have learned to use that can be applied to other interventions. Empowerment to reduce negative impact.	*"Planning is important just as important with the capacity that it has, for example the area of psychiatry where we are struggling with staff shortages, this can help.* *It depends on how the group is selected and with a view to the future, when it is verified that it works, whether we can do it with a larger group.* *The plan chosen is well adapted to health systems, we couldn't find a better one."*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	Cooperation with external entities, efforts to cooperate with the Ministry of Health. Mix´n´Match has enabled a more flexible project process.	*"There are smaller hospitals that don't have as many resources, but we can help them.* *Planning as a good mapping of steps, which can be checked back."*	
3.	If you started again the implementation process, what would you do differently?	Better plan whether the solution developed in house can be scaled up and used more widely.	*"It is necessary to focus from the beginning on expanding the solution to other hospitals"*	

8.1.1.18 USL Umbria 1

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	8				x		The decision of the interventions to be implemented was internal but the implementation was possible through the use of external suppliers. The intervention of an external agent made it possible to anticipate the times
Evidence Strength & Quality	2			x			The interested parties are aware of the need for the interventions made even in the face of national guidelines
Relative Advantage	8					x	Integrating existing software systems over adding alternative solutions has an efficiency advantage, reduces training costs, and overall system management effort
Adaptability	8					x	The telemedicine platform that incorporates all clinical information is extremely flexible and portable and can be integrated easily into all business applications. In this way, if the needs or tools should change, we can adapt the intervention
Trialability	7			x			The interventions relating to empowerment and direct booking agendas are easily scalable. All the interventions that have made it possible to integrate the software cannot be scalable
Complexity	6				x		All interventions are perceived as complex and, in the case of integrations, have made it possible to disseminate the complexity of the systems among the stakeholders. However, this did not have much influence on the outcome of the intervention
Design Quality & Packaging	7					x	The usability of a software determines its success, for this reason we have given great importance to the design and user experience in the software integrations. Patient empowerment training interventions and booking diaries use tools and designs in which we could not intervene
Cost	10					x	The integration interventions with the EHR primary care proved to be very costly and this led to the delays. The other interventions were not significantly affected by implementation costs
II. Outer setting							
Patient Needs & Resources	4			x			Attention was given to patient resources only for the empowerment intervention. The course, in fact, was focused on the different levels of collaboration of patients suffering from heart failure. Software integrations and multidisciplinary teams have been implemented considering the needs of healthcare professionals
Cosmopolitanism	3		x				Unfortunately we have not yet been able to establish a network for sharing the activities carried out with other organisations. We set out to create the sharing network in the coming months
Peer Pressure	2			x			No other health organization in the Umbria Region has implemented the interventions included in JADECARE
External Policy & Incentives	2			x			At the moment there is a strong push from the government aimed at integrating territorial care with primary care (AGENAS notebooks, PNRR mission 6, ministry guidelines). Influence and relevance are minimal because JADECARE started earlier than the national push, based on internal initiative.
III. Inner setting							

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Structural Characteristics	9	x					The internal resources of the USL Umbria 1 staff employed in the process innovation, digital transition and project management settings are insufficient. This has led to the centralization of all activities in a few human resources
Networks & Communications	9	x					From the beginning of JADECARE to now the IT department has changed 6 directors, the business management has been replaced 5 times. These changes and the poor stability negatively affected the quality of the communication network
Culture	7				x		On the basis of the Quinn and Rohrbaugh model we can say that in USL Umbria 1 we have: excellent team culture low hierarchical culture lack of entrepreneurial culture high rational culture The presence in USL Umbria 1 of official diagnostic therapeutic assistance pathways has facilitated the implementation but there is no internal culture aimed at enhancing and encouraging change and streamlining processes.
Implementation Climate	8		x				The effort to implement the change cannot be rewarded, the human resources necessary to face the digital transition are insufficient and the average age of the decision-making bodies is high. These factors made implementation more difficult
Tension for Change	4			x			Although the importance of implementing a change is perceived, the implementation climate does not facilitate its implementation
Compatibility	6				x		The people involved are adherents of the rules
Relative Priority	7		x				The multiple changes of personnel and managers did not allow a correct dissemination of the implementation within the organization and consequently the importance of the project is not currently perceived
Organizational Incentives & Rewards	8	x					A limit of the public administration is given precisely by the impossibility of incentivising those who bring added value to the organization.
Goals and Feedback	2			X			The objectives and the budget to achieve them are clear
Learning Climate	6				x		The leaders express their own fallibility and need for team members' assistance and input: high level. Team members feel that they are essential, valued, and knowledgeable partners in the change process: high level Individuals feel psychologically safe to try new methods: medium level. There is sufficient time and space for reflective thinking and evaluation: low level
Readiness for Implementation	10			x			It is easy to access the information necessary to develop the intervention because the work team has many skills and we have adequate financial resources to involve the suppliers in the activities. The lack of human resources and the consequent little involvement of the leadership remain constant
Leadership Engagement	7	x					The constant turnover of managers has made it difficult to involve them
Available Resources	10	X					The time resource greatly influenced the implementation of the project. The participants participated in the project also increasing their working hours. The JADECARE project was carried out by a working group that was already undersized for the amount of activity
Access to Knowledge & Information	7				X		Various professionals were involved in the working group in order to increase the diversity of skills
IV. Characteristics of the individuals							

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Knowledge & Beliefs about the Intervention	4					x	A meeting with about 400 GPs is scheduled to share the intervention
Self-efficacy	3			X			Not relevant
Individual Stage of Change	5		X				Staff are tired due to stress levels
Individual Identification with Organization	3	x					Lack of stability and continuity in decisions, lack of personnel have created disaffection with the organization
Other Personal Attributes	N/A						[….]
V. Process							
Planning	7	X					The current JADECARE project manager was appointed in March 2022, this did not allow for proper planning of the activities
Engaging	8		X				50% of the initial members of the working group have ceased or have changed organisation, furthermore, after the changes in company and project governance, the initial objectives have been revised. For this reason some figures initially involved are not "right people in the right seats"
Opinion Leaders	6					X	Opinion leaders have been involved in IT, GPs and Cardiology. This greatly facilitated the implementation
Formally Appointed Internal Implementation Leaders	8					X	All members of the working group and the related task or responsibility have been formally appointed
Champions	9				X		The project manager coordinated all phases of the project, involved the suppliers, involved additional stakeholders during the implementation phase and managed the various implementations on the front line
External Change Agents	7	X					One of the main weaknesses was not involving external change agents who would have facilitated and supported the implementation
Executing	4			x			As indicated in the "Planning" construct, the planning was carried out in progress and with a short-term vision, therefore the implementation according to plan is not significant
Reflecting & Evaluating	7			x			Lack of time has taken away resources for this activity which we still believe is important in a well-constructed project

8.1.1.19 VH

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
I. Characteristics of the intervention							
Intervention Source	6		x				Interventions are externally developed
Evidence Strength & Quality	10					X	
Relative Advantage	10					X	

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Adaptability	9				x		At the moment no need for further adaptation
Trialability	8				x		The ability to test the intervention on a small scale; we have mix & match approach, reflect on both interventions
Complexity	8				x		We have mix & match approach and the score reflect on both interventions
Design Quality & Packaging	9					X	Since we are in mix& match we asses both
Cost	9					X	Since we are in mix& match we asses both
II. Outer setting							
Patient Needs & Resources	6		x				Social determinants partly covered
Cosmopolitanism	10					X	
Peer Pressure	5			x			No pressure, voluntary implementation
External Policy & Incentives	9				x		On national level
III. Inner setting							
Structural Characteristics	3			x			
Networks & Communications	10					X	Communication is crucial
Culture	10					X	
Implementation Climate	10					X	
Tension for Change	6				x		There is a need for integration between social and health care, but resources and systems do not support the initiatives; mostly project based initiatives
Compatibility	10					X	We were looking for such solutions
Relative Priority	10					X	
Organizational Incentives & Rewards	9						Extrinsic incentives are important, needed, but not always the main driving force
Goals and Feedback	10					X	
Learning Climate	10					X	
Readiness for Implementation	10					X	
Leadership Engagement	10					X	
Available Resources	10					X	
Access to Knowledge & Information	10					X	
IV. Characteristics of the individuals							

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Knowledge & Beliefs about the Intervention	8				x		Since mix & match approach, the individuals' knowledge and resources not equally value placed. We had to keep in mind different cultures the interventions develop abroad & implemented locally
Self-efficacy	8				x		Reasoning is related to above mentioned explanation, in addition, one intervention implemented fitted smoothly on the developing process of the current practice, the other one was relatively new to our system.
Individual Stage of Change	8				x		Reasoning is related to above mentioned explanation, in addition, one intervention implemented fitted smoothly on the developing process of the current practice, the other one was relatively new to our system.
Individual Identification with Organization	9				x		Since the intervention is developed in another health care systems, we had to keep in mind the needed time; support from both oGP leaders and groups were very positive and highly appreciated, score10.
Other Personal Attributes	9				x		Positive attitudes, time needed, incl resources
V. Process							
Planning	10					x	
Engaging	10					x	
Opinion Leaders	10					x	
Formally Appointed Internal Implementation Leaders	10					x	
Champions	10					x	
External Change Agents	9					x	There is a will also on policy level, but resources are scarce, crucial regarding the sustainability on longer term
Executing	9				x		Since mix & match approach, the accomplishing of the implementation was not equally reached with maximum scores
Reflecting & Evaluating	10					x	

CFIR Focus Group

Next Adopter	Viljandi hospital, Estonia	**Local Good Practice**	
Setting	Viljandi hospital, Estonia	**oGPs that you transfer from**	Catalan Risk Patients Stratification & OptiMedis
Date of the Meeting	July, 11th	**Location**	Viljandi hospital
Start time	14.15	**End time**	16.00

Participants			
Name and surname		*Organization*	*Role*
1	Mart Kull	Viljandi hospital	Moderator
2	Saima Hinno	Viljandi hospital	Assistant

3	Kadri Oras	Viljandi hospital	Service manager
4	Anu Välis	Viljandi hospital	Social worker
5	Eneli Tulp	Viljandi hospital	Nurse

QUESTION		SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Evidence strengths & quality				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The intervention was strongly evidence based and held appropriate quality. There have been research results available. It was easy to convince partners since the implementation of intervention held strong evidence. We experienced that much so-called pre-work was done and such interventions were seen as logical steps to continue and supported the innovative approaches taken so far. It provided access to new knowledge.	"*This module is very professional; it is just that we needed*"; "*It was just like logical step further – we had done so much with PAIK and we had noticed several stumbling blocks to reach as well as to find the "right" risk patients*"; "*Actually it was very easy to convince others as we said to them that it is broadly used abroad, the evidence of the fact that it really works, makes difference was there*"; " *the reliability of the implemented practice was the key that helped me to understand and convince others*"; "Actually *there was already practical need for this step*"; "*The provided evidence was readily usable in health care, but I missed the social determinants aspect to be considered*"; *"It was not only much information, the module gave us new knowledge, I learned a lot and it was so interesting, I can really implement this knowledge"*	Participants were enthusiastic while talking about the evidence. They said that the strong evidence-based intervention helped them to understand the importance of the implementation process. Also, during the second questions, it was still emphasized the importance of the evidence base. We constantly returned to this aspect.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We were provided extra literature; evidence sources and the illustrative materials were very useful to get better understanding and to explain the interventions as well as the need for implementation for targeted audience. Engaging all team members was important along the process.	*"We included partners and team members to the discussions during the network meeting"; "It was hard to understand at first, but the illustrative materials promoted the formation of understanding"; "We had this module (…risk stratification module..) and it really added value and the implementation as well the intentions previously were valuable"*	To diminish negative effect was not discussed.
3.	If you started again the implementation process, what would you do differently?	The intervention was strongly evidence based and held appropriate quality. There have been research results available. It was easy to convince partners since the implementation of intervention held strong evidence. We experienced that much so-called pre-work was done and such interventions were seen as logical steps to continue and supported the innovative approaches taken so far. It provided access to new knowledge.	"T*his module is very professional; it is just that we needed*"; "*It was just like logical step further – we had done so much with PAIK and we had noticed several stumbling blocks to reach as well as to find the "right" risk patients*"; "*Actually it was very easy to convince others as we said to them that it is broadly used abroad, the evidence of the fact that it really works, makes difference was there*"; " *the reliability of the implemented practice was the key that helped me to understand and convince others*"; "Actually *there was already practical need for this step*"; "*The provided evidence was readily usable in health care, but I missed the social determinants aspect to be considered*"; *"It was not only much information, the module gave us new knowledge, I learned a*	Participants were enthusiastic while talking about the evidence. They said that the strong evidence-based intervention helped them to understand the importance of the implementation process. Also, during the second questions, it was still emphasized the importance of the evidence base. We constantly returned to this aspect.

			lot and it was so interesting, I can really implement this knowledge"	
CONSTRUCT 2: Compatibility				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	It was stressed that this process was highly relevant and, also timing was good. Participants noted that there was a need for such an intervention, thus the timing was right as there was need, there was support, the innovative climate was present already. It was seen as a new, but long waited way of working, improving current practice. It was said that it fitted very well for current situation, as there were many important elements in place, e.g. need for innovations to meet challenges, supportive management, educated staff with wide experience working with risk patients as well as building up networks.	"*It really linked with out thinking"; "We saw the needs, the risk stratification module fills the bottlenecks, it is official, I mean it is evidence based and quality is assessed, it is taken seriously, it really matters*"; "*We speak same "language", the module to find the risk patients is like a "common language" to understand the real problem, challenge*"; "*I really admired its coherence, I mean same things and it made up a whole system, there was logic, and it fitted really nicely into our developments*"; "*We had done already so much to map and get to know our context to help risk patients to find the proper care pathway*"	To sum up, timing for the intervention was right and the solution the intervention provided matched the expectations, was needed in practice setting. This construct was stressed as very relevant, even while by some participants not explained further, saying only. It is important and very relevant.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	Positive effect enhanced: As it was seen as a solution for challenges noted by staff working with direct care, the benefits were noted and it was implemented in current ways of working. Doing something innovative which is acknowledge by other hospital staff, it was motivating. Also the staff felt honoured being involved in doing something innovative.	*"It is just our way of doing things, now we have one extra tool to use"; "It is just part of my work, maybe doing just in a new way"; "I do feel myself a little special of doing something special": I have noticed my other colleagues start to understand the innovative aspect PAIK holds"; "This is also called innovation, it really makes difference";*	Participants talked very proudly about it.
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	Involve more and actively policy makers, decision makers.	"*It is really sad that the policy level representatives were weakly involved*"	Not much was noted by the majority – only said it is very relevant construct. Then the aspects of policy makers weak involvement was mentioned, everyone acknowledged and supported this statement.
CONSTRUCT 3: Leadership engagement				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	The support from the management and leadership was experience crucial. It was valued. Support form top management, their real engagement made visible difference in team and supported building up needed network. Also support to team-leads by management was very crucial. Open minded and easy access to approach managers and leaders with questions and queries provided smooth way for successful implementation.	"I*t is crucial, I really saw it in the practice, for some teams it (..support..) was present and its impact was great, and in another team it was missing, it really made difference. I saw how important it was to the team that their leaders were with them and support and really ask and listen for an answer."; "Being open for the collaboration, it is important, it keeps team going and it keeps team together"; "Our leaders were really thinking along, were truly interested, asked and waited for the answers and were really interested how we do the things*"	Somehow same ideas were said by different participants, everyone was sharing thoughts. It was experienced very relevant construct in implementation of oGP and briefly also the supportive climate and readiness for change were mentioned. It was great to see how deeply participants valued their leadership.
2.	How have you enhanced the positive effect or diminished the negative effect of	Experiencing the feeling "being involved" is important – from both sides – the management and the leaders as well as staff	*"Everyone is important to make it all work"; "Actually this is a way of doing real work, it is just like a norm for our*	It was noted that it is not easy to provide ideas of how we diminished the negative effect. One participant nicely said

	this construct in your implementation process?	itself. The intervention was supported as it supported also the organizational goals. Promote the implementation initiative in various occasions were organization was hosting important visitors, meeting etc.	*organization, we really care about people"; "We were invited to talk about PAIK in many occasions";*	– "Since this construct, actually all of them are extremely important, very relevant in the implementation process, it does not involve negative effect".
3.	If you started again the implementation process, what would you do differently?	Involving more actively policy makers. As this time, it was a local initiative with scaling up in two other counties, then with a new start we would aim much broader audience, involve more counties, hospitals, municipalities.	*"Again, I would say that the policy makers involvement was low"; "We should aim much higher, just cover all country, at least the majority if not all";*	
CONSTRUCT 4: Planning				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Planning is a foundation to successful implementation. Clear plan, explanation and constant support provided by oGP and local leads was important. Much of the planning is prepared in advance, alternatives are mapped and discussed as "real life" may provide some needed deviations.	*"Step-by-step, the roles were clear, it laid foundation for all process, I know what to expect and there were really alternatives discussed if something would not work"; "Everybody know how, what, why and when. Someone is taking the lead, common understanding is formed"; "I really appreciated the structure, and it made difference"; "There is an expression – if the pool is not filled, what then – I mean there was a plan B if external factors delayed the process"; "I appreciated the flexibility, it was there"; "Some people "had to hold several hats" (in Estonian: nagu Hunt Kriimsilm (this expression originates from Estonian famous children programme; read: someone who really has to perform several tasks and has all needed skills") and they managed"; "I would stress the open mindedness, it is very important is such a process"; "We all felt connected, involved and it is such a great feeling, actually I did not realize we were doing something new, it became so ordinary part of my daily work";*	"Very important, crucial" were the words constantly came up and were used while discussing this construct.
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	It was crucial to organize regular meetings both with leads and sub-groups. Nevertheless, also irregular meetings had to take place, flexibility is needed. Monitoring of the process became a regular practice. The materials provided by Jadecare and local implementation process were discussed and shared, access granted. Updating of the materials and processes was continuous. The risk was noted that one person would not get too much on his/her shoulders, we kept an eye on each other.	*"We had so many meetings and we talked a lot and explanation was provided, and we could really ask all questions, very supportive atmosphere"; "Many details were discussed, sometimes too many, but it still was useful, many ideas and alternative options were discussed and some of them had to be even implemented"; "We did prepare several worksheets, and they were tested and updated, actually now I acknowledge this was very useful work we did, I see the benefit now";*	
3.	If you started again the implementation process, what would you do differently?	To check timeline once again, it worked this time, but to share it with all partners and update is demanding, but rewarding.	*"Really keep an eye on the timeline"; "Hard to say, it has been very intensive period, I have learned a lot, for sure we would do something differently as we have now got through the process";*	
CONSTRUCT 5: Empowerment				

1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Having enough motivated staff is crucial. Their engagement is driving force. Their curiosity, willingness to learn and risk taking approaches are also needed - this forms the base. Team is important as well as sense of belonging. Team members became real change agents, they understood their role, they were listening to, they performed as expected and they provided support and shared their knowledge.	*"People, people, people – this is a key"; "To keep everybody onboard"; "We have a great team, I know what I am talking about. I know that it is not always like that in every team and therefore I do appreciate what we have"; "Our team-lead know how to engage us - we all had a role to full-fill, had tasks"; "Champions, this is a key. They need to be present and they were"; "Maybe we were lucky that we had enough time for planning as we really had time to ask, discuss and "test it", it workes"; "We were lucky, this new way of doing things became my usual way of working."; "Our network has really grown, we share similar passion and we see that this innovative solution provides us something we have been really looking forward";*	
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	The role of team leads in engaging staff is very important. Team members and teams were kept updated and milestones were celebrated and acknowledged. Forming the teams has been a learning process. It was a challenge to keep team members motivated and engaged once the process slowed down due to the external factors, it is hard but very important to keep staff engaged. They were provided meaningful tasks as well as they had an meetings with leadership to share their concerns and/or progress.	*"I was supported, we discussed the progress and we also shared the challenges we faced"; "We were informed about the progress, even if sometimes the information was not known, we still found it is good to update each-other constantly, even then there were no news";*	It was mentioned that there are similar aspects already discussed previously.
3.	If you started again the implementation process, what would you do differently?	Top-down approach will be discussed and implemented	"More engagement from policy level";	

8.1.1.20 ZZZS

CFIR Survey

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
VI. Characteristics of the intervention							
Intervention Source	8				X		Our implementation was positively influenced by the fact that the intervention came from outside, we took advantage of the opportunity to participate in the Jadecare project, and we also had a strong internal incentive, as the ZZZS Strategic Development Program requires us to research and introduce new payment models.
Evidence Strength & Quality	9				X		We carefully studied Optimedis' results, also obtained other analyses in the field of CKD, and based on the findings, we decided to go through the implementation.
Relative Advantage	8				X		All stakeholders saw a relative advantage in the chosen intervention: specialist nephrologists will get a renewed payment model (sooner than without JAdecare), ZZZS fulfilled the requirements of the Strategic Development Program, and patients got the opportunity to be educated and empowered.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Adaptability	8					X	We think it is important that due to legal restrictions, we were only able to implement a part of the Optimedis model (if we had insisted on the entire model, then it would probably not have been implemented at all).
Trialability	5			X			In our health system, we do not have the possibility to finance pilot projects, but also because of the small size of the country and the number of nephrology teams, we decided to implement it nationally.
Complexity	9		X				It was difficult to coordinate all stakeholders (ZZZS, professionals at the primary and secondary level and patients), which meant a more demanding implementation.
Design Quality & Packaging	7				X		We believe that adequate promotion of the intervention is of utmost importance for its acceptability in practice.
Cost	5		X				A large part of the costs (work of external partners, costs of additional tests, additional costs in the system due to the renewed payment model) were covered by the stakeholders from their own funds.
VII. Outer setting							
Patient Needs & Resources	9				X		Empowering patients is one of the main goals of the intervention, so their timely involvement was of utmost importance.
Cosmopolitanism	8				X		We believe that we have an extensive network of cooperation with the profession, from which we also receive a lot of research and data that contribute to the success of the intervention.
Peer Pressure	2			X			In our opinion, peer pressure is not an important factor, as we undertake changes primarily to regulate our payment models (in accordance with our rules, legislation, options).
External Policy & Incentives	9				X		An important factor is the implementation of the Strategic Development Program, the possibility of participation in an international project, cooperation with the Slovenian Society of Nephrology.
VIII. Inner setting							
Structural Characteristics	5			X			In this factor, we find both positive influences (narrowly specialized area of CKD) and negative influences (size and bureaucratization of ZZZS and the project itself).
Networks & Communications	10					X	Communication within the NAWG was up-to-date and responsive and as such significantly contributed to the success of the implementation.
Culture	2			X			This factor did not significantly affect the success of the intervention, as we always operate in accordance with the standard culture and values.
Implementation Climate	5		X				The implementation climate is very positive within the NAWG. However, the NAWG does not have the final say in implementing the intervention, decision-makers at higher levels do, but they can also decide differently than the NAWG suggests.
Tension for Change	9					X	All stakeholders (ZZZS, medical profession, patients) perceived a great need for changes (regulation of the payment model, paid additional services, opportunity for empowerment), which positively contributed to the engagement of the entire NAWG and the success of the implementation.
Compatibility	2			X			At the operational level (NAWG), we have not detected any problems with this construct.
Relative Priority	5				X		The entire NAWG was aware of the priority of this task (implementation within project deadlines, basis in the Strategic Development Program). Nephrologists also wanted changes in their field as soon as possible, which is why they approached the implementation of this intervention as a priority.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Organizational Incentives & Rewards	5			X			In the case of this intervention, members did not receive any incentives or rewards that would positively influence the implementation of the intervention. We treated it as other regular work.
Goals and Feedback	4		X				Objectives were clearly defined, and reporting within the NAWG took place on a regular basis. But there was too much additional reporting in Jadecare, which took up resources.
Learning Climate	8					X	As a department for the development and analysis of payment models at ZZZS, we already have a very positive learning climate, encouraged by the head of the department. Our job is to update and introduce new payment models, as well as cooperation with the profession, whose opinions and contributions we take into account to a large extent.
Readiness for Implementation	6			X			The participating stakeholders (NAWG) are committed to implementation, but the wider political environment is beyond the reach of the NAWG, their behaviour is unpredictable.
Leadership Engagement	8				X		The managements of all stakeholders support the implementation of the intervention.
Available Resources	8		X				This intervention was given little time (the duration of the project), not enough personnel, not enough resources (to use own resources), which had a negative impact on the implementation (some tasks were abandoned, some were postponed outside the duration of Jadecare).
Access to Knowledge & Information	6				X		We encountered no obstacles with this construct. We got what we needed (analyses, data, additional explanations...) without any problems.
IX. Characteristics of the individuals							
Knowledge & Beliefs about the Intervention	10					X	All individuals in NAWG approached the collaboration with enthusiasm, we shared knowledge and learned from each other, as each is an expert in his field.
Self-efficacy	5			X			We believe that the entire NAWG group performed their work adequately and correctly.
Individual Stage of Change	5				X		All individuals at NAWG are ready for change.
Individual Identification with Organization	1			X			We believe that this construct is not relevant to the implementation.
Other Personal Attributes	1			X			Not relevant.
X. Process							
Planning	8				X		Good planning is crucial to the success of the implementation. However, for the successful implementation of the plan, it is also important to find enough resources.
Engaging	10					X	Selecting the right people to participate in the NAWG is critical. They must be ready to cooperate with enthusiasm, be experts in their fields, ready to learn. And we think that our implementation is successful mainly thanks to this construct.
Opinion Leaders	9				X		Nephrologists participating in the NAWG are opinion leaders in their field and will readily transfer their views on this intervention to the entire profession and practice.
Formally Appointed Internal Implementation Leaders	8				X		The coordinator plays an important role in the implementation of the project and a good coordinator (project manager) can have a strong positive influence on the implementation.

CONSTRUCT	RELEVANCE	INFLUENCE					REASONING
		--	-	n	+	++	
Champions	8				X		The head of the area for the development and analysis of payment models ensured that the intervention was placed among the priorities within the organization.
External Change Agents	8				X		Nephrologists participating in the NAWG are leaders and authorities in their field and positively directed the implementation of the intervention towards the quadruple goal.
Executing	5		X				During the project, it turned out that the plan was too complex and the implementation of some activities is more complex than we originally thought. Stakeholders' expectations must be properly taken into account and directed, time consumption was high.
Reflecting & Evaluating	7				X		Further steps depend on evaluation and reflection. We carried out PDSA, on the basis of which we adjusted our activities, found out when more promotional activities should be carried out, when to involve additional colleagues, stakeholders...

CFIR Focus Group

Next Adopter	ZZZS	**Local Good Practice**	Integrated care in nephrology
Setting	Slovenia	**oGPs that you transfer from**	Optimedis
Date of the Meeting	31.5.2023	**Location**	On-line
Start time	12:00	**End time**	13:30

Participants

	Name and surname	*Organization*	*Role*
1	Martina Zorko Kodelja	ZZZS	Moderator, Project manager
2	Karmen Janša	ZZZS	Assistant, Medical doctor
3	Anka Bolka	ZZZS	Policy Board Member
4	Marjeta Zupet	ZZZS	Analytics expert

	QUESTION	SUMMARY STATEMENT	QUOTES	OTHER REMARKS
CONSTRUCT 1: Evidence strengths & quality				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	We collected a lot of evidence that the Optimedis model is effective, as well as a lot of evidence about the necessity of changes in the field of Chronic Kidney Disease, and with this evidence we convinced all the participants and the management of ZZZS that we should start the implementation in the first place.	We have evidence that CKD is important, common, according to research, 10% of the population has Chronic Kidney Disease, which is about as many as diabetics. Politicians are also aware of this.	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We searched for additional research in the field of chronic diseases from the past and from other environments, and presented them to the NAWG and the management of ZZZS.	The importance of CKD should be recognized by medical and political leaders.	The participants were satisfied with their work in the field of research.

			We have enhanced it with additional research.	
3.	If you started again the implementation process, what would you do differently?	In terms of evidence, we don't see what else could have been done better or differently. We obtained all the research and analyzes that were known or carried out by colleagues in the NAWG, which were available in the professional literature, and we also carefully analyzed all the data from this field that is collected by the ZZZS.	We have exhausted our data. We would provide additional funding for external participants of the NAWG, who were not paid anything for their work.	[….]
CONSTRUCT 2: Complexity				
1.	Meeting patient needs with one completely trustful and approachable resource is the most important idea in our implementation process.	The complexity of the implementation was manifested due to the fact that it was necessary to coordinate the primary and secondary health care levels. Another problem is the agreed additional tasks in the reference clinics at the primary level – how will they manage it in practise. An additional problem is the fact that all external partners in NAWG are health professionals, full-time employed in health care and therefore do not have much time to devote to such projects. An additional problem with national implementation is the fact that there are fewer and fewer nephrology specialists, as they are leaving for the private sector.	I see a negative effect mainly in the communication between the primary and secondary level. Resistance to something new, regardless of importance. All external workers are regularly employed in healthcare and lack time to participate in such a project.	Participants upset over occasional primary level negativity.
2.	Cooperation and communication within the team had a great impact on staying positive about implementation and maintaining the focus on the importance of the construct.	Through frequent formal and informal contacts with NAWG participants. Impressed the profession with the publication of articles and presentations at conferences. In the future, healthcare providers in the field of CKD will also receive more funding through a new billing model and new clinical pathways.	We are reducing the negative effect with a new billing model so that more money will reach these health care providers.	[….]
3.	It would be more helpful if we were able to conduct a larger study among patients and general practitioners beforehand to have a better understanding of their needs in everyday life and the challenges they face	Perhaps it would make sense to involve someone from the Ministry of Health at the very beginning of the implementation, who would help connect all the participants. However, at the same time, there is also a concern as to whether such a move would simply increase the complexity of the implementation. Additional funds (payment) should be provided for all participants who participated voluntarily and free of charge. Perhaps through the payment of the participants, their greater commitment to mutual coordination could be achieved.	Would it make sense to involve someone from the Ministry of Health right from the start? In the case of a stable ministry, yes, but in the case of ours, no. Provide resources for all participants.	[….]
CONSTRUCT 3: Patient needs & resources				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Addressing patient needs and empowering CKD patients is one of the main goals of implementation.	We put the patient at the center of the new clinical pathway and payment model. All new services, education and prevention... all this leads to greater patient empowerment.	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	We included a competent patient representative in the NAWG. All products of the project/implementation were also given for review and commenting. Educational materials were prepared in cooperation with the patients' association.	We included him (patient representative) in all implementation activities important for patients.	[….]

3.	If you started again the implementation process, what would you do differently?	NAWG or ZZZS independently would be more active in promoting activities in the patient association and obtaining their opinions.	For us (NAWG) to have more presentations at the patient association. Obtain the opinions of the entire patient association on an ongoing basis.	[….]
CONSTRUCT 4: Networks & Communications				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	At the start of the project and the establishment of the NAWG, we encountered a problem because not all stakeholders had the same understanding of the plans, goals, and time frames of the project/implementation. We quickly overcame this problem with appropriate explanations, regular formal and informal conversations and meetings. The quality of the network was also demonstrated by the fact that we included leaders in the field of nephrology in the NAWG, who were themselves strongly interested in change in the field of CKD.	Many stakeholders are involved (in the implementation), and without joint communication, each of them could not do anything for themselves. At the very start, we almost gave up because we did not have a unified understanding of the implementation plans. Engagement of those involved, leaders in their fields - a successful network	[….]
2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	With constant awareness of the importance of constant communication and exchange of information and conscious work in this area.	With constant mutual information sharing. That we all understood the content equally.	Those present at the focus group noted with relief that this construct, despite a bad start, then developed in a positive direction and contributed most crucially to the success of the implementation.
3.	If you started again the implementation process, what would you do differently?	At the beginning of Jadecare, we already had problems internally at ZZZS, because we, who were involved in the project imagined the goals of the intervention in a different way than the management of ZZZS. We came together with appropriate explanations and additions to our plans. We had the same problem again when establishing the NAWG, as different stakeholders had different ideas of what should be achieved within the framework of Jadecare. So, if we were to start again, we would have prepared precise plans, analyzes and explanations for all stakeholders from the start.	We got off to a bad start. We all thought we knew everything. Then we had to equate the different levels of understanding.	[….]
CONSTRUCT 5: Engaging				
1.	Please, describe the specific reasons for the consideration of the construct as highly relevant in your implementation process.	Selecting the right people to participate in the NAWG is critical. They must be ready to cooperate with enthusiasm, be experts in their fields, ready to learn. And we think that our implementation is successful mainly thanks to this construct.	We were lucky with the NAWG selection. Enthusiasts and the best experts in the field of nephrology. We had the most problems with the selection of the primary level and prevention representative.	Participants talk fondly about the nephrology specialists.

2.	How have you enhanced the positive effect or diminished the negative effect of this construct in your implementation process?	During the implementation of the intervention, we constantly informed the rest of the professional public and other stakeholders about our activities, which is why we paid a lot of attention to the joint preparation of articles and appearances at professional conferences. With this, we prepared the entire nephrology profession throughout the country for implementation of the new payment model and new clinical pathways.	Through the preparation of articles and promotions at conferences.	[….]
3.	If you started again the implementation process, what would you do differently?	If we were to start again, we would devote more time and effort to selecting primary level representatives, as this was the NAWG's only weak point. We would make use of more connections and acquaintances to find one, and insist on greater proactivity on the part of the primary level representatives.	Find a better primary level representative.	[….]

8.2 Annex 2: Survey for the satisfaction of Next Adopters with the original Good Practices' leaders support and follow-up

Please take 5 minutes to complete this form of the evaluation of the support and follow-upgiven by the leaders of the original Good Practices during the pre-implementation phase conducted in the first year of JADECARE.

Your feedback will help us assess the extent to which we have met both aims and expectations. All answers obtained are strictly anonymous; only aggregated data will be analysed and reported.

Demographics	
Country	
Organization's name	
Sector	
	National/regional MoHs (health system reps)
	Health Technology Assessment Agencies/insurances
	HealthCare Professionals/Experts/work force (Physicians, Nurses/ Care providerorganizations)
	Researchers/AcademiaDigital Health Industry
Age	
	20-29
	30-39
	40-49
	50-59
	60++
Years working in the institution	

Education	
Degree	
	Bachelor of Science
	Master of Science
	Doctor of Philosophy
	Post Doctoral
	Other
Specialization	
Have you participated in any other project adapting good practices in local settings?	
	Yes
	No

Support and follow-up of the original Good Practices (oGPS)						
Select the original Good Practices you are transferring from. (If you adopt a Mix and Match approach, please select one of the oGPs you transfer from. The survey will let you answer about the others later.)						
	Basque Health Strategy in Ageing and Chronicity: Integrated Care (Basque Country)					
	Catalan Open Innovation Hub on Ict-Supported Integrated Care Services for Chronic Patients (Catalonia)					
	The Optimedis Model-Population-Based Integrated Care (Germany)					
	Digital Roadmap towards an integrated Health Care Sector (Region of South Denmark)					
Please rate your perception of the general involvement of the oGP leader in the following dimensions:						
General support						
	No support	Very poor	Poor	Fair	Good	Very good
Technical support						
Scientific support						
Support during tasks						
	No support	Very poor	Poor	Fair	Good	Very good
The support you received from the oGP leaders during the Needs and scopedefinition (Task X.1)						
The support you received from the oGP leaders during the Situation Analysis (Task X.2)						
The support you received from the oGP leaders during the Development of the Local Good Practice and Local Action Plan (Task X.3)						
Provision of information/feedback						
The information provided by the oGP leaders and access to materials that enable the transfer of the practice						
The access to more precise topics, contact with experts of the oGP						
The feedback provided by the oGP leaders to the work developed by your team						
Meetings/attention to questions and demands						
The frequency of follow-up meetings organized by the oGP leaders, the content and how they were conducted						
The bilateral attention and answers provided by the oGP leaders, in case particular questions were sent						

Please write any other additional comment which is considered to assist in the development of the evaluation

Are you transferring Core features from any other oGP? If so, please select which and answer to the evaluation questions shown after	
	Basque Health Strategy in Ageing and Chronicity: Integrated Care (Basque Country)
	Catalan Open Innovation Hub on Ict-Supported Integrated Care Services for Chronic Patients (Catalonia)
	The Optimedis Model-Population-Based Integrated Care (Germany)
	Digital Roadmap towards an integrated Health Care Sector (Region of South Denmark)

If so, the same questions were answered for each of the applicable oGPs.

8.3 Annex 3: Survey for the assessment of implementation strategy

Dear Next Adopter,

As part of the assessment of the quality assurance of implementation, WP3 wants to assess the implementation process, the impact of the implementation strategy and its usability.

To the means, a survey has been designed with the objective of compiling the feedback of the Next Adopters about all these aspects. It will take you no longer than 15 minutes to complete it. Your responses are anonymous and all the information will be analysed in aggregated form.

Section 1: Implementation process

1. In which manner has the strategy helped to plan and implement your Local Good Practice?

Please type here…

2. In which way has the implementation strategy helped you to detect problems, bottlenecks and/or deviations during the implementation?

Please type here…

3. To what extent has the implementation strategy helped you to define and implement mitigation actions to solve problems, bottlenecks and/or deviations?

Please type here…

4. What is your opinion on the way the strategy was communicated to the Next Adopters? (Documents for each specific phase, explanatory sessions, etc.)

Please type here…

5. How do you value the support and guidance received by Work Package 3 - Evaluation as strategy developers? (Resolution of doubts, proximity, etc.)

Please type here...

Section 2: Impact of the implementation strategy

6. Please use the following scale to rate how much you agree with the statements below:

	Strongly disagree 1	*Disagree 2*	*Neither Agree nor Disagree 3*	*Agree 4*	*Strongly Agree 5*
I think that the implementation strategy has helped to design an appropriate practice (relevant, compatible, aligned and fit to local needs)					
I think that the implementation strategy has helped to design a feasible practice (high probability to be successfully used or carried out within a given setting)					
I think that the implementation strategy has helped to implement the local practice as it was conceived originally or as it was intended by members of the NAWG					
I think that the implementation strategy has helped to implement a practice highly integrated within the local service setting					
I think that the implementation strategy has helped to implement a sustainable local practice (high probability to be maintained or institutionalized within a service setting)					

Section 3: Usability of the implementation strategy

7. Please use the following scale to rate how much you agree with the statements below:

	Strongly disagree 1	*Disagree 2*	*Neither Agree nor Disagree 3*	*Agree 4*	*Strongly Agree 5*
I think that I would like to use this implementation strategy frequently					
I found the implementation strategy unnecessarily complex					
I thought the implementation strategy was easy to use					
I think that I would need the support of a technical person to be able to use this implementation strategy					

I found the various components of this implementation strategy very well integrated					
I thought there was too much inconsistency in this implementation strategy					
I would imagine that most people would learn to use this implementation strategy very quickly					
I found the implementation strategy very cumbersome to use					
I felt very confident using this implementation strategy					
I needed to learn a lot of things before I could get going with this implementation strategy					

8. Please, use this space for additional feedback that you would like to give about the JADECARE implementation strategy.

Please type here...

8.4 Annex 3: Implementation Evaluation Survey

Evaluation of Implementation phase

Please take 5 minutes to complete this form in order to assess the impact of the JADECARE project in your country.
Your feedback will help us assess the extent to which we have met both aims and expectations. All answers obtained are strictly anonymous; only aggregated data will be analyzed and reported.

* Indicates required question

Demographics

1. Country *

2. Organization's name *

3. Sector *

Check all that apply.

- [ ] National/regional Ministry of Health
- [ ] Health Technology Assessment Agencies/insurances
- [ ] Healthcare Professionals (Physicians, Nurses)
- [ ] Researchers/Academia
- [ ] Digital Health Industry

4. Age *

Mark only one oval.

- 20-29
- 30-39
- 40-49
- 50-59
- 60++

5. Years working in the institution *

Education

6. Degree *

Mark only one oval.

- Bachelor of Science
- Master of Science
- Doctor of Philosophy
- Post Doctoral
- Other

7. Specialization *

8. Have you participated in any other project adapting good practices in local settings? *

Mark only one oval.

- ◯ Yes
- ◯ No

9. Select the original Good Practices you are transferring from. *

Check all that apply.

- ☐ Basque Health Strategy in Ageing and Chronicity: Integrated Care (Basque Country)
- ☐ Catalan Open Innovation Hub on Ict-Supported Integrated Care Services for Chronic Patients (Catalonia)
- ☐ The Optimedis Model-Population-Based Integrated Care (Germany)
- ☐ Digital Roadmap towards an integrated Health Care Sector (Region of South Denmark)

OVERALL EXPERIENCE: **Measuring objectives at Joint Action level**

Objective 1. To support and reinforce digitally enabled integrated person-centered care (DEIPCC) in 24 European settings with different degrees of maturity

10. 1. Was there, in your city/region/country, any care pathway reorganization and/or change management that came as a result of the JADECARE implementation? *

Mark only one oval.

- ◯ Care Pathway reorganization
- ◯ Change management: including all process (not necessarily patient related)
- ◯ Both
- ◯ Other (please specify)

11. Comments:

12. 2. Did you increased your capacity to implement Digitally-Enabled Integrated Person Centered Care (DEIPCC) in your region? *

Mark only one oval.

- Extremely
- Very
- Moderately
- Slightly
- Not at all

OVERALL EXPERIENCE: **Measuring objectives at Joint Action level**

Objective 2. JADECARE is useful for governments´ commitment to support for further building the capacity to deliver integrated person-centered care

13. 3. During JADECARE, did you finally increased your implementation capabilities, had a small scale deployment (piloting) or a large scale deployment (system level)? *

Mark only one oval.

- ◯ Increased implementation capabilities
- ◯ Small scale deployment (piloting)
- ◯ Large scale deployment (system level)
- ◯ Neither
- ◯ Other (please specify)

14. 4.Was the scope of your implementation deployment finally aligned with your vision before JADECARE started? (The same survey was launched to NAs before the start of the Joint Action)? *

Mark only one oval.

- ◯ Yes
- ◯ No, we delivered a larger scope implementation
- ◯ No, we delivered a smaller scope implementation

OVERALL EXPERIENCE: **Measuring objectives at Joint Action level**

Objective 4. To improve next adopters´ digital transformation

15. Did you have any confirmed changes in the digital services of your region induced by the JADECARE implementation? If yes, please provide an estimation of the ratio of healthcare services digitalized over the healthcare services targeted to be digitalized in your local site thanks to JADECARE implementation and specify the area of application: *

Check all that apply.

- [ ] No
- [ ] Yes, at digital health system infrastructure and information and process management systems
- [ ] Yes, at data analytics at individual or population level
- [ ] Yes, at coordination and communication systems
- [ ] Yes, at citizen empowerment tools, patient reported data and tele-medicine
- [ ] Other: _____

16. (Continued from previous question) If you selected yes to the previous question, please specify ratio

_____

_____

_____

_____

_____

17. Comments:

_____

_____

18. 6. Did the end users of your health system perceive an improvement of the digital services in your region after JADECARE? *

Mark only one oval.

- ◯ Extremely
- ◯ Very
- ◯ Moderately
- ◯ Slightly
- ◯ Not at all

19. Comments:

_____

_____

_____

_____

_____

20. 7. Were any of your organization's software programs either improved or updated due to JADECARE? *

Check all that apply.

- ☐ No
- ☐ Yes, at digital health system infrastructure and information and process management systems.
- ☐ Yes, at data analytics at individual or population level
- ☐ Yes, at coordination and communication systems
- ☐ Yes, at citizen empowerment tools, patient reported data and tele-medicine
- ☐ Other: _____

21. (Continued from previous question) If you selected yes to the previous question, please specify the number

22. Comments:

23. 8. Were any of your organization's infrastructure/hardware either improved or updated due to JADECARE? If yes, please define the number and area of application *

Check all that apply.

- [ ] No
- [ ] Yes, at digital health system infrastructure and information and process management systems
- [ ] Yes, at data analytics at individual or population level
- [ ] Yes, at coordination and communication systems
- [ ] Yes, at citizen empowerment tools, patient reported data and tele-medicine
- [ ] Other: _____

24. (Continued from previous question) If you selected yes to the previous question, please specify the number

25. Comments:

26. 9. Approximately, how many individuals have access to new services and infrastructure created by JADECARE in your local region? *

Number:

27. Comments:

OVERALL EXPERIENCE: **Measuring objectives at Joint Action level**

Objective 5. To support next adopters in facilitating
the sustainability of the practice with plans for actions at local/regional/national level

28. 10. According to your perception, to what extent will the local practice that you implemented in JADECARE be sustainable after the end of the Joint Action? *

Mark only one oval.

- ◯ Extremely
- ◯ Very
- ◯ Moderately
- ◯ Slightly
- ◯ Not at all

29. Comments:

Measuring objectives at Joint Action level

Objective 7. To improve knowledge and skills of transfer methodologies and tools

30. 11. To what extent did the professionals that participate in the implementation of JADECARE improved their knowledge and skills of the of transfer methodologies? *

Mark only one oval.

- ◯ Extremely
- ◯ Very
- ◯ Moderately
- ◯ Slightly
- ◯ Not at all

31. Comments:

OVERALL EXPERIENCE: **Measuring objectives at Next Adopter level**

32. 12. To what extend were the needs of your local site covered by the implementation of JADECARE? *

Mark only one oval.

- ◯ Extremely
- ◯ Very
- ◯ Moderately
- ◯ Slightly
- ◯ Not at all

33. 13.In case you transferred a risk stratification feature, which is the target population that has been stratified?

Mark only one oval.

- ◯ No transfer of risk stratification feature
- ◯ <1.000
- ◯ 1.000-10.000
- ◯ 10.000-100.000
- ◯ 100.000-1.000.000
- ◯ >1.000.000

34. 14. In case you transferred patient empowerment features, how many citizens are using the tools implemented in JADECARE?

Number:

_____

35. Comments:

_____

_____

_____

_____

_____

36. 15. Have you considered PROMS and/or PREMs for the evaluation of your local good practice? *

Mark only one oval.

- PREMs
- PROMs
- Both
- None

37. Comments:

38. 16. To what extent did you created or modified any health policies as a consequence of the implementation conducted in JADECARE? *

Mark only one oval.

- Extremely
- Very
- Moderately
- Slightly
- Not at all

39. Comments:

40. 17. Did you launch training and research programs as a consequence of the implementation deployed in JADECARE? *

Mark only one oval.

- Yes
- No

41. If yes, how many programs?

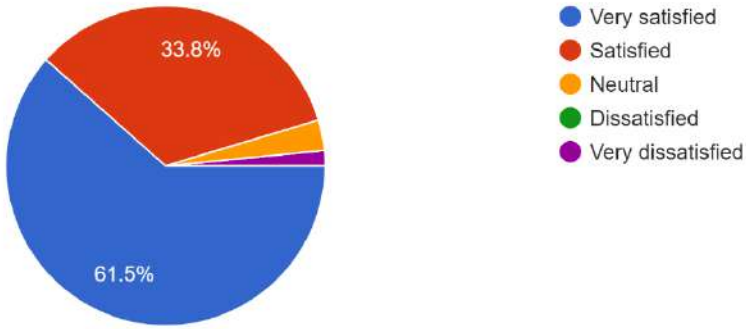
42. If yes, please, define the number of participants.

43. Comments:

8.5 Annex 4: Results of evaluation of Thematic Workshops

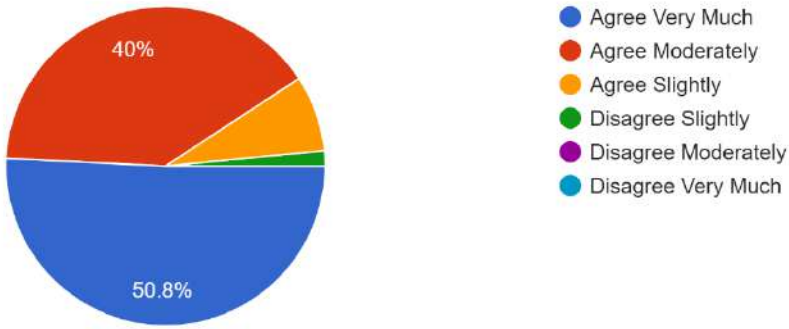
1. Rate your overall level of satisfaction with the thematic workshop.

65 responses



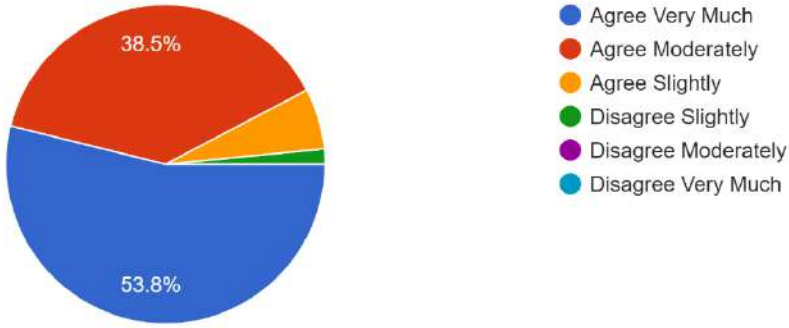
2. Overall, the knowledge I acquired during this workshop is applicable to my implementation process.

65 responses



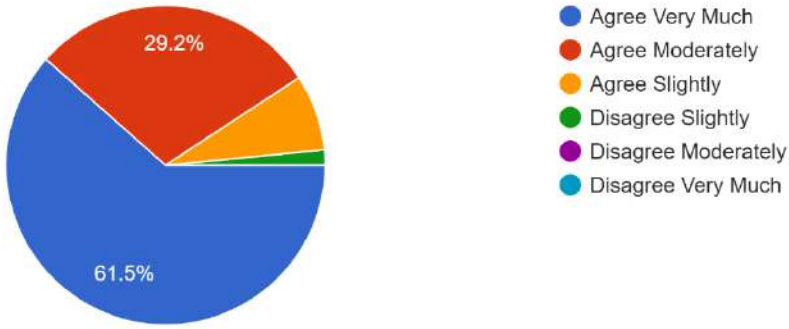
3. Overall, the knowledge I acquired during this workshop meets my needs

65 responses



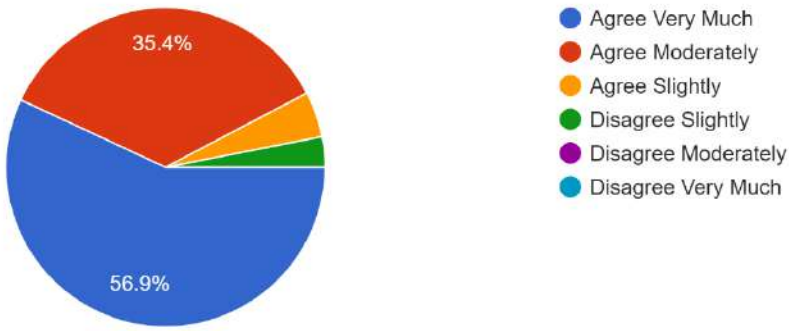
4. Overall, I am satisfied with the amount of knowledge exchange.

65 responses



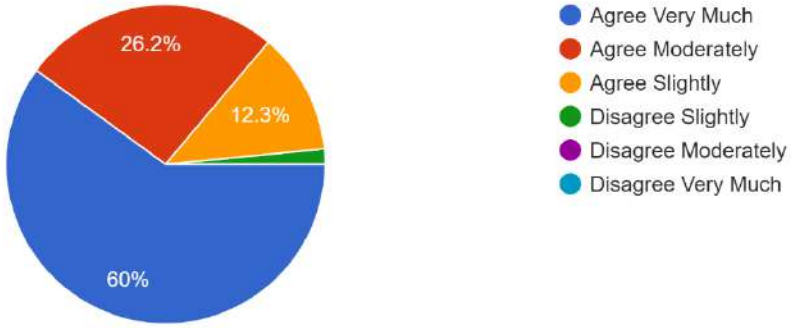
5. I am generally able to use what I learn in the workshop during the implementation process

65 responses



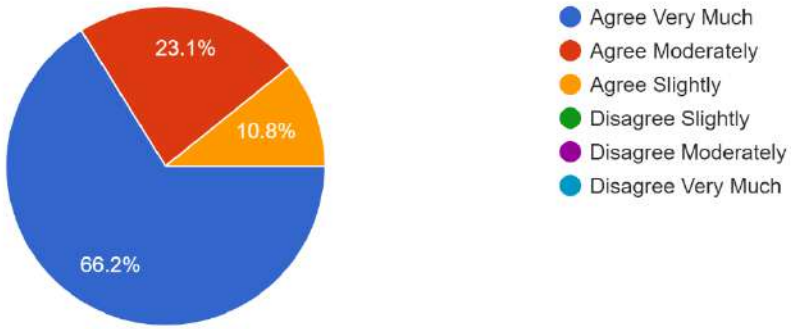
6. The thematic workshop helped build my capacity to respond to the needs of the NAWG

65 responses



7. The training increased my understanding about the key issues related to working on the implementation of this core feature

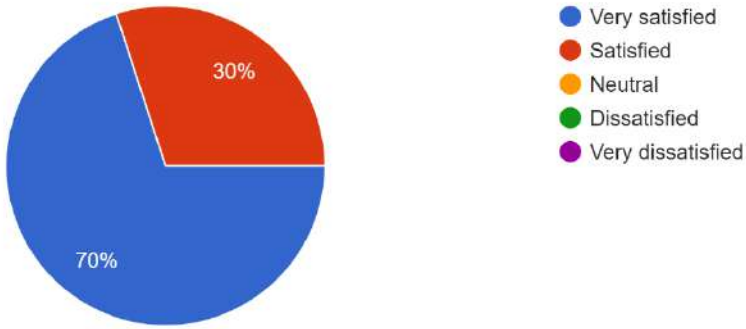
65 responses



8.6 Annex 5: Results of evaluation of Key Learning Workshops

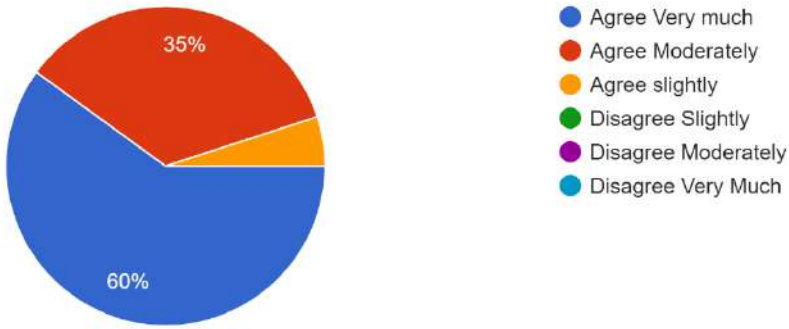
Rate your overall level of satisfaction with the implementation key learning workshop

20 responses



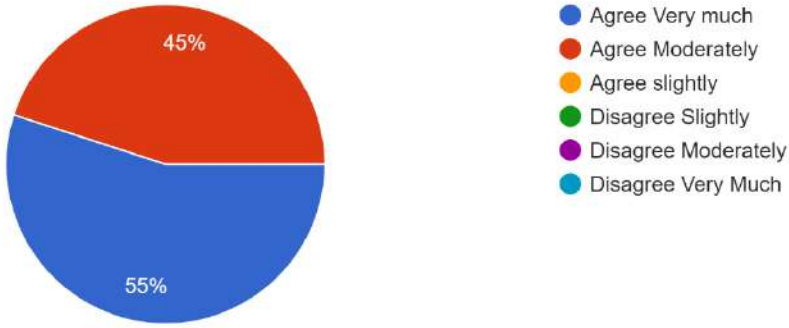
Overall, the knowledge I acquired during this workshop is applicable to my implementation and sustainability process

20 responses



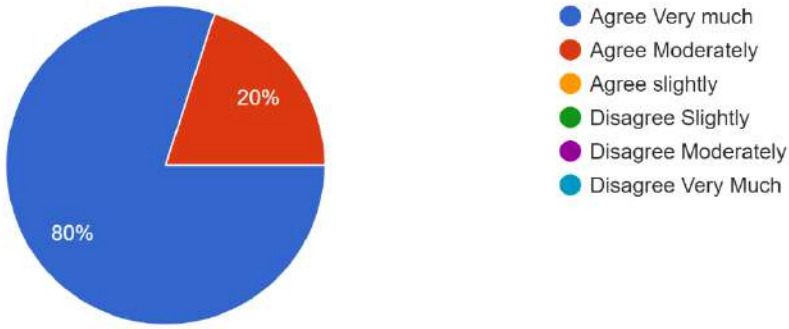
Overall, the knowledge I acquired during this workshop meets my needs

20 responses



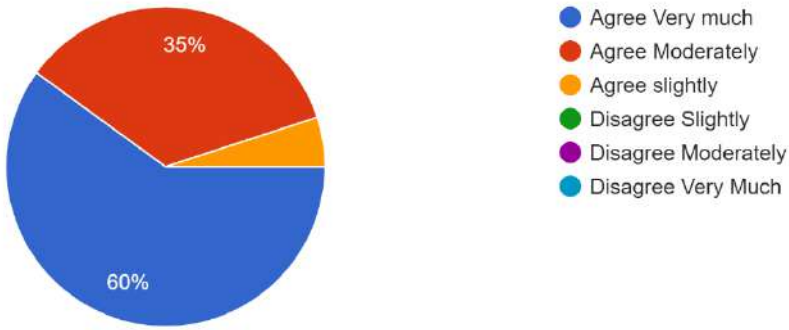
Overall, I am satisfied with the amount of knowledge exchange

20 responses



I am generally able to use what I learn in the workshop during the implementation and sustainability process

20 responses

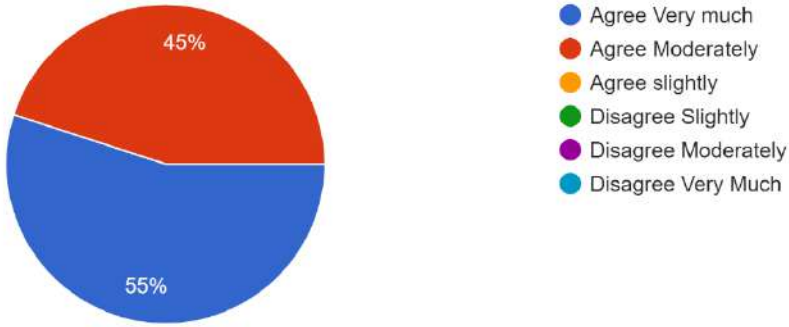


The implementation key learning workshop helped build my capacity to respond to the needs of the NAWG

20 responses

The training increased my understanding about the key issues related to working on the implementation and sustainability of my practice

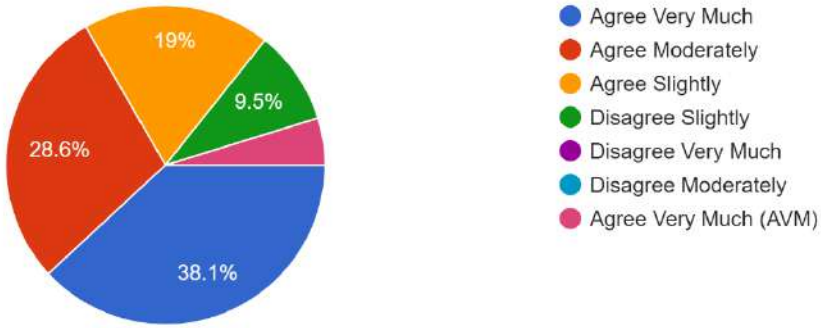
20 responses



8.7 Annex 6: Results of evaluation of Stakeholders' Forum

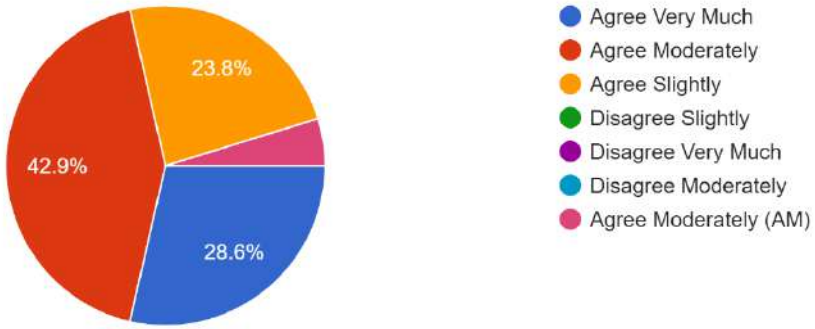
Overall, the knowledge I received is applicable for using digital tools to enhance integrated patient centered care

21 responses



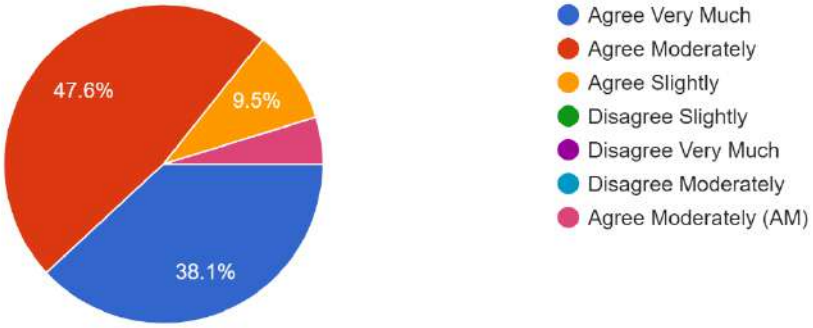
Overall, the knowledge I received meets my needs and increased my awareness towards using digital tools to enhance integrated patient centered care

21 responses



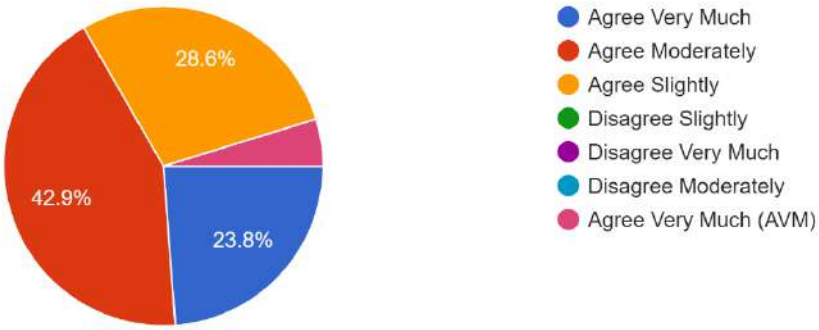
Overall, I am satisfied with the amount of knowledge I received regarding the use of digital tools to enhance integrated patient centered care

21 responses

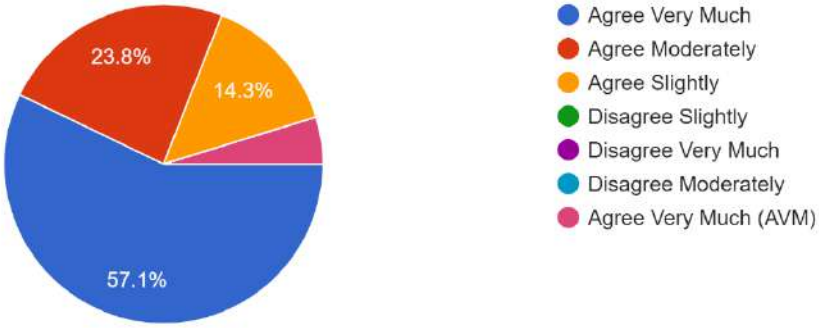


The 2nd Stakeholder Forum helped build my capacity to use digital tools to enhance integrated patient centered care

21 responses



The 2nd Stakeholder Forum increased my understanding about and new developments in Europe for greater integration of health and social care se...and how they can be supported by digital solutions
21 responses



The 2nd Stakeholder Forum helped me to increase the impact of the achieved JADECARE implementation and transformation results (only f...tium or Members of a Next Adopter Working Group)
21 responses