12-2017

SUPPORTING HEALTHCARE TEAMS WITH IMPLEMENTATION PROJECTS: SHAPING a TOOLBOX

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Recommended Citation
van der Sman, Carian, "SUPPORTING HEALTHCARE TEAMS WITH IMPLEMENTATION PROJECTS: SHAPING a TOOLBOX" (2017). Creative Studies Graduate Student Master's Projects. 267.
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SUPPORTING HEALTHCARE TEAMS WITH IMPLEMENTATION PROJECTS: SHAPING a TOOLBOX

By

Carian van der Sman

An Abstract of a Project
in
Creative Studies

Submitted in Partial Fulfillment
of the Requirements
for the Degree of

Master of Science

December 2017

Buffalo State
State University of New York
Department of Creative Studies
ABSTRACT OF PROJECT

SUPPORTING HEALTHCARE TEAMS WITH IMPLEMENTATION PROJECTS:

SHAPING a TOOLBOX

This project explores a) the challenges healthcare professionals experience when they work in a team to implement new (but elsewhere existing or proven) products or solutions into their practice and b) how a toolbox of creativity and change methods, tools and techniques might look like to support them to overcome these challenges. This project shows that healthcare professionals most likely benefit from 1) tools that provide teambuilding and would support the sense of growing together, 2) tools that would demonstrate an overview of types of resistance they could face and strategies to overcome them and 3) tools that provide an overview of the implementation process. The tangible result of this exploration is a draft “implementation scan” that could serve as a base for a teambuilding and project navigation toolkit.

Carian van der Sman
11 December 2017
BUFFALO STATE UNIVERSITY OF NEW YORK
DEPARTMENT OF CREATIVE STUDIES

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Master of Science
Winter 2017

Dates of approval:

11 December 2017
Dr. Selcuk Acar
(Assistant Professor)
International Center for Studies in Creativity

11 December 2017
Carian van der Sman
Graduate Student
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Acknowledgements

On 19 December 2014 I took the train from The Hague to Amsterdam to attend Gerard Puccio’s presentation about the master program in creativity and change leadership coming to Europe. When I entered the train, I knew I started an adventure. Three years later I realized it was not a train I took. It was a rollercoaster! Great fun, great fear, completely shaky and completely safe. Now the breaks are switched on and the safety harness is about to be released, I feel that I can use a bench to give my shaky body and mind a break to realize what happened. I deeply thank Branko Broekman and Gerard Puccio and the Buffalo and European staff for bringing this rollercoaster to Europe. I thank my husband Stef, my daughters Doris and Robin and my parents for their belief in me and the enormous amount of time they gave. I thank the Euriginals and most of all Gonnie and Anna for all the laughter, screams and shouts along the ride and great summer school camping experiences. And also, their husbands Guus and Jake for providing moments of relaxation, relativity and comfort. To a lifelong friendship!

According to this project I owe a big thank you to professor Mascha van der Voort and her employees Julia Garde and Daphne Karreman for the valuable discussions on the topic of implementation and its relation to creativity and design. And of course, to all participants in this project, in particular Roosmarijn and Ruth who spent a Friday afternoon literally playing with the subject. Last but certainly not least I thank both my business partner Ernst-Jan Wind and our client, the board and all participating healthcare professionals of Vechtverband, for your faith in me and your openness to all my suggestions, not afraid to experiment with concept tools. Without you, this whole master would have been just a theory.
# Table of contents

ABSTRACT OF PROJECT ........................................................................................................................................... ii

Acknowledgements................................................................................................................................................... vi

List of Figures .......................................................................................................................................................... x

List of Tables .......................................................................................................................................................... xii

SECTION ONE: BACKGROUND TO THE PROJECT ............................................................................................... 1

  Purpose and Description of the Project ............................................................................................................... 1
  Purpose and central questions ............................................................................................................................. 3
  Personal goals ....................................................................................................................................................... 4
  Rationale for the Project ........................................................................................................................................ 5

    Importance of adoption of innovations and scientific insights into healthcare practice................................ 5

    Importance of building creative competencies for dealing with change ......................................................... 6

SECTION TWO: PERTINENT LITERATURE AND EXPERTS .................................................................................... 10

  What is implementation? ...................................................................................................................................... 10

    What are creativity, innovation and change? And where to place implementation? .................................... 10

    Implementation in creative thinking and design processes ........................................................................ 12

    Implementation in Healthcare ......................................................................................................................... 23

    Success factors of implementation in healthcare .......................................................................................... 26

SECTION THREE: PROCESS PLAN .......................................................................................................................... 33
Plan to achieve goals and outcomes................................................................. 33
Project timeline.................................................................................................. 34
Evaluation plan ................................................................................................. 35
SECTION FOUR: OUTCOMES ............................................................................. 36
Inviting healthcare professionals to participate ............................................... 36
Questionnaire .................................................................................................... 37
Description of respondents and their projects............................................... 37
Challenges experienced by the respondents: open-ended question............... 38
Challenges experienced by the respondents: close-ended question............. 41
Planned workshops with respondents of the questionnaire ......................... 43
Design of the workshop ................................................................................. 44
Outcomes of the planned workshop ............................................................... 50
Extra test moment of the Implementation Scan ........................................... 53
Main outcome: answers to my central question.......................................... 57
SECTION FIVE: KEY LEARNINGS AND DISCUSSION .................................... 59
Learnings about implementation .................................................................... 59
Learnings from healthcare professionals....................................................... 60
Personal learnings .......................................................................................... 61
Process learnings ............................................................................................ 62
SECTION SIX: CONCLUSIONS ......................................................................... 65
REFERENCES .................................................................................................... 67
APPENDIX 1: CFIR CONSTRUCTS .............................................................. 70

APPENDIX 2: INVITATION FOR HEALTHCARE PROFESSIONALS TO PARTICIPATE .......... 74

APPENDIX 3: QUESTIONNAIRE .................................................................. 78
Section 1: Introduction .............................................................................. 78
Section 2: general ................................................................................... 79
Section 3: your challenges ...................................................................... 80
Section 4: possible challenges ................................................................. 80
Section 5: follow up ................................................................................ 83

APPENDIX 4: CHECKLIST IMPLEMENTATION SCAN ................................... 85

Permission to place this Project in the Digital Commons online .................... 96
List of Figures

Figure 1. Creative Change Model. Adapted from Puccio, Murdock and Mance (2011, p.26). .... 11

Figure 2. Creative Problem Solving, the thinking skills model. Adapted from Puccio, Murdock and Mance (2011, p.26) ...................................................................................................................................................... 13

Figure 3. The S2D4S approach of the University of Twente. Received personally with permission to print. .............................................................................................................................................................................. 15

Figure 4. The Design Thinking process. Retrieved from the Hasso Plattner Institute of Design at Stanford University. ........................................................................................................................................................................ 17

Figure 5. Intervention Mapping Steps. Retrieved from the official website of this methodology https://interventionmapping.com/ ......................................................................................................................................................... 19

Figure 6. Example of a Matrix of Change Objectives. Adapted from an online lecture about the Matrix of Change Objectives. Retrieved from the official website of this methodology http://interventionmapping.com/simpl/step2.html ......................................................................................................................................................... 20

Figure 7. Adaption to the Creative Change Model (Puccio et al. 2011), to take apart the implementation as part of a creative process and implementation as a process on its own at another location ........................................................................................................................................................................ 22

Figure 8. Consolidated Framework for Implementation Research. Adapted from Damschroder et al. (2009). ........................................................................................................................................................................ 30

Figure 9. Game board of the Implementation Scan. ........................................................................................................................................................................ 46

Figure 10 Implementation Scan board as used in the workshop ........................................................................................................................................................................ 47
Figure 11. Participants working together at building their strategy ........................................ 51

Figure 12. Board members using the implementation scan to look at the implementation projects in their organization................................................................. 54

Figure 13. Outcome of the scan.................................................................................................. 54
List of Tables

Table 1 Classification of thirty implementation challenges by using the CFIR (Damschroder et al., 2009) ................................................................. 39
Table 2 Number of times different challenges within CFIR constructs (Damschroder et al., 2009) are recognized by respondents ......................................................................................... 41
Table 3 Preference of respondents (n=10) about the format of a toolbox (more answers possible) ........................................................................................................ 43
Table 4 Summary of the findings from the questionnaire for checking with the workshop participants. ............................................................................................................ 49
SECTION ONE: BACKGROUND TO THE PROJECT

Purpose and Description of the Project

I have been studying creativity and change leadership at the International Center for Studies in Creativity at Buffalo State University for the two years. Throughout I have deliberately practiced what I have learned within the healthcare field. I have helped multidisciplinary project teams of local healthcare professionals (e.g., general practitioners, pharmacists, physiotherapists, dieticians, etc.). Together we chased several goals like:

- reducing the number of severe fall accidents amongst older people.
- reducing obesity (and a future risk of diabetes) in young families.
- increasing the physical activity of people with medical problems who have recently been insufficiently active (relative to health guidelines)
- improving the way patients can self-manage their conditions.

To meet their goals, these teams usually put components from existing programs, technologies or scientific insights into practice. Usually the team’s primary task is to make fellow professionals adopt those solutions to make a change for patients or clients. I call these projects “implementation projects”, in which a new solution is implemented in an existing environment.

The changes such implementation project teams are trying to achieve are not accomplished overnight. One of the reasons that these change processes usually take more than a year is the limited schedules of the care professionals. They cannot always make time for project work alongside their ongoing direct work with patients.
In my role as a process facilitator, team coach and hands-on co-creator, I have experienced that healthcare professionals may lack the necessary knowledge and skills needed for these projects like creative thinking, project management and behavior change models. Furthermore, I have experienced hesitation when it comes to collaboration with the target group (“patients”) and researchers, consultants or designers to co-create the vision of the future together. Finally, in most situations, the multidisciplinary team members often do not know each other very well at the beginning of the project. They all represent a different health discipline and different organizations. They often see the project as an opportunity to get to know each other better and to improve collaboration within their primary work with patients. Without any intervention from myself or other facilitators, all of the above factors would lead those teams to an unimaginative approach: only sharing what they already do to achieve the goal and making very practical arrangements to better use each other’s expertise. While this networking and sharing of information are important, failure to go beyond networking and information-sharing will probably not lead to creative change (see definition in Section Two).

I have often experienced that my interventions (e.g., letting the group frame a challenge statement and diverge for ideas) encounter resistance. It sometimes makes the project team perceive the project to be more complex and time consuming (and sometimes more expensive) than they expected. Fortunately, I also experienced that my interventions eventually increase joy and pride within the teams when they experience the results. I enjoy this work very much and I hope I can support many more teams. However, my current method of support is face-to-face. It would be great if I can expand my support by also delivering “services” that does not
exclusively rely on my physical presence. This project therefore aims to gain insight in how to support healthcare professionals (in their role as innovators) with tools. I believe that products in general are most effective when they are designed with and for the target group. Therefore, this project aims to generate tools or approaches by working with the healthcare professionals with the hope of finding out how they experience their implementation work and how they think they should be supported best.

**Purpose and central questions**

The main challenge that this project aims to address is “How might I support multidisciplinary healthcare implementation teams with a toolbox?” I divided this challenge in three sub questions to answer by this project:

1. What challenges do healthcare professionals face when they work in a multidisciplinary project team at implementing new, but usually elsewhere existing and/or proven, interventions (e.g. new products, new procedures or processes or prevention programs) into their practices?
2. How might a "toolbox" of creativity and change methods, tools and techniques look like that will help healthcare professionals overcome these challenges? What would they make their project work easier and more joyful?
3. What might be the best way to present or deliver such a "toolbox"? Should it become a book, or a series of videos, blogs, an app, a training program or something else?
**Personal goals**

On a personal level, I hope that this project will help me to find a way towards making a bigger impact with my knowledge. Beyond the teams I am currently working for, making practical knowledge and tools available to other professionals would allow me to help more teams in the same time.

It would also be great if this project will help me to present myself as a creative person. Ultimately, I would like to cultivate my own sense of being the creative person my nearest and dearest already know me to be. So far during this master, I have still thought of others as creative leaders. I do not yet see myself as such. I would like this master’s project to be part of a transitioning step toward feeling that I am a creative leader.

An important obstacle towards feeling myself a creative leader is that I find it difficult to incorporate playfulness into my own work. Normally, I approach my work with dedication and seriousness, telling myself “you can do better”. This often results in working harder and under stress. It would be great if my own creative work could be accompanied by more playfulness and fun. This brings along an ironic twist to this project: Trying to build on my successful facilitation of client achievement, although I am rarely so nurturing or accommodating to myself.

Stated shortly, my goals at a personal level includes the following:

- To make knowledge and tools accessible in a way that healthcare professionals can understand and apply them without an external facilitator.
- To step into the spotlight as a creative leader.
• To experience a greater joy and fun with my work.

Rationale for the Project

An important motivation behind this project, besides my personal interest as stated above, is two-fold: the rising acknowledgement of the importance of successful adoption of innovations and the importance of building creative competencies. Each of these is explained below.

Importance of adoption of innovations and scientific insights into healthcare practice

As stated in the purpose and description section, usually the starting point of the teams I facilitate is an existing product, service or other available solution for their problem. The objective of these teams is to put these solutions into practice, rather than (re)inventing their own solution. The process of finding a new solution takes a lot more time than adoption of the existing solutions. However, adoption of the existing project is not as easy as it seems.

In the introduction of the book “Improving Patient Care: The Implementation of Change in Healthcare”, Richard Grol and colleagues (2013) very precisely described the importance of making these adoption processes more successful:

In the field of healthcare an enormous number of valuable insights, procedures, and technologies become available each year. They derive from well-planned scientific research or from careful experiments and evaluation in everyday practice. Only a small proportion of these methods and technologies are, in the short term, adopted in the daily practice of patient care. Thus patients, clients, and care users could be needlessly deprived of effective care or receive unnecessary, outdated, or, even worse, harmful care.... Therefore, it is
important that great care be taken not only to develop innovations and scientific insights but also to take care that valuable insights and procedures are adopted into daily practice (p. xiii).

There is no healthcare professional who does not want to give his or her patients the most effective treatment. This highlights the importance of finding the roadblocks to adoption and ways to overcome them. Otherwise, patients’ health is at stake.

**Importance of building creative competencies for dealing with change**

In collaboration with Radboudumc (which is an academic hospital in the Netherlands), the Dutch Ministry of Healthcare concluded this year that nearly all affiliated health organizations and institutions are turning to innovation to cope with, and remain relevant within, this rapidly changing environment. They claim that innovation is now a necessary competency for everyone in healthcare regardless of role or level at the organization [http://zorginnovatieschool.nl/about/](http://zorginnovatieschool.nl/about/). Furthermore, they noticed a vital gap in current courses, master classes and human resources systems to build and enable innovation leaders. As a result of this need, they developed a training program to teach future leaders about how to enable and lead innovation based on the “Design Thinking” approach.

Likewise, U CREATE (Centre of Expertise Future Health Design), recognized that the success of innovations largely depends on the way in which end-users, such as patients and healthcare

---

1 I would argue that innovation is not a competency. Rather innovation is the possible outcome of a creative process (see section two of this project). One can speak of innovation when a creative product (new and useful solution) has been successfully (at large scale) adopted. So, the competency refers to the skills associated with creativity and / or implementation of creative outcomes.
professionals, are involved in the development process. In other words, successful change initiatives are the product of effective co-creation; a popular Dutch term for teamwork of different stakeholders, in particular patients. They have initiated a knowledge exchange about co-creation in healthcare (Van der Laan, Alfenaar, van der Lugt, & Moser, 2017) and featured a co-creation initiative by the University of Applied Sciences Leiden, faculty of physiotherapy (Hesselink, van Wely, Siemonsma, Verkleij, Eijckelhof & Verhoef, 2017). This faculty initiated a project in which they brought together bachelor physiotherapy student, physiotherapist and senior persons to work on the implementation of an effective training program. They did this because they see that “to be prepared for the current / future professional field of healthcare and welfare, students need to be trained in co-creation and in how to use creative thinking processes to work together with their surrounding and their clients in the most optimal way” (p. 33). The objective of their project was not only to successfully implement this program, but mainly to train their student in the process of co-creation.

Commissioned by the Dutch Minister of Health, the Committee of Innovation Healthcare Professions & Education has drafted an advice to new healthcare and care professions (Kaljouw & Van Vliet, 2015; van Vliet, Grotendorst & Roodbol, 2016). They foresee a future in which functioning, resilience and ownership are the central components of care and welfare. In this vision, a team of multidisciplinary care and welfare professionals provide a variety of intervention options that fits best for a given patient and allow for tailored solutions.

---

Note that they have a design perspective in which they see the healthcare professional as an end-user. Their focus is more about the creative process to come up with the initial “product” instead of implementing that product.
The major difference from the current situation is that behavior and health will become the central focus, instead of illness and cure. Another difference is that arrangements will be patient-needs focused, instead of service-offering focused. This vision is also explained as a transition from ‘caring for’ to ‘making sure that’ point of view. Using creativity language, one might restate that this is a transition from ‘this is how we do this’ to ‘what might be ways to do this?’

The current care practice is not equipped for this vision. Care and welfare professionals are still divided in silos of different expertise (although a lot of innovative initiatives take place). For example, within healthcare there are more than 2400 different professions and more than 1700 curriculums (van Vliet, Grotendorst & Roodbol, 2016).

The consequence of this vision for future education is that professionalism is no longer just characterized by craftsmanship. This craftsmanship must be accompanied with the ability to cooperate and the capacity to learn. This means that care and welfare professionals should also be able to take the role of, for example, collaborator, communicator, and researcher (van Vliet, Grotendorst & Roodbol, 2016).

Van Vliet, Grotendorst and Roodbol do not use creativity and innovation language such as ‘creative problem solver’, or the role of ‘change process facilitator’ or ‘creative leadership’. However, the words they do chose like ‘cooperation skills’, ‘lifelong learning’ and being able to adapt care arrangements to the needs of the patient could be interpreted as a wish for the development of creative problem-solving skills.
All the above shows that there is a perspective shift related to the expectations of healthcare professionals. As a result of this change, merely providing (process-based) tools is not enough for successful implementation. There seems to be a need for building creative competencies of the healthcare professionals. Indeed, tools should also contribute to the development of creative professionals.

These visions show that professionals need creativity or co-creation knowledge and attitudes, not only for their role in implementation projects but also in their primary work for patients. This is because their primary work is no longer a solitary practice.

The perspective shift shows the bigger picture of a national search for how to cultivate these ‘new professionals’. The present project contributes to this call by exploring the areas of need among the healthcare professionals themselves. It is hoped that the discovery of the needs allows finding possible ‘tools’ leading the healthcare professionals to become this aspired ‘new professional’ and to perform well in their task to implement new insights.
SECTION TWO: PERTINENT LITERATURE AND EXPERTS

In this section I will take a theoretical dive into the topic of healthcare implementation. To be able understand the challenges professionals face in implementation, I need to understand what implementation exactly is and what might be challenges in general in this field.

In the first part I focus on implementation. I will look at definitions, “implementation” within creative processes, and implementation processes in healthcare. This part will reveal that implementing a product has, like creating a product, its own process with a focus on finding strategies to make people adopt the solution. Following that process is an important factor for the success of the project.

The second part focusses on other success- and fail factors known for healthcare implementation processes.

What is implementation?

Implementation is a critical step of creativity, innovation, and change. Therefore, first the concepts of creativity, innovation, and change are discussed. Then I will look at how implementation is defined within creative processes like Creative Problem Solving (CPS) and Design Thinking (DT). This part ends with how implementation is defined by specific healthcare implementation models.

What are creativity, innovation and change? And where to place implementation?

The recognized standard definition of creativity is “a novel work that is accepted as tenable or useful or satisfying by a group in some point in time” (Stein, 1953, p. 311; see also Runco & Jaeger, 2012). One of the many variations of this definition in the academic field is the
following: "Creativity is the interaction among aptitude, process, and environment by which an individual or group produces a perceptible product that is both novel and useful as defined within a social context" (Plucker, Beghetto & Dow, 2004, p. 90). This definition resonates clearly with the creative change model of Puccio, Murdock, and Mance (2011):

![Creative Change Model](image-url)

Figure 1. Creative Change Model. Adapted from Puccio, Murdock and Mance (2011, p.26).

Puccio et al.‘s (2011) model demonstrates the interaction between person(s), process and environment leading to a “product” (which can be an intervention, but it does not need to necessarily be tangible). This interaction is called creativity when the outcome is novel and useful within a given context. The emergence of this new product, idea, or solution implies a potential change, which can be called creative change. Puccio et al. (2011) defined creative change as “the adoption of a creative product, a novel and useful idea that has been embodied
in either an intangible or tangible form, which adds value to an individual, team, organization or society” (p. 26). In their model, they define innovation as a specific type of creative change. They argued that “innovation occurs when an organization has successfully commercialized a new product or implemented a new program or service” (p. 26).

The focus of this master project lies on this final adoption step in the model above. In the healthcare field, the term “implementation” is mostly used to describe this planned process and systematic introduction of an innovation or a change initiative of proven value. All of this is aimed at solidifying its place in professional practice (Grol et al., 2013). Within this paper I will use the term “implementation” to refer to the adoption of a creative product.

**Implementation in creative thinking and design processes**

The next question is, “What different views are there about implementation that give insight into the possible needs or challenges one could face in this activity?” In this part I would like to start with how the term ‘implementation’ is explained and used in known creative processes.

Within the Thinking Skills Model (TSM), which is the latest version of the Creative Problem Solving (CPS) process, implementation is described as the stage in which solutions are refined and a plan is put together for taking effective action (Puccio, Murdock, & Mance, 2011; See Figure 2).
Implementation, as seen in this model, is divided in two steps: exploring acceptance (for the formulated solutions) and formulating a plan. The first one is about anticipating on both positive and negative reactions to the solutions the team or leader wish to implement. The latter is about the actual implementation by making and following a step-by-step plan, in which the outcomes of the acceptance check are deliberately incorporated. CPS offers tools for exploring acceptance, called “assisters and resisters” and “stakeholder mapping”, and a framework for setting up an action plan. Puccio et al. (2011) emphasized the importance of exploring acceptance because novel and useful ideas and solutions may not always be welcomed. In fact, people may hold biases about them. A study by Mueller, Melwani and Goncalo (2012) on the bias against creativity, show that when people feel uncertain or want to
reduce uncertainty for some reason, they may have negative associations with creativity. Creative ideas are evaluated lower in the presence of uncertainty. For example, when healthcare professionals lack knowledge about change processes, and are also not sure whether a potential solution will work in their context, their uncertainty will rise. Ironically, this might reduce their ability to recognize creative solutions, when they need it the most (Mueller, Melwani, & Goncalo, 2012).

At the University of Twente, a creative and cross-disciplinary ecosystem was launched to connect science and society through design. The facility is called the DesignLab. Faculty and students from the departments of engineering, natural sciences, social sciences and the humanities work together with companies and government institutions to develop scientific and technological insights that can lead to creative, innovative and meaningful solutions for complex societal challenges. They call this “bringing Science to Design for Society” (S2D4S) and have developed their own process to achieve this (see Figure 3).
Like CPS, the S2D4S approach consists of six steps (see the green hexagons in the figure above). Where in CPS the final two steps together (exploring acceptance, and formulating a plan) are called implementation, here only the final step is called implementation. However, the explanation of the two final S2D4S steps, Evaluate and Implement are quite similar to the CPS steps Exploring acceptance and Formulating a plan. In a concept version of a flyer about this model (received personally, not published yet) they state that the first four phases of the S2D4S approach led to a concept and prototype of a final product, service or system. After that,
the proposed solution or product should still be evaluated as to whether the product will indeed function as anticipated. In the evaluation phase, the design team reflects on the desired impact. If this seems to be the case, the team can produce and implement the product, service or system on society. During the implementation phase, evaluation moments must be taken and acted upon to ensure efficacy.

I conducted two interviews with two different employees of the University of Twente, both affiliated with the DesignLab: Dr. Julia Garde who is an associate professor at the faculty of Human Centred Design and Dr. Daphne Karreman who works on the methodology development as a post-doctoral researcher. In my interview with these two experts, both underscored the importance of the different steps within each phase (see the inner circle in their model), especially Join and Inspire. To encourage a certain target group to adopt a new product or situation, according to these experts, one should make sure that people from this group could join the design process. For that to happen, creating a sense of team spirit is crucial. Furthermore, they believe that to have people accept things that are unfamiliar and beyond their own imaginations, or comfort zones, you should inspire them to show greater openness to new possibilities. For example, Julia and Daphne often invite experts to share inspirational insights and the possibilities of new technology.

A more well-known creative (design) process is Design Thinking (DT) as it is taught at Stanford’s d.School. Figure 4 summarizes the steps taken in their proposed process. Utley and Kembel (2012) explain this process in their Virtual Crash Course video. The word
“implementation” is not found in this model. They call the last step “test”, to indicate the phase, in which a solution is tested with the users of the solution.

Figure 4. The Design Thinking process. Retrieved from the Hasso Plattner Institute of Design at Stanford University.

In “The virtual crash course playbook” (Hasso Plattner Institute of Design at Stanford University, n.d.) that comes with the video, they advise to test prototypes in the real-life situations of the users. The test phase is another chance to understand the user’s perspective by observing their reactions to a prototype. Stanford’s Institute of Design share in their process guide (n.d.) the following rule of thumb: “always prototype as if you know you’re right, but test as if you know you’re wrong—testing is the chance to refine your solutions and make them better”.
When I compare DT with CPS and S2D4S, one could say that the test phase of DT is similar to exploring acceptance (CPS) or evaluate (S2D4S). On the other hand, DT does not have an implementation or project planning step like CPS does.

The final model of creative process is called Intervention Mapping (IM). The IM approach focusses on planning health promotion programs, which are simply called “interventions” (Bartholomew Eldredge, Markham, Ruiter, Fernández, Kok, & Parcel, 2016). IM provides a clear step-by-step process to define expected behaviors for a certain group whose health is at risk. Based on the most important behavior determinants (factors that influence the behavior), behavior change methods are selected to design a health program to influence the determinants. See Figure 5 for an overview of this process.
An important “tool” within Intervention Mapping is the Matrix of Change Objectives. It helps to clarify the behavior objectives one intends to achieve through the intervention. Figure 6 below presents an example of such a matrix.
Parents manage asthma in their children

<table>
<thead>
<tr>
<th>Determinants</th>
<th>Attitudes</th>
<th>Self-Efficacy/Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O.1: Observe child for specific symptoms</td>
<td>A.1a: Expect that if symptoms are monitored, asthma can be managed.</td>
<td>SE.1a: Express confidence in being able to recognize symptoms</td>
</tr>
<tr>
<td>P.O.2: Identify and give medication for symptoms</td>
<td>A.2.a: Expect that if they give medicine it will not harm the child. A.2.b:...</td>
<td>SE2a: Demonstrate identifying appropriate medicines for different symptoms</td>
</tr>
</tbody>
</table>

Figure 6. Example of a Matrix of Change Objectives. Adapted from an online lecture about the Matrix of Change Objectives. Retrieved from the official website of this methodology http://interventionmapping.com/simpl/step2.html

In this matrix, the main desired behavior (in this case, that parents manage asthma in their children, see top left) is broken into smaller performance objectives (see P.O.1 and P.O.2) which all contribute to the main objective. Each performance objective is linked to different personal determinants (e.g., attitudes, self-efficacy, preferences, and knowledge). The matrix is then filled with specific change objectives related to a combination of performance objective and determinant (See A.1a, A.2a, SE1a, SE2a). The following crucial step in Intervention Mapping is to select theory and evidence-based change methods to address the objectives. Bartolomew Eldredge et al. (2016) provided an extensive list of methods and related theories categorized by personal determinants.

Based on the change objectives and matching change methods and theories a health program (intervention) is then designed and produced. When it comes to implementation of
this program, IM deliberately uses the same matrix approach to determine what change methods would make sure that specific stakeholders (e.g., parents or teachers or healthcare professionals) adopt, implement and maintain this program in their context (see step 5 in Figure 5). Interestingly they distinguish adopting from implementing. Adopting refers to accepting a solution whereas implementation is related to putting the solution into action or practice. The implementation itself (see left-lower corner of the model, in figure 5) is limited to, putting the solution into practice, which resembles the implementation phase in the S2D4S approach.

Based on the summarized models above, I recommend the following adaption to Puccio et all’s (2011) Creative Change Model (see Figure 7).
In the upper part of the model I show the effect of persons interacting with one on the above described creative processes. Although implementation is part of these processes (in steps like testing, evaluating, acceptance exploration, planning) the outcome will not necessarily be a product or solution. The outcome will also be a local change, or at least insights into what happens when one puts the solution in practice.

In the lower part, I demonstrated that the outcome of the creative process as the starting point for further implementation at other locations (and the starting point of this master project). A question that rises is, whether the process needed for this secondary
implementation differs from the initial creative process. To what extent, for example, do these new teams need to go through the clarifying, ideation and development stages? To learn more about this “secondary implementation”, the next part will describe a closer look into healthcare implementation processes.

Implementation in Healthcare

I found two specific models that specifically describe a process to implement solutions in healthcare. The first is a general process by Grol et al. (2013). The second is a specific process related to the implementation of e-health (modern technology) by Dohmen (2012).

Grol et al. (2013) stated that when it comes to implementing innovations or new routines it is critical to consider the complexity of usual patient care. A large number of factors can hinder or facilitate change (I will examine these factors in the next part). To overcome this complexity, Grol et al. (2013) stated that “a systematic approach and careful planning of the implementation activities is needed. One single action is seldom effective. There is a clear need for a well-planned process of change in which all factors are addressed, progress is evaluated regularly, and the plan is adapted to respond to the results and challenges” (p.41). The process they propose consists of seven steps:

1. Developing a proposal and targets for change, which include (amongst others) the desired improvement and a description of the quality and credibility of the new product/routine/program.
2. Analysis of actual performance, intending to gain insight in the current way of working and deviations from the desired care. This will help to create a sense of urgency.

3. Analysis of the target group to understand “who wants what change and for what reasons?” It is also important to know in which phase of change people are and what could facilitate or hinder change.

4. Development or selection of improvement strategies based on the factors found in the previous analysis phases. One should at least make sure that there are strategies to increase interest and positive attitudes, and strategies to encourage actual adoption.

5. Development, testing and executing of an implementation plan with the target group.

6. Integrating change into practice routines, to guarantee the sustainability of an improvement.

7. Evaluation and (possible) adaptations to the plan, to find out the effect of the project.

In this process I found step 4 remarkable because it seems to represent the core of this model. Implementation seems to be a process of looking for a correct combination of strategies to bring something new into practice. The last step is also important as Grol et al. (2013) showed in their model, which does not represent a linear process. They also specifically warn that their model is only a guideline and that actual practice might ask for another sequence or rehearsal of the steps.
The same applies to the model of Dohmen (2012). Gaining and processing feedback is an explicit part of his model not only to consider possible relapse but to also make the model applicable for building an innovation culture. In an innovation culture, a successful implementation serves as a basis for a next innovation. Dohmen (2012) speaks of an innovation flywheel in which new energy arises. He therefore called his model the E5-implementation model. The E refers to the E numbers of fuels (like benzine) and 5 for the phases of his model:

1. Explore: for management and professional support of an idea, a business case (including a vision and concrete goals), formation of a project team, or planning.
2. Experiment: selection of technology and small experiments with a number of enthusiastic professionals only (not a representative group, no patients yet), choosing a technology and checking for infrastructure implications; followed by starting a pilot within the project organization based on measurable benchmarks.
3. Evaluate: the benchmarks are used to evaluate and draw conclusions; a decision is made to continue the implementation.
4. Effectuate: bringing the technical application to the whole organization, with necessary training and communication.
5. Evolve: periodic checks on whether the application still lives up to expectations and then looking for new ideas.

What strikes me most about this process is the growth mindset: To bring “just an idea” alive, step by step. And not only bringing the first idea alive, but also making sure that this brings an innovation culture alive, where new ideas can be born. The step by step growth,
makes me think of Viral Change (Herrero, 2008). Viral Change is a vision and method of change, based on the idea that behaviors travel through a population by imitation and copying (not through classrooms and PowerPoints). The idea of Viral Change is to start new behavior in a small group who then infect others. I also see this idea of spreading something slowly but deliberately also in Dohmen’s model.

The models of Grol et al (2013) and Dohmen (2012) show me that implementation is an iterative process of bringing something new to an existing organization by building enthusiasm and trust, together with a strong evaluative focus on the target at hand.

In comparison to the creative processes, the focus lies more on finding strategies to connect people to a product or new way of working, rather than building that product. Despite this difference, both types of processes do show a lot of overlap. Both processes have a strong component for understanding the current situation, developing a vision and targeting points for a future state. Also, both processes have components for finding concrete solutions (either a product or strategies to “sell” that product) and components to try them out to see what happens.

**Success factors of implementation in healthcare**

The former part of this literature section showed that a process should be followed to succeed in healthcare implementation. The focus of this process lies in finding (creative) strategies to make people adopt and use a certain product or start following a certain procedure. To find these strategies, implementation teams would most probably benefit from theories about behavior change. This would help to define factors of current behavior and any
possible resistance to the introduction of something new. Then the focus would be on how to influence those factors.

This second part of the literature section focuses on other factors that influence implementation and that could reveal possible challenges for healthcare professionals during implementation.

Dohmen (2012) made a list of fifteen different critical success factors. They are:

1. Management support based on a business case about how to scale the solution
2. Perspective on productivity improvement or labor savings
3. Professional internal project organization
4. Involvement of healthcare professionals at the initial design
5. Socio-technical description and conditions of the end situation
6. Measurable goals and clear planning
7. Fiat of healthcare professions in their faith in the innovation
8. Implication for the infrastructure are known
9. Necessities for education, information and communication are known
10. Feedback of patients and healthcare professionals has been processed
11. Support by the project organization during the pilot
12. Evaluation of benchmarks
13. Support is transferred from the project organization to the normal organization
14. Information, training and communication for all users
15. Innovation flywheel / Technology assessment (continuous evaluation)
All these success factors are incorporated in the E5 model as described above. I would like to explicitly mention two of them that are not process steps. The first one is “having a perspective on productivity improvement or labor savings”. Dohmen (2012) found that (technological) implementations should be focused on one of these points, because projects focused solely on cost reduction or on quality improvement, have an increased risk of failing. The second is “a professional internal project organization.” This is important because when projects are run by external professionals (consultants, advisors, technology suppliers) they miss the corrective power to keep listening to the organization.

Grol et al. (2013) looked at different “process theories” to determine crucial elements or principles for successful implementation. Here, these elements are also incorporated in the process steps. The three that stands out are “give attention to the innovation, guideline or new routine (the “product”) that is implemented”, “pay attention to organizational aspects” and “distinguish between different strategies”. The first factor refers to the fact that the “product” in most cases must be tailored to the situation. The implementation team needs to make sure that the “product” is well-designed (that it is built on a reliable background) and attractively presented. The second factor explains that it is important to check whether organizational conditions like expertise, budget and schedule are in place. The third refers to (as mentioned earlier) the fact that a single strategy will not be enough. The innovation team should distinguish between strategies for dissemination and actual implementation and between the organizational, team and individual levels.
The third factor was also confirmed by a systematic meta-review to find factors influencing the implementation of clinical guidelines (Francke, Smit, de Veer, & Mistiaen, 2008). Based on twelve systematic reviews, they distinguished five influencing factors:

1. Effective strategies often have multiple components; corollary to that, the use of a single strategy (only sending reminders or doing one training session) is less effective.

2. Characteristics of the guideline itself: the easier the implementation is to understand and to use with current resources, the more successful it will be.

3. The awareness and familiarity of professionals with the guidelines.

4. Patients can resist the recommendations of the guidelines. And in the case of patients with co-morbidity the chance is greater that professionals do not strictly adhere to guidelines.

5. Environmental characteristics that may negatively influence implementation are a lack of support from peers or superordinates, and insufficient staff/staff time.

In 2009, researchers developed an overarching typology of all constructs included in healthcare implementation theories (Damschroder, Aron, Keith, Kirsh, Alexander, & Lowery, 2009). They found that in the many published implementation theories, there is a considerable amount of overlap between the constructs, but also that each lack important aspects included in other theories. They developed the Consolidated Framework for Implementation Research (CFIR). The framework is presented in the figure below.
The framework consists of five major domains. I will now describe them briefly and discuss the most important challenge for each construct.

1. Characteristics of the intervention

Damschroder et al. (2009) stated that without adaptation, interventions usually fit a setting poorly, and are then resisted by individuals who will be affected by the intervention. Usually, interventions are multi-faceted with many components - some are the core components, forming the essential and indispensable elements of the intervention. Others are in the adaptable periphery, so, can be modified. The challenge is, “How to redesign the intervention to make it fit the current situation?”

2. Inner setting

Figure 8. Consolidated Framework for Implementation Research. Adapted from Damschroder et al. (2009).
This component includes the structural, political and cultural context through which the implementation process takes place. Implementation teams might face challenges like unstable teams, not enough autonomy, and insufficient existing communication networks. Maybe the culture and values of the organization (or of society) are not in line with the proposed change. Teams might lack intrinsic motivation. They might not feel enough tension or sense of priority for the proposed change; they can even lack extrinsic incentives, leadership engagement, or struggle with unavailable resources such as time, money, space and knowledge.

3. Outer setting

This includes the economic, political, and cultural context of the organization implementing the intervention. In this model, patient needs, and resources are part of the outer setting. The main challenge here is “how to be(come) a patient-centered organization?” Other questions are, “what might be barriers in relation to the organization’s connections to other external organizations, competition with other organizations and the wider, current political climate and regulations?”

4. Characteristics of individuals

This component is related to people involved in change efforts. The goal of the intervention is to influence them and to change their behaviors. Damschroder et al. (2009) stated that organizational change starts with individual change; as such, two essential elements to consider for change are the level of self-efficacy, the individual’s
knowledge and beliefs. So “what might be the current knowledge / beliefs and self-
efficacy levels that lead to assistance or resistance of the planned change?”

5. Implementation process

A successful implementation usually requires an active change process that is embraced
by the entire organization with all people involved. Although the way the process is
handled may vary, the following activities are always part of the process: planning,
engaging, executing and reflecting / evaluation. The challenge here is to find an optimal
way of using them that also suits the team.

All of these constructs are individually explained by multiple topics. In Annex I, a table is
added with the five major domains and their topics.

The above summarized approaches from the literature review provided me with insights
about challenges that professionals may face in implementation. This overview shows that they
might perceive problems related to a (lack of) process structure. They also might face
challenges with adapting the “product” to their situation and attractively introducing the
problem / proposed solution combination to the target groups. They might also face challenges
when finding the right strategies for influencing their colleagues and patients to utilize the
“product”. Finally, I expect that they might face challenges with regard to sufficient resources
such as time and funding.
SECTION THREE: PROCESS PLAN

In this section I will outline the process of this project and specify all performed activities.

Plan to achieve goals and outcomes

I will call this master project successful when I know how I might support multidisciplinary healthcare implementation teams with a toolbox. I would like to be able to see the contours of a toolbox, and I would like to feel ready to finalize it.

Specifically, in the course of this project I will:

• Gather data to create an overview of factors involved in successful implementation in healthcare (see Section Two)

• Gather more data to gain insight on the perceptions of healthcare professionals currently working on implementations. I will do this through a questionnaire, followed by workshops.

• Summarize and formulate the challenges that healthcare professionals face.

• Explore ideas and test possible solutions, in the same workshops as mentioned above. I might also send out an additional comment sheet by mail to check iterations of possible solutions. My initial thought on the solution is that it will be a collection of tools that address the needs of healthcare professionals. Those tools could be presented as a pack of solution cards or a collection of instructional videos about how to approach these challenges. For the final outcome, see Section Four.

• I will summarize my findings by answering my central questions and include a plan for further development and market introduction, see Sections Four and Six.
### Project timeline

<table>
<thead>
<tr>
<th>Week nr.</th>
<th>Project plan &amp; orientation</th>
<th>Gathering data (literature / experts)</th>
<th>Gathering data (healthcare professionals)</th>
<th>Translating insights into ideas and solutions</th>
<th>Write up &amp; contact with advisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td>Working on initial project idea</td>
<td></td>
<td></td>
<td></td>
<td>Sent it to Selcuk in preparation of skype meeting</td>
</tr>
<tr>
<td>36</td>
<td>Reading course information, adopt a master project from the database</td>
<td></td>
<td></td>
<td></td>
<td>Skype meeting Selcuk</td>
</tr>
<tr>
<td>37</td>
<td>Discussing goals with SB, Discussing the subject and goals with Mascha van der Voort University of Twente</td>
<td></td>
<td></td>
<td></td>
<td>Mail contact with Selcuk and sending First concept paper</td>
</tr>
<tr>
<td>38</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Skype meeting Selcuk</td>
</tr>
<tr>
<td>39</td>
<td>Rewriting section 1, being more specific about goals</td>
<td>Google scholar search and scanning articles</td>
<td>Writing an invitation to healthcare professionals – application procedure + preliminary questionnaire</td>
<td></td>
<td>Sharing invitation and questionnaire set-up</td>
</tr>
<tr>
<td>40</td>
<td>Continuing collecting and reading</td>
<td>Recruiting participants, by mailing clients and a linkedIN message (shared by Dutch “Euriginals”)</td>
<td></td>
<td></td>
<td>Feedback on questionnaire</td>
</tr>
<tr>
<td>41</td>
<td></td>
<td>Working on and Sending questionnaire to participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Describing literature findings</td>
<td></td>
<td></td>
<td></td>
<td>Next version of concept paper</td>
</tr>
<tr>
<td>43</td>
<td></td>
<td>12 responses, analyzing results</td>
<td></td>
<td></td>
<td>Summarizing insights</td>
</tr>
<tr>
<td>44</td>
<td>Discussion with SB, Interview with assistant professor University of</td>
<td>design workshop</td>
<td>Further summarizing and looking for possible tools to</td>
<td></td>
<td>Mail response to concept paper</td>
</tr>
<tr>
<td></td>
<td>Twente</td>
<td>Workshop</td>
<td>check in workshop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------</td>
<td>----------</td>
<td>-------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Interview with postdoc University of Twente</td>
<td>Workshop with 2 participants and colleague</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Workshop with board members / leaders of implementation teams</td>
<td>Summarizing findings from workshops</td>
<td>Adaptations to chapter 1-3 and start with 4-6. Sent in for feedback</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 47 | | | Working on references and APA check
Skype with Selcuk |
| 48 | | Add final insights / responses by participants | Sending complete paper – for final check |
| 49 | | | Adapt to feedback and Sent in Final report |
| 50 | | | Presentation |

**Evaluation plan**

For me the most important objective of this master project is the extent to which I am able to meet the needs of healthcare professionals. I consider the functionality and usefulness of this project to be more important than its originality. Nonetheless, it would still be great if I can come up with a surprise. Something enjoyable that they will experience as something which was not there before. So, to me my target group will be my most important judges.

I hope I will be able to trust the process and have the confidence that there will be an outcome.

For me the final product does not have to be finished. It would be great if I can answer my central questions and have a product in mind and directions about how to bring it to market.
SECTION FOUR: OUTCOMES

In this section I will present the different outcomes of this project. It will start with the invitation and questionnaire I sent to healthcare professionals. Then, the results of the questionnaire will be described, followed by the scripts and outcomes of the two workshops I organized to gain more insight into the challenges healthcare professionals face and to test possible tools. I will end this section with my final ideas about the product I would like to develop and test further.

Inviting healthcare professionals to participate

After completing my own goals and clarifying my central questions for this master project, I started to invite healthcare professionals to participate in this project. I had hoped that between 15 and 25 participants would fill in the questionnaire and that 5-10 of them would also participate in a workshop. The questionnaire was meant to gain initial insights about the challenges they face. The overarching goal was to get a sense for the direction of tools that may work specifically for this audience. The workshop was meant to discuss and validate these findings and to provide a co-create opportunity to develop workable solutions and to check possible ideas together. The invitation for participating in this project is presented in Appendix 2. I used the MailChimp webservice so that people could easily sign-up for participation. This invitation was targeted to my current clients and those of my business partner (altogether, around 50 professionals). It was further spread by putting a message on LinkedIn which was actively spread by my Dutch cohort colleagues (it was viewed 1425 times). Finally, the invitation was placed in the newsletter of one of the organizations my colleague works for. This resulted
in 12 participants who all filled in the questionnaire. Initially, four of them applied for the workshop, with two of them actually attending. Although I had fewer participants than I had hoped for, the number was good enough to make meaningful analyses. Without participants and the opportunity to think and create with them, this project would have been meaningless.

**Questionnaire**

I designed the questionnaire around my central question (see Appendix 3 for the questionnaire in Dutch and English). The part I was most curious about was the open-ended question about the challenges: “What are your top three challenges in your change project? Describe below shortly. In the next questions you can give more explanation.” The next point was, “Describe below a situation in which you have experienced this challenge.” Before diving into the challenges, I will first briefly describe the background of the respondents and their projects. I will end this part with what kind of solutions the participants already tried and their preferences for the way or format they would like tools to be delivered.

**Description of respondents and their projects**

Of the 12 respondents, two did not meet my inclusion criteria of primarily being healthcare professionals. One was a local government advisor and the other was a project manager and consultant. The other 10 respondents were all healthcare professionals. Most of them were physiotherapists or exercise therapists (6). Of those, one worked in a hospital (the others in local practices), one was a general practitioner, one social agent, one psychosocial therapist and one occupational therapist. The synopsis below is based on the information received from the 10 healthcare professionals.
Most of the projects they are working on are preventative in nature. Example projects are the prevention of fall accidents in the elderly, the prevention of obesity in children or reducing the negative effects of too much bedrest in hospital. Some of them seem to be very practically oriented (e.g., starting a gym class for older people) others are more organization oriented (e.g., implementation of a care path). Other projects focus on multidisciplinary collaboration (e.g., multidisciplinary reporting) or on process and performance objectives (e.g., electronic patient dossiers, reduction of bureaucracy). One of the projects was mono-disciplinary (only physiotherapists were involved). In all the other projects at least four different disciplinaries were involved.

From the respondents, six are the project leaders of the projects. Some of them were also members of another project. The others were members of the project team. Three out of ten respondents indicated that patients were not included in the project. In the other projects patients were not involved in the project team, but were included as advisors and testers. In all projects except one, an external person was involved. In most of the cases, the teams include both a project/process leader (in some of these projects that might be me) and further experts, researchers and designers.

**Challenges experienced by the respondents: open-ended question**

When reading through the challenges my respondents described, at first glance, they all seemed very unique. Although I saw some relatedness, it was not instantly clear in which direction I should steer tool development. I discussed the outcomes with my business partner Ernst-Jan Wind and we decided to map the thirty different challenges by using the CFIR
framework. We put all the challenges with brief terms on a post-it and try to place it within one of the main constructs of the CFIR (or at the border of two). The outcome showed that most challenges were related to the “inner setting” and “characteristics of the individual”.

After this first sorting and mapping activity, I classified each challenge in an excel file for both the main CFIR construct(s) and possible sub construct(s). The results are presented in the table below. As mentioned in the literature section, the constructs are summarized in Appendix 1.

Table 1

*Classification of thirty implementation challenges by using the CFIR (Damschroder et al., 2009)*

<table>
<thead>
<tr>
<th>CFIR main construct</th>
<th>Total main constructs</th>
<th>CFIR sub construct, including examples</th>
<th>Total subconstructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inner setting</td>
<td>18</td>
<td>Implementation climate (most related to relative priority)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“people respond to me with: again something new? Do we have to invest time again?”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“a general practitioner agreed to participate, however when it comes to deeds, he does nothing”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I recognize that people want to invest less then I had expected, I tend to do it myself to keep things going”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Readiness for implementation (most related to available resources)</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“all these projects I do on the fly, if there is a crisis with a patient then the project will be put in second and I run behind”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“while there are officially no hours for these kinds of projects, we need to deliver our normal production. This causes stress”</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Networks &amp; Communication</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“the project needs to be carried by the whole organization [hospital], but it is difficult to involve everyone”</td>
<td></td>
</tr>
<tr>
<td>Characteristics of individual</td>
<td>9</td>
<td>Could not be defined (why people are not motivated)</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“that everyone works on the project with the same”</td>
<td></td>
</tr>
</tbody>
</table>
**Process**

| 8 | Planning | “sometimes we want to go too fast, which causes problems later”
|   |         | “several times we lost the overview of where in the process we are, and what is important in that phase. If this is unclear nothing really happens”
|   | Reflecting & Evaluating | “it would be great to have very concrete and small goals, however new ideas keep coming”
|   | Could not be defined | “everyone has its own opinions and ideas. I find it difficult to be a leader to give room for everyone or to stop them if they change the subject too much”

**Intervention characteristics**

| 4 | Relative advantage | “I want to start with gym lessons for people who hardly sport, but I have to find a volunteer to give this lesson. Why can’t it be given by a physiotherapist?”
|   | Trialability | “when a general practitioner sends a patient to me to meet others (to activate that person), I need more patients to start a group”

**Outer Setting**

| 2 | Patient’s needs & resources | “it is difficult to reach the target group”

These findings should be interpreted with caution. The sub constructs were especially difficult to derive from the narratives, because the response was not detailed enough. I had to make some assumptions based on the narratives. This is also why a lot of challenges are categorized under more than one construct. In the case where I put “could not be defined”, that means that it required guesswork. However, I still tried to label the narratives to get an overview of what challenges might face healthcare professionals. The insight it gave me is that my respondents seem to struggle to involve others, either because of their individual characteristics, the organization climate or lack of resources. Or maybe because the new
situation they tried to create is not important or interesting enough. Most likely, it is a combination of these factors.

**Challenges experienced by the respondents: close-ended question**

Alongside the open-ended question about their challenges, I also provided my respondents with a list of possible challenges, based on the literature. I asked them (after the open-ended question) to select all challenges that they immediately recognized for their project(s). See the table below for the results.

**Table 2**

*Number of times different challenges within CFIR constructs (Damschroder et al., 2009) are recognized by respondents*
In line with the response to the open-ended questions, most (important) challenges seem to be related to the “inner setting” and the “characteristics of individuals”. The work pressure in the primary process featured in second place for 8 of the 10 healthcare respondents. Also, a lack of resources is a problem that respondents face.

Interestingly, all response options were recognized in the category of “characteristics of the individual”.

In summary, it looks like the respondents work with colleagues who are not that enthusiastic about implementing a solution (which is in line with the open-ended question). Furthermore, some of the projects of the respondents could benefit from better management, better communication about the project, and better contact to other organizations that deal with the same topic and solutions and some pressure from outside the organization.

Solution, tools and next step

Respondents have tried different strategies to overcome their challenges. These strategies included a wide variety of options ranging from persistently sending e-mails to make someone responsible at each department, from conducting training sessions to running a risk analysis, to team profiling and interviews with target group. I asked them in what format they might want to receive “tools” or “help” with their challenges. The preferences of the respondents (n=10) is as follows:
Table 3

Preference of respondents (n=10) about the format of a toolbox (more answers possible)

<table>
<thead>
<tr>
<th>Format</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching on the job for the project team</td>
<td>9</td>
</tr>
<tr>
<td>Group course</td>
<td>6</td>
</tr>
<tr>
<td>Online database with tools</td>
<td>5</td>
</tr>
<tr>
<td>Personal coaching on the job</td>
<td>4</td>
</tr>
<tr>
<td>Online training</td>
<td>3</td>
</tr>
<tr>
<td>Online instruction videos</td>
<td>3</td>
</tr>
<tr>
<td>Game</td>
<td>3</td>
</tr>
<tr>
<td>App</td>
<td>2</td>
</tr>
<tr>
<td>Book</td>
<td>2</td>
</tr>
<tr>
<td>Other: network?</td>
<td>1</td>
</tr>
<tr>
<td>Other: an oracle and more insight in change management</td>
<td>1</td>
</tr>
</tbody>
</table>

With the final questions I asked the respondents whether they were able and willing to attend my planned workshop. Four of the respondents said yes to the workshop. Due to personal circumstances, two of them did not attend. In the next part, I describe the purpose and outcome of this workshop.

**Planned workshops with respondents of the questionnaire**

My initial plan for the workshop was to introduce my participants some “tools” that might be interesting for them, based on the results of the questionnaire. My idea was that the reaction of my respondents towards tools would teach me more about their needs and about what kind of tools they would possibly benefit from. However, the outcome of the questionnaire was too general to give a clear idea about the nature of the potential tools that are needed. The outcome only showed me that I should focus on tools to get colleagues more inspired or motivated and energetic, and tools around the implementation climate and
available resources. It was clear that I needed more information about the challenges before suggesting tools. So, I wondered how I could get the most out of my workshop? How could I gain more insight into the factors behind the challenges? Would I be able to check some possible tools with them, even when I don’t yet have ideas about what kind of tools I would like to present?

**Design of the workshop**

I consulted my business partner Ernst-Jan Wind, and my sounding board partners, Julia Garde and Daphne Karreman (both University of Twente). They all agreed that it was important to focus on learning more, to let my participants tell and even develop the possible solution. Together with Julia, I decided to use Serious Lego Play to provide a deeper understanding of the challenges and to let them prototype solutions out of Lego. She shared information with me about how to approach a Lego session (Garde & Van der Voort, 2016). I designed a process based on this information and decided to instruct my participants as follows:

1. Individually, build a tower of 12 Lego pieces (warming up exercise)
2. Individually, adapt your tower to create an image / model of what you like about your work and then share the results (getting familiar with building metaphors)
3. Individually, think about a situation within your project work which was not easy or fun, or when the energy level was low. Use the Lego to build an image / model that symbolizes that moment and share the result (insight on challenges)
4. Individually, think about a situation within your project work in which is was easy, fun or there was high energy (insight on elements that are important to have)
5. With the whole group, imagine you could step into a new project. How would your strategy look like to make sure that your project will have a lot of easy, fun and energetic moments and create as few problematic moments as possible? What would you bring or do to make that happen? (insight on the “tools” they would bring).

So, with this part of my workshop I hoped to give them a “tool” to express themselves more deeply than within the questionnaire and to also give them the opportunity to share ideas about what would be available in an optimal project team.

In conversation with Ernst-Jan about the questionnaire results, we thought that it would be useful to show the participants the complexity of implementation processes as found in the literature and the questionnaire results. We agreed that it would be great to show them the CFIR in order to discuss the complexity but also to discuss in more detail where their real problems lie. I worked on that idea (showing complexity) by drawing alternatives of the CFIR framework. I was looking for a way to present it more clearly and attractively. Ultimately, I came to this format, which I called the Implementation Scan, see Figure 9.
Figure 9. Game board of the Implementation Scan.

I divided the CFIR construct “characteristics of individuals” into three subgroups:

1. the project team itself,
2. the healthcare professionals who need to adopt the intervention or product, and
3. the patients or clients who are influenced by the intervention, and who also have to adapt to a new process, product or service.

I also chose to combine the CFIR construct “characteristics of the intervention” as part of the process. The intervention is the actual product or process, program or other solution the team has selected to implement in their situation. The selection and possible adaptation is a
process step (and maybe the starting point) of the project team. For the workshop I drew The Implementation Scan on a brown paper to be able to place it on the table and to have enough space for the participants to place tokens (see Figure 10).

Figure 10 Implementation Scan board as used in the workshop

With this model I hoped to give my participants a tool that would help them express which elements help and hinder during the process and to discuss why. To make it an interactive interview tool, I made a checklist of items for each element of the model (see Appendix 4). The prepared instructions were:

1. Choose one project you are working on

2. Read the check items for each element in this model and decide for each element whether this item is available in your situation
3. After checking all items, decide whether you think that this element helps or hinders your implementation project

4. If you (overall) think this element helps, then put a green token on the model. If you think it hinders, than put a red token on the model.

5. Put a token on each element in the model

6. I now give you two extra red tokens. If you could say which two elements are most important to you to discuss, because they hinder the project the most, where would you put them?

7. Share what you learned by using this “tool”. What hinders your project and why? What do you need to turn this hinderance into a helping element?

In summary, the main program of the workshop consisted of two “tools” or “techniques” to help my participants express what their challenges are: the Lego Play and the Implementation Scan. I also hoped that the interaction would also lead to ideas about “tools” to provide healthcare professionals with these challenges. While designing the Implementation Scan as a technique to let my participants reveal more about their challenges, the idea hit me that this scan could possible be part of the “toolbox” I was still hoping to design.

Finally, I also summarized my questionnaire findings to present to my participants at the end of the workshop. My goal was to have a kind of check at the end of the workshop whether the workshop outcomes still represented the items from the questionnaire or whether we had only explored some of the challenges. See the table below for my summary.
Table 4

Summary of the findings from the questionnaire for checking with the workshop participants.

<table>
<thead>
<tr>
<th>1. The implementation process gets stuck, people don’t really seem motivated. A motivated project leader or team member pushes and pulls, investing a lot of energy to keep things going. Question: what is the cause of the lack of motivation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. The implementation process is done within the primary care businesses. Sometimes even without a budget. Question: is there too little vision and focus on the importance of change processes? Is there a lack of budget? Is this the cause of Challenge Number 1?</td>
</tr>
<tr>
<td>3. Lack of focus. Some teams start too fast (not enough thinking), others are too ambitious, or some keep having new ideas without time to work on them or there are no clear boundaries.</td>
</tr>
<tr>
<td>4. Reaching the target / patient group is problematic. Making sure that there are enough enthusiastic patients to start a group intervention can also be problematic.</td>
</tr>
</tbody>
</table>
Outcomes of the planned workshop

As stated before, two of the questionnaire respondents attended the workshop. Additionally, my business partner Ernst-Jan participated. The Lego Play revealed the following insights:

- My participants mostly believe that the professionals they have to influence are enthusiastic, but that as soon as they leave the session, it is business as usual.
- The same observation applies to the project teams. Sometimes they think that they move forward but at the actual point of taking action, there is resistance within the project team.
- By using the Lego, I hoped to learn from them why this resistance takes place (the reason behind it), however the Lego Play revealed that they don’t know exactly. The situation is that they think they have it under control, while actually they do not. It seems part of their challenge, to find ways to learn what is on the mind of the other person and to find ways (together) to move forward.
- The Lego reveals that the most important thing for them is to see and feel growth; that there is a spirit of building something / growing.
- This is especially true when the effects on patients become apparent. The participants see that there are success stories, that the solution worked! Some professionals might have experienced initial resistance from the patients; they are later proud to see patient improvement. This is, after all, the moment they do it all for.
• An important strategy for them when entering a new project is to take time for project team selection and team building. Before the start, it is important to make sure that people know each other. One should understand their motivations and ambitions rather than jumping into a project without knowing each other very well.

• The participants would also have a kind of open space instead of fixed project team. This should give people the opportunity to leave or to jump in...an open atmosphere to join.

• The participants would benefit from a “good radar”; to monitor each other’s energy and where everyone is going.

• The participants emphasized the importance of celebrating small wins – to show how you grow together.

• They also wished-for encouragement from outside the project team, such as from policy makers and those at the management level.

*Figure 11. Participants working together at building their strategy*
After this Lego Play and the break, I took them to the Implementation Scan. We started as planned and I let the participants talk out loud while they went through the scan. The reactions and input they gave while working with this scan were:

- “That is such a nice checklist to have at the start of a project and to use at some points along the project!”
- “I am not able to check everything; some elements are not relevant for my project”
- “Can I also get a blue token? It is hard to choose between red and green”
- “Sometimes the element of the patient is not relevant, while the project is purely concentrated on an organizational issue”
- “The evaluation step; we are not there yet. But it’s good to see. I will give it a place in my project planning”
- “This scan really teaches me that it is all about making baby-steps”
- “It would be nice if there was also an option on this board to formulate actions for the red areas”
- “It is nice to see that we are actually doing the right things; we are pretty much on track!”
- “This whole table gives a nice overview”
- “I learned that there are a lot of things I know that people in my team are working on, however I don’t quite know what they are exactly doing. When I would do this scan with my team I would be able to ask more deliberately about their work”
• “What I like about this is that you work together on something in the middle of the table. That makes everyone focused on the project instead of focused on each other. This is a team intervention in itself”

While the participants worked on the Implementation Scan, our conversation turned quite naturally from the project they were judging with the checklist to the scan as an instrument for them. The participants spoke about how much it helped them to get an overview (see the quotes above). They combined the outcome of the Lego Play in which they showed the importance of a good team. They saw the scan as a good instrument to work as a team and to build a team. Two participants took the checklist with them; one for a colleague who was about to start a project “this will really help them start!”. The other simply stated “I want to have this!”

Extra test moment of the Implementation Scan

In the week after my planned workshop I had the opportunity to test this game again. The board of the integrated healthcare cooperation I work for as a coordinator had their regular meeting. For this meeting they had asked me to spend an hour reflecting on the results so far; and to share first ideas about the direction of the cooperation. While this cooperation mainly consists of 5 project teams - all working on implementation - I used this game to let them check for themselves what are (in general) the supporting elements in the implementation projects of their cooperation and what might be the barriers. I introduced blue tokens for neutral elements.
After they all put their coins on the different elements I asked them to write down two or three successes (pink post-its) and two or three challenges (yellow post-its).

**Figure 12.** Board members using the implementation scan to look at the implementation projects in their organization

After they all put their coins on the different elements I asked them to write down two or three successes (pink post-its) and two or three challenges (yellow post-its).

**Figure 13.** Outcome of the scan
The outcome of the scan gave this board insights into where to focus in leading this cooperation and the project teams. The outcome was then input for a strategy session a few weeks in the future. The board was very enthusiastic about this “tool”. They all liked the feeling that they were invited for a game, instead of a serious discussion. They also liked the fact that they were able to work for themselves. The scores of this board gave both them and me insight into possible challenges and needs. Here are the main outcomes of this scan on the challenge perspective:

- Most participants in the project teams experience their work for this cooperation as something extra, something besides the direct patient work and not as an integral part of their job.

- The professionals who are not participants in the teams were not interested and involved. Especially, the interest of assistants was low.

- We should find a better balance in putting energy and time into projects and the return on this investment.

- We are unexperienced with change processes and project management.

- As care professionals, we are craftsmen, dedicated to the work we learned to do, that does not match with change and innovation.

- We don’t have a good overview about what really happens in the teams.

The following outcomes show the successes:

- We are a learning organization.
• We have two beautiful projects directly contributing to our patientcare. These are the projects we are doing this for.

• In hardly two-year period, we have built an organization.

• As a side effects of doing projects we know each other better and it became easier to connect and work together in the primary process.

• We provide a safe climate to experiment.

• For those who do like working on projects, our collaboration offers a way to get inspired and to gain new input and perspectives on our work.

In about an hour time the board was able to reveal all these successes and challenges. They were happy with this result and looked forward to the strategic session to build further. I was happy with this test situation, because it reveals an important challenge. Healthcare professionals are and see themselves in the first place as craftsmen, whose primary work is to see and help patients. Innovation and change projects are all extra and not seen as an important part of their work. This refers also to what I state in the first section of this paper under the rationale for this project, about a perspective shift going from professionals as experts to professionals as co-creators and innovators. Policymakers and educators do see a significant role for the healthcare professional as innovator. However, the current professionals are not grown up with that perspective.
Main outcome: answers to my central question

I started this master project to learn with what kind of tools or toolbox I would be able to support healthcare professionals who work at incorporating new (but elsewhere existing) interventions (products, procedures, processes, prevention programs) into their practices.

What I learned is that healthcare professionals mostly benefit from:

- Tools that provide teambuilding and would support the sense of growing together.
- Tools that would gain an overview of types of resistance they could face and strategies to overcome them.
- Tools that provide an overview of the implementation process.

During this project an “Implementation Scan” emerged from my literature review and my wish to gain a better understanding of the needs of healthcare professionals. The use of this scan by professionals showed that a tool like this supports them in terms of teambuilding and the process overview. I sense that this scan, in an improved version, can serve as a basis for the toolbox.

What I see myself doing as a result of this project is to explore further how this scan can evolve to a toolbox that I can use in my business. Specific issues I want to explore are:

- How might I link this scan to personal and team style tests?
- What might be ways to include behavior change perspective (to be equipped to overcome resistance), e.g. provide the Change Objective Matrix structure of the Intervention Mapping (see Section Two)?
- What might be ways to include creative problem solving as a skill to find strategies to make people adopt the intervention / to overcome resistance?

- What might be ways to deliberately show project progress with this scan?

- How might I link this scan for project teams to the cultural issues that innovation is not seen as part of the job at all or only as part after the job?

- Most of my respondents seem to have a preference for a toolbox that is delivered by team coaching on the job or by a group course. So, how might this scan be a starting point for a team coaching day activity and / or a course for teams who like to (re)start an implementation?

- How might I be able to contribute with this scan to the education of future healthcare professionals?
SECTION FIVE: KEY LEARNINGS AND DISCUSSION

The key learnings of this project can be divided in four major parts. The first part is related to the learnings involved in the exploration of “implementation”. I was curious about the world behind that one single arrow in the Creative Change Model by Puccio et al. (2011) that refers to the adoption of a creative product leading to change. The second part is related to the things I learned by listening to healthcare professionals. The third is concerned with the learnings about myself in relation to the creative process and creative leadership. The fourth is about what I learned from the process and the unexpected things that happened. In this chapter I will not repeat the learnings in relation to my project goal. I will try to reflect on the process and discuss what I (did not) learn.

Learnings about implementation

Implementation looks so simple and obvious. When you have a creative product, the only thing is to make people adopt it. Yet, those in the field know that it is not that simple. But how does one exactly systematically introduce something new? What is the process behind implementation? What I learned from this project is the distinction between implementation as part of a creative or design process in which one tries to find a new solution to a problem versus implementation as a process by itself in case a creative product or solution is already available but needs to be introduced in a new context. This understanding was a major key learning for me. It might even be the biggest win from this project because it gave me new ground to stand on. Before this project I relied on CPS or DT as the processes to provide my
clients in implementation projects. From now on I can adapt these processes to the context of implementation projects.

I observed from the healthcare implementation literature, that creative thinking skills are hardly mentioned. Despite the mentioning of the importance of “co-creation”, it seems that both academic fields (implementation in healthcare and creative thinking) have not found each other yet. I suggest that it is important to explore the relation between creative abilities and implementation success as well as the relation between creative environments and implementation success. Research in this field will teach us more about how to foster healthcare implementation.

**Learnings from healthcare professionals**

I expected that healthcare professionals would have come up with challenges around the process of implementation and the part of adapting a solution to the current context. However, their focus on challenges lies on influencing others.

As stated earlier, this might be their blind spot. While I believe that the starting point of introducing something new, should be something that is well “designed” or “thought through” with (peers of) the group who needs to adopt it. The better that design process, the easier the adoption would be. Or the other way around, when the adoption gets stuck, it might be that the solution needs to be adopted. But it might be that the introduction strategy needs to change. Due to the participants in my project my focus is shifted more into this aspect of implementation. I also found it very interesting to learn that the whole culture and climate, or the inner setting, plays such an important role for the healthcare professionals. They do their
innovation work in a context where innovation is not experienced as part of people’s job. I learned that it is not only my job to help the team itself but also to look for ways to influence the climate around the team as well.

Personal learnings

Although this project did not lead to a specifically described and designed toolbox, I feel myself able to start developing a toolbox including teambuilding program. The creative ideas and energy flows. I also feel that these ideas could grow into a product with which I will be able to serve clients without necessarily facilitating them personally. In other words, to make a product and service that will help me to have a bigger impact without making more working hours.

More importantly is that I wished this project to help me experience more joy and fun and make myself see as a creative leader. I tried! And succeeded sometimes. But I also failed. I enjoyed the workshops and especially the first and planned one very much, including the preparation with Ernst-Jan, Julia and Daphne. I learned that I succeed in experiencing fun when I work together with people. Moments in which I which I lack joy and fun are moments when I need to be tolerant for ambiguity. I recognize the need for this tolerance and I can hold myself from jumping into conclusion, however not without a lot of frustration. It would be nice if I can be more relaxed or mindful when I don’t have the answer.

Another personal issue I faced is the fact that I am not proud of the results. In fact I am a little disappointed that I cannot present a toolbox yet. While this is rationally complete
nonsense, I keep thinking that I could and should have achieved more. So, how might I be
proud of what there is, instead of disappointed about what is not?

What makes me proud of myself is that I showed flexibility, openness and persistence in
this project. The picture I had of what a toolbox might look like, completely differs from the
picture I have now. The project shifts my perspective from a focus at the product and creative
process to people and implementation processes. I thank my own creative mindset for that.

What I also realize is that I feel myself able to bring creativity to the implementation
process. This might sound a bit weird, when you see implementation as a step in the creative
process. To follow me here, you should see, as I described in this paper, implementation as a
new process when the creative product or solution is available. The current healthcare
implementation processes do not deliberately describe the creative skills needed. They should
have a place, and I am the one to make that connection. To this point I can step into the
spotlight as a creative leader and “claim” the domain of creativity as an essential skillset in
implementing solutions for better healthcare.

Process learnings

When I look at the process in retrospective, I would have liked to find the focus of my
project sooner. This topic of implementation has been on my mind since the first summer
school and became even more important after taking an elective course in Scenario Based
Product Design at the University of Twente. However, I am also deeply interested in the
relation of creativity with our wellbeing. Furthermore, I like to take long walks, which helps me
to be and stay creative. Also, this relation, walking and creativity, and specifically how I could
combine creative leadership with walking or specifically mountain leadership is on my mind. On top of this, right before summer, teachers of my daughters’ school approached me to work with them on the translation of the CPS process and creative skills in primary school Dutch. This gave me the opportunity to turn this into a project.

Eventually I chose for healthcare implementation while it is directly relevant for my current work and because I could easily involve the people I work with. This made this a shared project, rather than a solitary event. I am still very happy that I made this choice, however it would have been nice to made up my mind earlier. During summertime I spent time writing a paper about walking, which I retrospectively rather would have spent on implementation. This would have given me probably a jump-start for this project instead of the slow start I have experienced.

Another thing I would do differently if I could do this project over again is exchange the questionnaire for interviews. If I had arranged face-to-face or telephone interviews I might would have been able to receive deeper insights. Even more interesting could have been a diary approach in which healthcare professionals collected their experiences directly after implementation project activities. This would only have been possible if I had started recruiting professionals before summer, so this relates to finding a focus soon.

I also wonder what would have happened If I had immediately focused on organizing a co-design workshop. It is difficult to know whether I would have come up with the Implementation Scan as an interview / co-design tool. However, if I had used this together with the Lego directly at the start I probably would have gained the same insights about their challenges and would have had more time for designing a toolbox. I am aware that this is speculating about “what if”.
I am even more aware that I am looking at how the process could have been improved in a way that I would have been able to deliver a concrete product. The fact that the process did not lead to a tangible product or service (yet) teaches me to appreciate other things that it did bring me. Like it did transforms me from a student bringing new insights from this master into practice to listen to people in practice about what I might could bring as a master. I should be thankful to the process for not giving me a tangible outcome. The lesson I needed to learn most is that the value and joy of a creative process does not depend on its outcome.
SECTION SIX: CONCLUSIONS

What I know now about creativity and change leadership that I did not know when I began the project is what comes between creativity and change. And that is implementation. This project made me see clearer the way implementation forms the linking pin between a new solution and a new situation. This project taught me how implementation is a process on its own, other than the implementation merely as phase of a creative process. I hope that the way I visualized this as an extended Creative Change Model will also be helpful for others.

I have a much better understanding about how creativity and implementation (as the systematic introduction of something that is designed and / or proven elsewhere) are linked. Most important, I have a better understanding about how healthcare professionals perceive this process.

As a result of the gained insights I have a better understanding about how I can contribute to implementation processes in healthcare with my creativity knowledge and skills. The “implementation scan” can be the base for a toolbox and use for training and teambuilding program. This would lead to a toolbox that may not solve all challenges, but has the potential to support implementation teams.

What I see myself doing next is to go over the different challenges I phrased at the end of section four to see whether and how it is possible to link all the criteria of a good supporting toolbox with the initial scan I made. I see myself cooperating in this with the people involved in this project plus a graphic designer. I see myself working towards a new workshop to test the concept with two or more existing teams, and with teachers in healthcare education before
introducing it as a new product and service. I will ask my sounding board partners to keep me accountable for this action.
REFERENCES


Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science, 4*, 50-x.


# APPENDIX 1: CFIR CONSTRUCTS

These are the constructs with short description from the Consolidated Framework for advancing Implementation Research (CFIR), by Damschroder et al. (2009)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Short description</th>
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<tbody>
<tr>
<td><strong>I. INTERVENTION CHARACTERISTICS</strong></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Intervention Source</td>
</tr>
<tr>
<td>B</td>
<td>Evidence Strength &amp; Quality</td>
</tr>
<tr>
<td>C</td>
<td>Relative advantage</td>
</tr>
<tr>
<td>D</td>
<td>Adaptability</td>
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<tr>
<td>E</td>
<td>Trialability</td>
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<tr>
<td>F</td>
<td>Complexity</td>
</tr>
<tr>
<td>G</td>
<td>Design Quality and Packaging</td>
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<tr>
<td>H</td>
<td>Cost</td>
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<td><strong>II. OUTER SETTING</strong></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Patient Needs &amp; Resources</td>
</tr>
<tr>
<td>B</td>
<td>Cosmopolitanism</td>
</tr>
<tr>
<td>C</td>
<td>Peer Pressure</td>
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</table>
an intervention; typically, because most or other key peer or competing organizations have already implemented or in a bid for a competitive edge.

| D  | 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. |

III. INNER SETTING

| A  | Structural Characteristics | The social architecture, age, maturity, and size of an organization. |
| B  | Networks & Communication   | The nature and quality of webs of social networks and the nature and quality of formal and informal communications within an organization. |
| C  | Culture                   | Norms, values, and basic assumptions of a given organization. |
| D  | 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. |

1. Tension for Change The degree to which stakeholders perceive the current situation as intolerable or needing change.

2. 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.

3. Relative Priority Individuals’ shared perception of the importance of the implementation within the organization.

4. 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.

5. Goals & Feedback The degree to which goals are clearly communicated, acted upon, and fed back to
6. 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 psychological safe to try new methods; and d) there is sufficient time and space for reflective thinking and evaluation.

<table>
<thead>
<tr>
<th></th>
<th>Readiness for Implementation</th>
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<tr>
<td>E</td>
<td>Tangible and immediate indicators of organization commitment to its decision to implement an intervention.</td>
</tr>
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</table>

1. Leadership Engagement

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

2. Available Resources

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

3. Access to knowledge and information

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

IV. CHARACTERISTICS OF INDIVIDUALS

A Knowledge & Beliefs about the Intervention

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

B Self-efficacy

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

C Individual Stage of Change

Characterization of the phase an individual is in, as he or she progresses toward skilled, enthusiastic, and sustained use of the intervention.

D Individual Identification with Organization

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

E 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.
<table>
<thead>
<tr>
<th></th>
<th>V. PROCESS</th>
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<tbody>
<tr>
<td>A</td>
<td>Planning</td>
<td>The degree to which a scheme or method of behavior and tasks for implementing and intervention are developed in advance and the quality of those schemes or methods.</td>
</tr>
<tr>
<td>B</td>
<td>Engaging</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Opinion Leaders</td>
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<tr>
<td></td>
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<td>Individuals in an organization who have formal or informal influence on the attitudes and beliefs of their colleagues with respect to implementing the intervention.</td>
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<td></td>
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<td>2. Formally appointed internal implementation leaders</td>
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<tr>
<td></td>
<td></td>
<td>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.</td>
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<td>3. Champions</td>
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<td></td>
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<td>Individuals who dedicate themselves to supporting, marketing, and ‘driving-through’ an implementation, overcoming indifference or resistance that the intervention may provoke in an organization.</td>
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<td></td>
<td></td>
<td>4. External Change Agents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals who are affiliated with an outside entity who formally influence or facilitate intervention decisions in a desirable direction.</td>
</tr>
<tr>
<td>C</td>
<td>Executing</td>
<td>Carrying out or accomplishing the implementation according to plan.</td>
</tr>
<tr>
<td>D</td>
<td>Reflecting &amp; Evaluating</td>
<td>Quantitative and qualitative feedback about the progress and quality of implementation accompanied with regular personal and team debriefing about progress and experience.</td>
</tr>
</tbody>
</table>
APPENDIX 2: INVITATION FOR HEALTHCARE PROFESSIONALS TO PARTICIPATE

The invitation was sent in Dutch, see the translation below

Beste zorgveranderaar,

Als geen ander weet je dat een verandering teweegbrengen in de zorg taai kan zijn. Als je bijvoorbeeld werkt aan een valpreventieprogramma, de implementatie van bewegen op recept of een e-health toepassing in een huidig proces probeert te krijgen....dan krijg je met meerdere uitdagingen te maken. Uitdagingen die een hoop tijd, energie en frustratie kunnen kosten. Ik weet er alles van! Tot ik dacht, maar wat nou als er oplossingen bestaan die het samenwerken aan verandering leuker en makkelijker maken?

Met die overtuiging, dat veranderprojecten vast leuker en makkelijker kunnen zijn, ben ik 2 jaar geleden begonnen aan de master "Creativity and Change Leadership" aan het International Center for Studies in Creativity (Buffalo State University in Amerika). Om te verkennen welke methoden, tools en technieken er zijn voor het realiseren van verandering.

Mijn rugzak zit inmiddels aardig vol. En ik heb al heel wat kunnen toepassen in mijn praktijk als o.a. Grip op Zorg GEZ coördinator (geïntegreerde eerstelijnszorg) bij Vechtverband in Breukelen. Nou kan ik die rugzak natuurlijk gewoon leegstorten. Op een website bijvoorbeeld. Zo van....kijk maar wat je eraan hebt. Maar dat lijkt me niet zo zinvol. De vraag die me dus bezig houdt is,

Wat houdt jou bezig als het gaat om het realiseren van verandering in de zorg? Waar loop jij tegenaan? Waarmee zou jij geholpen zijn?

Dit is mijn afstudeerproject. Te verkennen waarmee en hoe jij geholpen bent om samen met anderen op een leukere en makkelijker manier zorgveranderingen te realiseren. En om de uitkomsten te vertalen naar iets concreets. Verken je met me mee?
Ben je:
Een zorgverlener, welzijns werker, buurtcoach etc? Ofwel is je primaire werk het werk met patiënten of cliënten?
Werk je op dit moment met anderen samen om een verandering te bewerkstelligen?
En wil je graag dat jouw veranderprojecten (nog) leuker en makkelijker worden?

Meld je dan hieronder aan. Aanmelden kan t/m 11 oktober

Je ontvangt 12 oktober de uitnodiging voor een vragenlijst die je 15-25 min tijd kost.
Op basis van de uitkomsten zal ik een selectie maken van de inhoud van mijn rugzak. Deze leg ik graag aan je voor op vrijdag 10 november. Ik organiseer dan een interactieve workshop van 14-18 uur, waarin je een aantal verandertechnieken leert toepassen. Welke dat zijn....dat hangt dus helemaal af van jouw antwoorden.

Meedoen op 10 november hoeft uiteraard niet. In de vragenlijst kan je aangeven of je daar interesse voor hebt.

Heb je vragen? Bel of mail me gerust: carian@carean.nl of 06-48310368

Alvast dank!
Carian
Dear healthcare changer,

As no one else, you know how tough it could be to realize change in healthcare. If you for example work on a fallprevention program, the implementation of 'move on prescription' or implementing an e-health application within a current process ... then you are faced with multiple challenges. Challenges who could cost a lot of time, energy and frustration. I know everything about it! Untill I thought, what if there are solutions who could make collaborative work to achieve change could be more easy and fun?

With that conviction, that changeprojects could be more easy and fun, I started two years ago with the master "Creativity and Change Leadership" at the International Center for Studies in Creativity (Buffalo State University in Amerika). To explore which methods, tools and techniques there are for realizing change.

In the meantime my backpack is pretty stuffed. And I have had the opportunity to put a lot of it in practice in my work as a coordinator at Grip op Zorg. I could just emptying my backpack. On a website for example. Like....see what you could use. But that seems pretty useless. The question that keeps my mind busy is what keeps you busy when it comes to realizing change in healthcare? what problems do you face? With what would you be helped?

This is my graduation project. To explore with what I could help you to make collaborations with others to realize change more easy and fun. And to translate the outcomes into something tangible. Do you explore with me? (this questions is also in the picture)

Are you:
A healthcare professional? That means primary occupied working with patients / clients?
Do you collaborate currently with others to realize change?
And do you want to make your change project (even) more easy and fun?

Then please subscribe below.

You will receive on 12 October the invitation to fill in a questionnaire that will cost you 15-25 min of your time.
Based on the outcomes I will make a selection of the tools in my backpack. And will wrap this in a form that might be useful for you. I would like to explain them to you on 10 November. Then I will organize an interactive workshop from 2pm – 6pm, in which you learn to apply change techniques. Which that will be...that depends on your answers.

Participating at 10 November is offcourse not necessary. Within the questionnaire you can express your interest for this workshop.

In case of any questions, don't hesitate to contact me: carian@carean.nl or 06-48310368

Thank you in advance,
Carian
APPENDIX 3: QUESTIONNAIRE

The questionnaire was sent in Dutch, see below the original questionnaire with translations presented in italic.

Section 1: Introduction

Hoe kunnen we samenwerking in veranderprojecten in de zorg leuker, makkelijker en effectiever maken?

How can make collaborations in change projects in healthcare, more fun, easier and more effective?

Beste zorgveranderaar,

Wat fijn dat je samen met mij wil verkennen hoe we samenwerking in veranderprojecten in de zorg leuker, makkelijker en effectiever kunnen maken.

Hieronder de vragen die ik je wil stellen. Wil je de vragenlijst uiterlijk 24 oktober invullen?

Met de antwoorden ga ik op zoek naar bestaande tools en technieken die interessant voor jou kunnen zijn. Het idee is dat ik dat zo ga "verpakken" dat het bruikbaar is voor jou als zorg of hulpverlener zonder dat je persé kennis hoeft te hebben van veranderen of innoveren. Een bruikbaar EHBI (eerste hulp bij implementatie) kit...of iets dergelijks.

In de vragenlijst krijg je de mogelijkheid om aan te geven of je ook verder bij het project betrokken wil blijven. Bijvoorbeeld om mee te doen met een workshop op 10 november of om resultaten per mail te ontvangen.

Hartelijk dank vast voor je antwoorden,
Carian van der Sman

www.carean.nl
www.gripopzorg.nl
carian@gripopzorg.nl
06-48310368
Dear healthcare changer,

Thank you for helping me explore how to make collaboration in healthcare change projects more easy, fun and effective.

Please find below the questions I would like to ask you. Would you response before October 24th?

With your answers I will looking for existing tools and techniques that might be interesting for you. The idea is dat I will "wrap this up" in a way that is useful for you and applicable without knowledge about change or innovation. A usable first aid kit for implementation...or something similar.

Within the questionnaire you will get the opportunity to register for further involvement in this part. For example, to participate in a workshop at 10 November or to receive results by mail.

Thank you in advance for your answers,
Carian....

**Section 2: general**

- Wat is je primaire zorg-/welzijns-/hulpverleningsberoep? *What is your primary profession in healthcare or welfare?*
- Aan welk veranderproject werk jij op dit moment? Beschrijf hieronder kort wat jouw/jullie einddoel of opdracht is. *At what change project are you currently working on? Describe below shortly your goal or assignment.*
- Wat is jouw rol in het project? *What is your role in the project?*
- Welke zorg-/ welzijnsdisciplines zitten er in de projectgroep? *What professional disciplines are there in the project group?*
- Nemen er patiënten / cliënten deel aan het project? *Do patients take part in this project?* (select options)

<table>
<thead>
<tr>
<th>Option</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>ja, er zit een patiënt / client vertegenwoordiger in het projectteam</td>
<td>Yes, patient / client in project team</td>
</tr>
<tr>
<td>ja, we hebben geïnventariseerd hoe zij tegen het onderwerp aankijken</td>
<td>Yes, we have inventoried their view on the subject</td>
</tr>
<tr>
<td>ja, we hebben patiënten / cliënten geselecteerd voor een pilot</td>
<td>Yes, we have selected patients / clients for a pilot</td>
</tr>
<tr>
<td>nee</td>
<td>no</td>
</tr>
</tbody>
</table>
Zijn er "externen" betrokken bij het project? Dat wil zeggen mensen van binnen of buiten de organisatie die geen primaire zorgtaak hebben. Are there externals involved in the project? People from inside or outside the organization without a primary care profession or task.

<table>
<thead>
<tr>
<th>projectleider / procesbegeleider</th>
<th>Projectleader / processleader</th>
</tr>
</thead>
<tbody>
<tr>
<td>inhoudelijk adviseur op het thema of de interventie</td>
<td>Advisor / expert</td>
</tr>
<tr>
<td>onderzoeker</td>
<td>Researcher</td>
</tr>
<tr>
<td>ontwerper</td>
<td>Designer</td>
</tr>
<tr>
<td>nee</td>
<td>No</td>
</tr>
</tbody>
</table>

**Section 3: your challenges**

- Wat is jouw top 3 van uitdagingen in jullie veranderproject? Beschrijf hieronder in een paar steekwoorden wat jouw 3 belangrijkste uitdagingen zijn. In de volgende vragen kan je meer toelichting geven. *What is your top 3 of challenges in your change project? Describe below shortly. In the next questions you can give more explanation.*
- Toelichting op uitdaging 1. Beschrijf hieronder een situatie waarin deze uitdaging tot uiting komt en wat jij daarin precies ervaart. *Explanation of challenge 1. Describe below a situation in which you have experienced this challenge.*
- Toelichting op uitdaging 2. Beschrijf hieronder een situatie waarin deze uitdaging tot uiting komt en wat jij daarin precies ervaart. *Explanation of challenge 2. Describe below a situation in which you have experienced this challenge.*
- Toelichting op uitdaging 3. Beschrijf hieronder een situatie waarin deze uitdaging tot uiting komt en wat jij daarin precies ervaart. *Explanation of challenge 3. Describe below a situation in which you have experienced this challenge.*
- Wat zijn oplossingen voor deze uitdagingen die je al geprobeerd hebt? *What kind of solutions have you tried for these challenges?*

**Section 4: possible challenges**

Welk van de onderstaande uitdagingen of obstakels herken jij in het implementeren van een oplossing? Dat wil zeggen, welke ervaar jij zelf als een probleem in jullie project? Selecteer de antwoorden die je direct herkent. Bij twijfel mag je het antwoord overslaan. *Which of the challenges or obstacles below do you recognize in implementing solutions? That means, which do you experience as a problem in your project? Select the answers you directly recognize. In case of doubt skip the answer.*
<table>
<thead>
<tr>
<th>Dutch</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontbreken van een duidelijk doel of probleemomschrijving</td>
<td>Lack of clear goal or problem description</td>
</tr>
<tr>
<td>Ontbreken van een &quot;business case&quot;, duidelijkheid over wat het project op kan leveren voor wie</td>
<td>Lack of business case, clearness on the benefits of the project for whom</td>
</tr>
<tr>
<td>Management of bestuur meekrijgen</td>
<td>Involvement / support of management</td>
</tr>
<tr>
<td>Onvoldoende kennis over hoe een project te leiden</td>
<td>Lack of knowledge about project management</td>
</tr>
<tr>
<td>Niet weten waar te beginnen</td>
<td>Not knowing where to start</td>
</tr>
<tr>
<td>Neiging het wiel zelf uit te vinden / niet eerst kijken naar wat er al is</td>
<td>Tendency to reinvent the wheel / not first looking for what already is available</td>
</tr>
<tr>
<td>Werkdruk in het primaire proces waardoor project op achtergrond raakt</td>
<td>Workpressure in primary process</td>
</tr>
<tr>
<td>Gebrek aan meerdere ideeën om het probleem echt goed aan te pakken / het eerste de beste idee wordt opgepakt</td>
<td>Lack of multiple ideas to solve problems / the first idea is directly picked</td>
</tr>
<tr>
<td>Te weinig kennis over wat er leeft bij patiënten / cliënten</td>
<td>Little knowledge about the experiences of patients / clients</td>
</tr>
<tr>
<td>Onvoldoende energie of spirit in het projectteam</td>
<td>Lack of energy and spirit in the project team</td>
</tr>
<tr>
<td>Teveel vergaderen, te weinig doen</td>
<td>Too much meetings, too little doing</td>
</tr>
<tr>
<td>Een te groot vertrouwen in één oplossing / onvoldoende mix van manieren om de verandering voor elkaar te krijgen</td>
<td>Too much trust in one solution / lack of mix of different ways to achieve the change</td>
</tr>
<tr>
<td>Moeilijk om een oplossing die elders werkt goed te vertalen of aan te passen naar jullie situatie</td>
<td>Difficulties with translating a solution tot he current context</td>
</tr>
<tr>
<td>Onvoldoende communicatie over het doel van het project</td>
<td>Insufficient communication about the goal of the project</td>
</tr>
<tr>
<td>Onvoldoende kennis bij collega's om de oplossing echt goed te kunnen implementeren</td>
<td>Lack of knowledge at colleagues to implement the solution</td>
</tr>
<tr>
<td>Onvoldoende zelfvertrouwen bij collega's om de oplossing echt goed te kunnen implementeren</td>
<td>Lack of self-efficacy at colleagues to implement the solution</td>
</tr>
<tr>
<td>Onvoldoende geloof bij patiënten / cliënten dat de oplossing voor hen zal werken</td>
<td>Lack of belief at patients / clients that the solution will work for them</td>
</tr>
<tr>
<td>Onvoldoende kennis hoe je een netwerk opbouwt</td>
<td>Lack of knowledge about building a network</td>
</tr>
<tr>
<td>Onvoldoende geloof bij professionals dat de oplossing tot de gewenste uitkomsten gaat leiden</td>
<td>Lack of belief of professionals that the solution will lead tot he wished outcomes</td>
</tr>
<tr>
<td>De oplossing is te complex om te implementeren</td>
<td>The solution is too complex to implement</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Moeilijk om de oplossing op kleine schaal te testen</td>
<td>Difficult to test the solution on a small scale</td>
</tr>
<tr>
<td>Onvoldoende bestaand netwerk om de oplossing te implementeren</td>
<td>Insufficient network to implement the solution</td>
</tr>
<tr>
<td>Er wordt te weinig druk / urgentie gevoeld door professionals om de oplossing te implementeren</td>
<td>Too little pressure or urgency is felt by professionals</td>
</tr>
<tr>
<td>Onvoldoende beloning voor professionals om de oplossing te adopteren</td>
<td>Lack of incentives for professionals to adopt the solution</td>
</tr>
<tr>
<td>Onvoldoende &quot;innovatie klimaat&quot; waarin gestimuleerd wordt dat professionals experimenteren en leren</td>
<td>Lack of an innovation climate of stimulation of experimenting and learning</td>
</tr>
<tr>
<td>Onvoldoende middelen als geld, tijd, opleiding, fysieke plek</td>
<td>Lack of resources as money, time, education, physical space</td>
</tr>
<tr>
<td>Onvoldoende toegang tot kennis en informatie t.a.v. de oplossing en hoe dit te gebruiken</td>
<td>Insufficient access to knowledge and information about the solution and how to use it</td>
</tr>
<tr>
<td>Onvoldoende zelfvertrouwen bij patiënten / klanten om de oplossing echt goed te kunnen implementeren</td>
<td>Lack of self-efficacy with patients / clients to implement the solution</td>
</tr>
<tr>
<td>Onvoldoende houding bij professionals om nieuwe dingen te proberen en door te blijven gaan als het tegenzit</td>
<td>Lack of attitude at professionals for trying new things and being persistent when things fail</td>
</tr>
<tr>
<td>Ontbreken van een duidelijke planning</td>
<td>Lack of clear planning</td>
</tr>
<tr>
<td>Eenzijdige communicatie over het project (bijv alleen nieuwsbrief, niet én nieuwsbrief, én rolmodel, én social media, én informatiebijeenkomst)</td>
<td>Unilateral communication about the project</td>
</tr>
<tr>
<td>Gebrek aan &quot;champions&quot;, mensen die helemaal zijn toegewijd om de oplossing in te bedden.</td>
<td>Lack of champions, people dedicated to implement the solution</td>
</tr>
<tr>
<td>Onvoldoende committeren aan een planning</td>
<td>Lack of commitment to a planning</td>
</tr>
<tr>
<td>Onvoldoende feedback cirkels om de voortgang te bepalen</td>
<td>Too little feedback cirkels to determine the progress</td>
</tr>
</tbody>
</table>

- Als je wilt kun je hieronder je antwoord(en) op de vorige vraag toelichten of een aanvullende uitdaging noemen die door het bekijken van deze lijst bij je opkomt. *If you wish you could give an explanation about the challenges you selected.*
- Wat zijn oplossingen die je voor de aangekruiste uitdagen hebt geprobeerd? *What are solutions you have tried for the selected challenges?*
Alle uitdagingen die je genoemd hebt kunnen je veel tijd en energie kosten. Stel je voor dat er "tools" zijn die dit een stuk leuker en makkelijker maken (bijv een checklist, een brainstormtechniek, een gedragsveranderingsmethode). In welke vorm zou jij die dan willen ontvangen? (meerdere antwoorden mogelijk). All the challenges you have mentioned could cost a lot of time and energy. Imagine there are “tools” that would make it more fun and easy. In what form would you like to receive this tool? (multiple answers possible)

| online training | Online training |
| online instructie videos | Online instruction videos |
| Een groepscursus | A group course |
| boek | Book |
| online database met tools | Online database with tools |
| persoonlijke coaching on the job | Personal coaching on the job |
| blogs | Blogs |
| app | App |
| coaching on the job voor het projectteam | Coaching on the job for the project team |
| spel | game |

Section 5: follow up

Mijn volgende stap is om voor de meest genoemde uitdagingen een oplossing te presenteren. Dat worden één of meerdere tools in een vorm die mogelijk bij jou past (denk aan een video instructie of een spel). Ik wil een concept graag voorleggen aan een aantal zorg-/welzijnverleners. Wil je daaraan meedoen? Kies hieronder jouw voorkeur. My next step is to present a solution for the challenges that are mentioned most. That will become one or multiple tools in a format that possibly suits you (think of a video instruction or a game). I would like to demonstrate you a concept. Like to participate? Choose your preference here:

| Workshop 10 november in Utrecht van 14-18 uur (vul bij de volgende vraag je mailadres in) | Workshop 10 November in Utrecht from 2pm till 6pm (please leave your e-mail at the next question) |
| Per mail zodat ik daar zelf op kan reageren (vul bij de volgende vraag je mailadres in) | By mail, so that I can respond by myself (please leave your e-mail at the next question) |
| Ik ontvang graag de uitkomsten van dit onderzoek / project maar ik heb geen tijd of behoefte om daar op te reageren | I like to receive the outcome of this project, but I don’t have time or feel the need to respond. |
Wat is je mailadres? Ik heb dit nodig voor verdere informatie over 10 november, om je een concept per mail te kunnen sturen of om de eindresultaten te sturen. Deze gegevens worden losgekoppeld van je antwoorden. Antwoorden worden dus anoniem verwerkt.

What is your e-mail? I need in case to send more information about 10 November or to sent you a concept by mail. This email address will be separated from your response. So, your response will be anonymous.

Bedankt voor je antwoorden!
Thank you for your answers!
APPENDIX 4: CHECKLIST IMPLEMENTATION SCAN

See English translation in italic below

Deze implementatiescan is gebaseerd op succesfactoren die in de literatuur zijn beschreven voor implementatie van nieuwe “producten” in de zorg. Dat kunnen richtlijnen of protocollen zijn, dat kunnen ook tastbare producten of diensten zijn. In deze scan wordt het woord “interventie” gebruikt, hiermee wordt “hetgeen” bedoeld dat geïmplementeerd wordt.

Beantwoord voor elk onderdeel van deze implementatiescan de succesfactor stellingen met ja, nee of niet van toepassing. Is je antwoord “soms”, plaats dan een kruisje tussen ja en nee in. Voel je vrij om 1 of 2 (of meer) succesfactoren toe te voegen die jij voor dit onderdeel belangrijk vindt en die aan- of juist afwezig zijn.

Concludeer voor jezelf voor elk onderdeel of dit onderdeel de implementatie bevordert, belemmert of neutraal is. Jij maakt zelf die balans op. Dit wordt niet bepaald door een vast hoeveelheid kruisjes bij ja of nee. Sommige factoren wegen voor jou misschien zwaarder dan anderen. Je gebruikt de scan dus puur als hulpmiddel om je oordeel te vormen. Laat je conclusie op het spelbord zien door een groen (bevordert) of rood (belemmert) of blauw (neutraal) fiche in te zetten.

This implementation scan is based on success factors found in the literature for implementation of new “products” in healthcare. That could be guidelines or protocols, that could also be tangible products or services. In this scan the word “intervention” is used to indicate “the thing” that is implemented.

For each part of this implementations can, answer all statements with yes, no, or not relevant. If your answer is “sometimes” then put a cross between yes and no. Feel free to add 1 or 2 (or more) success factors your think are important for this element.
Make a conclusion by yourself whether this element helps or hinders the implementation or is neutral. You decide. This is not determined by a number of crosses at yes or no. Some factors might be more important for you than others.

Show your conclusion on the gameboard by putting a green (helping) or red (hindering) or blue (neutral) coin.
### Basisteam / Projectteam

**Basic team / project team**

<table>
<thead>
<tr>
<th>Stelling Statement</th>
<th>n.v.t.</th>
<th>ja</th>
<th>nee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Er is in het team voldoende diversiteit (kennis, ervaring, disciplines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is enough diversity in the team (knowledge, experience, disciplines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diversiteit in het team wordt gerespecteerd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diversity in the team is respected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Het team is voldoende stabiel voor de uitvoer van de implementatie</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The team is stable enough for the implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In het team is voldoende kennis en ervaring met veranderprocessen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The team has enough knowledge and experience with change processes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alle teamleden zijn intrinsiek gemotiveerd om met het thema of vraagstuk aan de slag te gaan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All team members are intrinsically motivated to work on this theme or challenge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Het team heeft voldoende beslissingsbevoegdheid / autonomie</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The team has sufficient decision-making power / autonomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamleden zijn in het algemeen in voor nieuwe dingen, nieuwsgierig</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team members are in general in for new things, curious</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamleden zijn bereid om risico’s te nemen, dingen te proberen waarvan de uitkomst niet vastligt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team members are willing to take risks, try new things of which the outcome is not set in stone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teamleden kunnen omgaan met situaties waar geen eenduidige oplossing of antwoord voor is / situaties die nog een beetje vaag zijn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team member are able to deal with situations for which is not only single answer/ situations that can be vague</td>
<td></td>
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</tr>
</tbody>
</table>

**Mijn conclusie:**

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
**Proces – Visie / doel / uitdaging  
Process – Vision / goal / challenge**

<table>
<thead>
<tr>
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<th>nee</th>
<th>Stelling</th>
</tr>
</thead>
</table>
|        |    |     | Het team bepaalt waar ze heen wil en formuleert een heldere visie of droom  
*The team determines where to go and formulate a clear vision or dream* |
|        |    |     | Het team stelt vast wat de grootste uitdagingen zijn  
*The team determines the biggest challenges* |
|        |    |     | Het team betrekt de kennis en ervaringen van alle stakeholders  
*The team involves the knowledge and experiences of all stakeholders* |
|        |    |     | Het team maakt een helder / visueel verhaal voor iedereen buiten het team over wat ze willen bereiken en waarom  
*The team make a clear / visual story for everyone outside the team, about what they want to achieve and why* |
|        |    |     | Het team toetst of die visie herkend wordt  
*The team tests whether this vision is recognized* |
|        |    |     | Het team weet goed de stap te maken naar de selectie / ontwerp van een interventie  
*The team is able to make the step to selection or design of the intervention* |

**Mijn conclusie:**

- Dit onderdeel bevordert de implementatie
- Dit onderdeel is neutraal in de implementatie
- Dit onderdeel belemmert de implementatie
### Proces – Interventieselectie & aanpassen / ontwerp
*Process – Intervention selection & adoption / design*

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</table>
|       |    |     | Het team verkent breed welke interventies er voor handen zijn / geschikt kunnen zijn voor hun doel  
*The team explores which interventions are available / suited for their purpose* |
|       |    |     | Het team betrekt alle stakeholders in de keuze en definitief ontwerp van de interventie  
*The team involves all stakeholders in the choice and definitive design of the intervention* |
|       |    |     | Het team is in staat de interventie aan te passen aan de huidige situatie  
*The team is able to adapt the intervention to the current situation* |
|       |    |     | Het team maakt benodigde materialen om de interventie te kunnen uitvoeren (bijv. flyer, informatie op een website, training / instructie voor professionals, draaiboek)  
*The team makes necessary materials to execute the intervention (like flyer, information on the website, training / instruction for professionals)* |
|       |    |     | Het team start met het uitvoeren en naar buiten brengen als materialen (iiig in concept) klaar zijn.  
*The team starts with the execution when all materials (at least in concept) are ready.* |

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**Proces – Interventie uitvoeren**

*Process – execution of the intervention*

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<tbody>
<tr>
<td></td>
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<td></td>
<td>Het team maakt een mix van manieren om de interventie onder de aandacht te brengen bij stakeholders (bijv. sociale media, team overleggen, wachtkamerschermen, posters, informatiebijeenkomst, nieuwsbericht of krant, referenties) <em>The team makes a mix of ways to get attention for the intervention (like social media, team meetings, posters, information meetings, newsletter)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Het team heeft een planning mbt wanneer ze welke strategie toepassen om aandacht te vragen voor de interventie <em>The team has a planning in regard to when its time for which strategy to ask attention for their intervention</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Professionals en patiënten/ cliënten die ermee aan de slag willen snappen wat ze moeten doen <em>Professionals and patients / clients understand what is expected from them</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Er is een vraagbaak voorhanden <em>There is an oracle available</em></td>
</tr>
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<td></td>
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<td></td>
<td>Het team zoekt en belooft de ‘early adopters’ <em>The search for and rewards early adopters</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Het team maakt gebruik van early adopters om anderen mee te krijgen <em>The team uses early adopters to get others on board</em></td>
</tr>
</tbody>
</table>

**Mijn conclusie:**

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### Proces – Interventie evalueren

*Process – evaluate intervention*

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</table>
|       |    |     | Het team evalueert regelmatig hoe de implementatie loopt en of doelen bereikt (lijken te) worden  
|       |    |     | *The team evaluates regularly*                                                                                                              |
|       |    |     | Het team voelt aan wanneer er extra de schouders ondergezet moeten worden of dat er (tijdelijk) gestopt moet worden of koersverandering nodig is  
|       |    |     | *The team senses when its time to work harder, to stop or to change the direction*                                                          |
|       |    |     | Resultaten (hoe klein ook) worden gedeeld en gevierd  
|       |    |     | *Results (even small ones) are shared and celebrated*                                                                                  |

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### Professionals buiten het basisteam die de interventie moeten uitdragen / uitvoeren

*Professionals outside the basic team / project team who needs to carry or execute the intervention*

<table>
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</thead>
</table>
|       |    |     | Er zijn voldoende professionals die de interventie uitdragen en weerstanden wegnemen  
|       |    |     | *There are enough professionals who carry the intervention and remove resistances*                                                       |
|       |    |     | Professionals zijn gemotiveerd/ hebben de intentie om de interventie uit te voeren. Indien nee, gebruik de onderstaande aspecten om de mogelijke reden te achterhalen (zie hieronder):  
|       |    |     | *Professionals are motivated / have the intention to execute the intervention. In case the answer is no, use the statements below to find out possible reasons* |
|       |    |     | Ze zijn over het algemeen gemotiveerd om nieuwe dingen uit te proberen  
|       |    |     | *They are motivated in general to try new things*                                                                                 |
|       |    |     | Ze ervaren dat er iets aan de huidige situatie, waar de interventie iets aan probeert te veranderen, moet gebeuren  
|       |    |     | *They experience that the current situation needs to change*                                                                         |
|       |    |     | De waarden van de interventie passen bij hun persoonlijke waarden  
<p>|       |    |     | <em>The values of the intervention match with their personal values</em>                                                                      |
|       |    |     | Ze vinden de interventie belangrijk in relatie tot andere interventies / uitdagingen                                                   |
|       |    |     |                                                                                                                                 |</p>
<table>
<thead>
<tr>
<th>They think that the intervention is important in relation to other interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ze hebben kennis en vaardigheden om de interventie uit te voeren</td>
</tr>
<tr>
<td>They have knowledge and skills to execute the intervention</td>
</tr>
<tr>
<td>De gevraagde handelingen / gedrag is makkelijk uit te voeren, het ligt als het ware “voor het grijpen”, er zijn geen verschillende randvoorwaarden of obstakels</td>
</tr>
<tr>
<td>The activities / behavior asked by the intervention are easy to perform, it is “easy to grasp”, there are no different conditions or obstacles</td>
</tr>
<tr>
<td>De interventie past goed in de huidige processen of “workflow”</td>
</tr>
<tr>
<td>The intervention suits the current processes or workflow</td>
</tr>
<tr>
<td>Ze geloven dat de interventie gaat werken / effect zal hebben</td>
</tr>
<tr>
<td>They believe that the intervention will have effect</td>
</tr>
<tr>
<td>Ze hebben een positief gevoel bij de interventie</td>
</tr>
<tr>
<td>They have a positive feeling about the intervention</td>
</tr>
<tr>
<td>Ze hebben de perceptie dat collega’s de interventie ook uitvoeren</td>
</tr>
<tr>
<td>They have the perception that other colleagues will execute the intervention</td>
</tr>
<tr>
<td>Ze hebben een positief gevoel bij wat anderen ervan zullen denken als ze de interventie uitvoeren</td>
</tr>
<tr>
<td>They have a positive feeling about what others would think about the fact that they execute the intervention</td>
</tr>
<tr>
<td>Ze hebben de perceptie dat de interventie makkelijk uit te voeren is</td>
</tr>
<tr>
<td>They have the perception that executing the interventie is easy</td>
</tr>
<tr>
<td>Ze hebben zelfvertrouwen dat het uitvoeren van de interventie gaat lukken</td>
</tr>
<tr>
<td>They have self confidence in executing the intervention successfully</td>
</tr>
</tbody>
</table>

Mijn conclusie:

| Dit onderdeel bevordert de implementatie | Dit onderdeel is neutraal in de implementatie | Dit onderdeel belemmert de implementatie |
### Patients / clients for which the intervention is mentioned

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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Patiënten/ cliënten zijn gemotiveerd / hebben de intentie om de interventie uit te voeren. Indien nee, gebruik de onderstaande aspecten om de mogelijke reden te achterhalen: <em>Patients or clients are motivated / have the intention to execute the intervention. In case the answer is no, use the statements below to find the possible reason(s) for resistance:</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze ervaren dat er iets aan de huidige situatie, waar de interventie iets aan probeert te veranderen, moet gebeuren <em>They experience that something needs to change about the current situation</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>De waarden van de interventie passen bij hun persoonlijke waarden <em>The value of the intervention suits their personal values</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze vinden de interventie belangrijk in relatie tot andere interventies / uitdagingen (er speelt niet iets anders dat nu belangrijker is) <em>They think that the intervention is important in relation to other interventions (there is nothing else more important than the topic of the intervention)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze hebben kennis en vaardigheden om de interventie uit te voeren <em>They have the knowledge and skills to execute the intervention</em></td>
</tr>
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<td></td>
<td></td>
<td>De gevraagde handelingen / gedrag is makkelijk uit te voeren, het ligt als het ware “voor het grijpen”, er zijn geen verschillende randvoorwaarden of obstakels <em>The activities / behavior asked by the intervention are easy to perform, it is “easy to grasp”, there are no different conditions or obstacles</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>De interventie past goed in het dagelijks leven van de patiënt / cliënt <em>The intervention fits well into the daily life of patients / clients</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze geloven dat de interventie gaat werken / effect zal hebben <em>They believe the intervention will work / will have effect</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze hebben een positief gevoel bij de interventie <em>The intervention gives them a positive feeling</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze hebben de perceptie dat anderen in hun situatie de interventie ook uitvoeren <em>They have the perception that others in their situation would also execute the intervention</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ze hebben een positief gevoel bij wat anderen ervan zullen denken als ze de interventie uitvoeren <em>They have a positive feeling about what others might think that they execute the intervention</em></td>
</tr>
</tbody>
</table>
Ze hebben de perceptie dat de interventie makkelijk uit te voeren is  
*They have the perception that executing the intervention is easy*

Ze hebben zelfvertrouwen dat het uitvoeren van de interventie gaat lukken  
*They are self-confident in executing the intervention*

---

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### Ondersteuning interne organisatie  
*Support by internal organization*

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</table>
|        |    |     | Praktijkhouders / managers tonen betrokkenheid bij de implementatie  
  *Managers show involvement with the implementation* |
|        |    |     | Aangesloten praktijken / afdelingen zijn stabiel (geen grotere veranderingen gaande)  
  *Practices or departments involved are stable (no substantial changes / unrest going on)* |
|        |    |     | Er is sprake van een “community gevoel” tussen aangesloten praktijken / afdelingen. Er is grote bereidheid om met en voor elkaar iets te doen.  
  *There is a sense of community between practices / departments. There is willingness to work with and for each other* |
|        |    |     | De communicatie vanuit de organisatie en/of betrokken praktijken / afdelingen wordt overwegend als helder en open ervaren  
  *The communication by the organization or involved practices or departments are in general perceived as clear and open* |
|        |    |     | Medewerkers van betrokken praktijken / afdelingen ervaren dat hun ideeën en feedback op prijs worden gesteld  
  *Employees of involved practices / departments experience that their ideas and feedback are valued* |
|        |    |     | Medewerkers van betrokken praktijken / afdelingen ervaren dat ze essentieel zijn en gewaardeerd worden in veranderprocessen  
  *Employees of involved practices / departments experience that they are essential and valued in change processes* |
|        |    |     | De implementatie van interventies past over het algemeen bij de cultuur en waarden van betrokken praktijken / afdelingen  
  *The implementation of interventions in general suits the culture and values of involved practices / departments* |
|        |    |     | De organisatie inclusief onderliggende praktijken / afdelingen biedt  
  *The organization and sub-practices / departments offer* |
The organization provides enough resources as time, money, training
The organization provides a sufficient “information system” to share information about the intervention
The organization has a culture / atmosphere in which one is allowed (or even encouraged) to make mistakes

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**Ondersteuning buitenaf**
*Support from outside the organization*

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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Er zijn externen betrokken die door middel van expertise of rol de implementatie positief beïnvloeden</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>Externals are involved who have, by their expertise or role, a positive influence on the implementation</em></td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Er zijn goede relaties met externe partijen die nodig zijn om de implementatie uit te voeren</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>There are good relations with external parties necessary to implement the intervention</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Er is sprake van een bepaalde druk van buitenaf om de interventie te implementeren</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>There is a certain pressure from outside to implement the intervention</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Er zijn externe factoren die de implementatie positief beïnvloeden zoals wet- en regelgeving, richtlijnen, aanbevelingen, benchmarks, campagnes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><em>There are external factors that positively influence the implementation like regulation, guidelines, recommendations, benchmarks, campaigns</em></td>
</tr>
</tbody>
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___________________________
Carian van der Sman
11 December 2017