Stakeholder Engagement—
Designing the HARP CDM Program:
Southern Health Catchment
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Key Objectives of the Report

The “Stakeholder Engagement – Designing the HARP CDM Program: Southern Health Catchment” report is concerned with the analysis of the stakeholder engagement and consultation process during the design phase of the Southern Health HARP CDM model. The analysis was informed by the principles of the Centre for Disease Control and Prevention’s “Framework for Planning and Implementing Practical Program Evaluation” (Fink, 2005) with particular emphasis on an action research approach.

Specifically, the key objectives of this report were to:

- identify stakeholder experiences of the design process, including stakeholder engagement and the development of the HARP CDM model;
- provide information on potential and actual facilitators of stakeholder engagement during the design and implementation phase;
- provide information on potential and actual barriers of stakeholder engagement during the design and implementation phase;
- broadly disseminate these findings to relevant stakeholders;
- inform the Southern Health HARP CDM implementation phase.
Executive Summary

Background:

The HARP CDM program, funded by the Department of Human Services (DHS), is a major initiative, the objective of which is to mainstream and extend the principles of the successful Hospital Admission Risk Programs (HARP) throughout Victoria. The program involves regional-level development of a large scale, integrated chronic disease management (HARP CDM) program, and can be divided into three broad phases: the design phase, wherein the program’s model of care is designed and the plan for implementation developed; the implementation phase; and the embedding phase, in which the program becomes a core component of the health services system. Southern Health management engaged a research and evaluation (R&E) team from the School of Psychology at Deakin University to identify, analyse and report on stakeholder experiences of the design phase of HARP CDM.

Key objectives of the report:

The key objectives of the report were twofold. The primary objective was to identify, analyse and report on stakeholder experiences of the design process, including stakeholder engagement and the development of the model. The second objective was to utilise these findings to inform the Southern Health HARP CDM implementation plan.

Methodology and Findings:

Research methodology included stakeholder interviews, participant observation and a review of the relevant literature. Findings from the data sources are presented with reference to both generic organisational change literature as well as research focusing more specifically on large-scale initiatives within health care settings.

Thirty-one key stakeholders involved in the HARP CDM design phase were consulted via semi-structured individual and group interviews. The vast majority of the interviewees were involved with the design of Southern Health HARP CDM from
inception. They were part of a larger group that had been invited to attend the original HARP CDM forum, which was held in September 2005 at Cape Schanck.

Interested stakeholders from the Cape Schanck forum were identified as the HARP CDM Alliance. Members of the original Alliance Group were subsequently invited to participate in either the Implementation and/or the Working groups. These groups were intrinsically involved in the system design across a range of key areas. The stakeholders continued to be deeply involved in the design process and in the activities of more than one group. For example, many participants were members of the Alliance, Implementation Group (IG) and one or more of the Working Groups (WG).

The interviews were designed to collect data regarding stakeholder views of the current service system and their experiences of the design process. The focus of this report is on the **stakeholder experiences** of the design phase. Interview questions were grouped into three areas:

- How engaged in the design process did stakeholders feel?
- What were the facilitators of engagement?
- What were the barriers to engagement?

Interviews were transcribed and qualitative analysis focused on identifying emerging themes utilising a content analysis approach. Responses were analysed from an organisational psychology perspective, evaluating levels of stakeholder engagement as an indicator of successful change management practice.

Overall, the stakeholders reported high levels of engagement with the design process and identified more facilitators (n=60) than barriers (n=27) to their involvement. Stakeholders identified positive factors such as inclusive facilitation during the full-day Stakeholder forums and well-organised Implementation/Working Group (IG/WG) meetings as important facilitators. Adequate lead-time during the design phase; consistent, broad membership of both management and stakeholders were also identified as major factors in their satisfaction with the process. Barriers to the process primarily focused on the time commitment involved in participating in both the two-day forums and the IG/WGs; the volume of documentation and
communication difficulties associated with the magnitude of the initiative. In addition, some internal stakeholders reported a lack of acknowledgement of existing learnings within the service. Findings from participant observation were generally consistent with the findings from interviews and are incorporated into the critical findings section.

It was concluded that Southern Health had been highly successful in engaging a broad range of stakeholders in the system redesign of HARP CDM. Best practice principles of consultation, collaboration, commitment by management and a culture of communication have resulted in a model which has the capacity to produce sustained improvement in delivery of HARP CDM to the Southern Health catchment. Based on findings from stakeholder interviews, participant observation and a review of best practice literature, six recommendations are proposed.

**Key recommendations:**

The six key recommendations made below are relevant to both the ongoing development of HARP CDM, as well as to other large scale system redesign projects within a health care network. It is recommended that:

1. **Management continue the strategy of utilising both internal and external expertise to assist the HARP CDM design and implementation process**

Professional facilitation of stakeholder forums encouraged full engagement with the design process and was well received by participants. Provision of an external change management consultant enabled staff to work with management on issues related to workforce development and organisational change. Management maintained strong links with researchers who possess specialist competencies in organisational theory, action research methods and knowledge of the relevant health care literature.

2. **Management continue to prioritise adequate lead time when engaging in system change**

An important element of success was management’s recognition of the time commitment required from participants, and allowing reasonable time for
stakeholders to contribute to the lead-up and planning commitments associated with a large system redesign such as HARP CDM.

3. **Key learnings from existing staff involved in similar projects are acknowledged and utilised**

Many of the stakeholders involved in HARP CDM had prior experience with HARP projects and were keen to make an even greater contribution to the redesign process. Whilst these stakeholders were involved in many of the working groups and forums, greater utilisation of their learnings could capitalise on positive experience and ensure that mistakes are not repeated.

4. **Broad representation and consultation is maintained**

It is recommended that Southern Health maintain the strategy of broad representation and consultation with stakeholder groups both from within and external to the organisation. Stakeholder groups include government, peak bodies and community agencies, health service staff, consumers and their families.

5. **HARP CDM management further formalise the communication strategy**

It is recommended that Southern Health consider a range of strategies that ensures clear communication between IG/WG, targets the delivery of information to attendees (i.e., reduce the volume of documentation), and defines a formalised strategy for the subsequent dissemination of information to others within their organisation.

6. **Southern Health ensure a stable presence of HARP CDM management**

Given the integral importance of relationships and partnerships between stakeholders, it is highly recommended that where possible, a stable presence of management and stakeholders be encouraged, providing stability of vision and investment in the initiative.
Background to HARP CDM

Chronic and complex diseases constitute a substantial and growing health and economic burden across the Western world. Those with chronic disease are not well served by existing fragmented health service systems, more suited to the delivery of episodic care for acute health problems (Department of Health, 2004; WHO, 2002). The need to improve outcomes for clients and reduce acute health care costs has prompted national efforts in the United Kingdom and America, as well as regional efforts in many Western countries, to put in place models for the effective management of chronic disease.

The Hospital Admission Risk Program (HARP) was established in 2001-02 by the Victorian Government to develop preventive models of care involving hospitals and community agencies, which focused on people with chronic and complex conditions. HARP Chronic Disease Management (HARP CDM) involves embedding models of care that have emerged through HARP into the Victorian service system. The system redesign entails regional-level development of a large scale, integrated chronic disease management program, to be designed and implemented over an initial period of three years. Three broad phases can be identified: the design phase, wherein the program’s model of care is designed and the plan for implementation developed; the implementation phase; and the embedding phase, in which the program becomes a core component of the health services system.

Southern Health recognised the need for collaborative management of the design of the HARP CDM program and has invested significant resources to involve stakeholders at all levels. Stakeholders of a public health service provider as large as Southern Health range from the State government (the source of the majority of funding and the prescribers of service delivery requirements), peak bodies and community agencies; to health service staff and health service consumers and their families (Bachman & Duckworth, 2003; Goding, 2005). Input from consumers is especially important, as it is the needs of the consumer that usually drive the initial change (Bachman & Duckworth, 2003).

When considering a health service network as large as Southern Health, creating organisational culture change from within requires a variety of strategies, such as
education and communication, participation and involvement, facilitation and support. Visionary leadership is required to guide, drive and inspire stakeholders and change agents alike throughout the organisation. Long-term, stable leadership has the added benefit of reinforcing and institutionalising change, resulting in a sustainable outcome (Graetz, Rimmer, Lawrence, & Smith, 2002; Kanter, Stein, & Jick, 1992).

The two main components of the HARP CDM design phase were a stakeholder engagement process, and development of the HARP CDM model of care and the plan for its implementation. Southern Health’s HARP CDM leadership team adopted a consultative/collaborative approach, engaging a diverse range of stakeholders in a comprehensive participatory process to develop and implement the HARP CDM model of care.

**Southern Health Design Strategy**

The initial key elements of the HARP CDM model, developed though broad consultation with Southern Health Staff, Consumers, General Practitioners (GPs), Local Government Services, Community Health Services, the Royal District Nursing Service and other organisations; were presented to DHS in December 2005. Stakeholder representatives involved in this stage of the consultation process were termed the “Alliance”.

Subsequently, an Implementation Group was established to oversee and guide the ongoing development of the model. Reporting to the IG were three Working Groups; expert advisors from Human Resources; health service and organisational psychology consultants from Deakin University; Information Management; and Change Management consultants.

The Working Groups’ terms of reference required each to address one of three major components of the HARP CDM model: Eligibility for HARP CDM; Referral Mechanisms and Defined Point of Access; and Program Care Coordination & Care Planning. In addition to WG meetings, six full-day forums were held over the period of September 2005 to July 2006.
A further three key stakeholder forums, a consumer forum, and a number of presentations including one to the Southern Health Consumer Advisory Committee and the Southern Health Executive Management Team were conducted. These forums and presentations gave opportunity for feedback and input into the model. The consultative process resulted in the development of an integrated model of care, which aimed to address many of the issues identified in the HARP Evaluation Reflections Report to DHS in February 2005.

Current HARP project staff were involved in the initial planning and subsequent forums and IG/WG meetings. A decision was made by management at the beginning of the process to approach HARP CDM as a ‘Greenfield site’ in order to facilitate the generation of new and innovative ideas, through broad input from a diverse range of stakeholders, not constrained within the framework of existing projects.

**Evaluation Methodology**

DHS prepared a framework to guide the evaluation of HARP CDM, which stated the overall evaluation aim to be:

“To identify, monitor and provide timely advice about key areas that will appropriately inform the planning, implementation, program development and quality management of HARP CDM.” (DHS, 2005, p.1).

These objectives constitute the evaluation framework developed to guide the various health service regions in regard to embedding ongoing evaluation and feedback as part of the HARP CDM program.

Southern Health prioritised ongoing evaluation within an action research framework, engaging the Deakin University R&E team early in the design phase. This allowed for ongoing input and reflection at regular intervals. The first major task of the R&E team was to report on stakeholder engagement during the design phase. In line with best practice qualitative research, multiple methodologies were utilised. These included participant observation, stakeholder interviews, and a review of relevant literature on organisational change within health care settings.

Three main questions guided the methodology and the type of interview questions asked. These were:
How engaged in the design process did stakeholders feel?

What were the facilitators of engagement?

What were the barriers to engagement?

**Participant Observation**

Participant observation was conducted at several forums and workshops between September 2005 and April 2006 (refer Appendix). Observations concerning stakeholder attitudes, perceptions, and experiences of the engagement and design process were recorded and analysed. Findings regarding potential facilitators and risks to the project were presented to project leaders over the course of the design process, in written and verbal form, to enable their proactive management.

Data collection was in the form of notes taken by the participant observer during the event, and written up immediately thereafter. Relevant themes identified through content analysis were interpreted in the context of the literature. The validity of findings was subsequently confirmed through consistent findings from interviews.

**Stakeholder interviews**

The Deakin R&E team, in consultation with HARP CDM senior management and a HARP project worker, developed two interview schedules. Broad areas for inquiry were sourced from the relevant literature and the participant observation findings. The first was a pre-interview questionnaire (for completion prior to the interview) and the second was a semi–structured interview schedule (for use during interviews). Schedules were tailored to specific stakeholder groups, that is, staff of existing HARP projects, Southern Health employees, and external stakeholders. Interviews were conducted following piloting of the schedules.

Upon completion, interview data was transcribed and entered into the qualitative data analysis program NVIVO for interpretation. Consistent with qualitative research methods, the data were analysed to identify emerging themes and common threads. Data from each stakeholder group were analysed both independently and collectively, to identify commonalities and differences across the sources. In order to ensure anonymity of the participants, large or identifiable quotes were not included in the report.
Stakeholder Sample

A list of key stakeholders was obtained from Southern Health management. The R&E team, in consultation with the Southern Health HARP CDM management team and representative stakeholders, identified potential interviewees from within the Alliance, Implementation and Working Groups.

A total of 50 stakeholders (consisting of individuals both internal and external to Southern Health) were invited to participate in either individual or group semi-structured interviews. Nineteen declined or were not available and subsequently, 31 stakeholders (62% response rate) were interviewed during June and July 2006. All participants signed an informed consent form and were assured of the confidentiality of the data. The Deakin University Human Research Ethics Committee approved the project.

The gender, age and employment details of the sample are listed in Table 1 below. The majority of stakeholders interviewed were female, in the 51-60 year age group.

Table 1: Demographic details of stakeholder sample

<table>
<thead>
<tr>
<th>Gender</th>
<th>N = 31</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>81</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>N = 31</th>
<th>%</th>
</tr>
</thead>
<tbody>
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<td>19</td>
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<td>41 – 50</td>
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<td>26</td>
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<td>51 – 60</td>
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<td>35</td>
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<tr>
<td>&gt; 60</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
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<td>4</td>
<td>13</td>
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<tr>
<td>Total</td>
<td>31</td>
<td>100</td>
</tr>
</tbody>
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Stakeholders represented a range of professions both internal and external to Southern Health (refer to Table 2). Thirty percent of the stakeholders were external to Southern Health, the majority whom were from divisions of General Practice. Existing HARP project staff comprised 29% of the interviewees and the remaining 42% comprised other Southern Health staff.

Table 2: Employment details of stakeholder sample

<table>
<thead>
<tr>
<th>Places of Employment</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External to Southern Health</strong></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>7</td>
</tr>
<tr>
<td>Local Government</td>
<td>3</td>
</tr>
<tr>
<td>Divisions of General Practice</td>
<td>19</td>
</tr>
<tr>
<td><strong>Internal to Southern Health</strong></td>
<td></td>
</tr>
<tr>
<td>Community Health Services</td>
<td>16</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>3</td>
</tr>
<tr>
<td>Primary Care</td>
<td>13</td>
</tr>
<tr>
<td>HARP CDM project staff</td>
<td>29</td>
</tr>
<tr>
<td>Hospital/medical staff</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100</td>
</tr>
</tbody>
</table>

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Critical findings

Key findings emerging from the data are presented under the headings below. Findings are grouped under the three main research questions:

- How engaged in the design process did stakeholders feel?
- What were the facilitators of engagement?
- What were the barriers to engagement?

**Key findings**

**How engaged were stakeholders during the design phase?**

- Stakeholders reported high levels of satisfaction with the process;
- Collaborative effort was considered to be very productive;
- Stakeholders appreciated the opportunity to be involved in the design process, and the stability of both leadership and membership.

Participant observation findings suggested that stakeholder engagement was strong, and this was confirmed by interview findings. Overwhelmingly, interviews revealed stakeholders to be very satisfied with the process of the HARP CDM design phase. The majority of stakeholders reported that the collaborative effort was “very productive” and that the forums and IG/WG were “well facilitated and organised” and provided “clear goals” for each of the sessions.

Despite the large time commitment, stakeholders appreciated the opportunity to be involved in the design of a model that will affect the way health services are delivered within their region. In addition, stakeholders embraced the opportunity to provide feedback to management in the anonymous interview environment, with many of the individual interviews running over time. High levels of involvement and input such as these are excellent indicators of a personal commitment to the outcome and of successful stakeholder engagement.

“Consistent attendance” whereby “players didn’t change (and) stakeholders didn’t change” was recognised as an important factor in the continuity of the design process,
contributing to the sustainability and legitimacy of the HARP CDM program. One respondent reported “it was almost like a reunion when you got back together”. The benefits of consistent involvement include stability of vision as well as the nature of the relationships developed during the process.

Key Findings

What factors facilitated the process of engagement?

- Broad representation of stakeholders provided balanced input;
- Strong culture of communication and quality of documentation;
- Professional facilitation promoted information sharing and productive collaboration;
- Adequate lead-time allowed opportunity for input and reflection on the change experience;
- Time away encouraged a direct focus on the model.

Participant observation findings suggested that the commitment by Southern Health to broad stakeholder consultation in the design phase, evidenced in the provision of adequate lead time, professional facilitation, and inclusion of a broad range of stakeholders, was highly valued. This was confirmed in interview findings.

Interviewees greatly appreciated the broad representation of stakeholders involved in the process. Typical responses for interviewees referred to the attention paid to ensuring “multi-skilled, multi-disciplinary type mixes”, allowing everyone the “opportunity to participate and network” and to provide opportunities “for trust and partnership building”. Diversity of representation was particularly appreciated by those stakeholders external to Southern Health, a group that represented the majority of GPs involved in the initiative. One of whom noted that the design process provided “the opportunity to meet with a whole lot of very keen, dedicated people. It has been quite inspiring.”

Interviewees commended Southern Health management for fostering a strong culture of communication around the change initiative, with interviewees reporting that the
culture “encourages information sharing.” Effective communication was supported by “the documentation (which) facilitates information sharing about HARP CDM in my workplace”.

A strategy of extensive communication, combined with professional facilitation, engendered collaboration amongst stakeholders, who identified several factors that created opportunities to speak such as encouragement to “share their individual knowledge and experience” and an “inclusive, friendly environment”. Typical sentiment expressed by one GP was an appreciation for the “acceptance of GP issues and how they interact with the program”.

Stakeholders reported that their opinions were solicited and heard. They appreciated the flexibility which was demonstrated in the incorporation of people’s input and ideas into the evolving model. A typical comment was that “issues were clearly heard and taken up, and the model reflected those issues”. Those stakeholders external to Southern Health were particularly supportive of the facilitation within the two-day forums and the level of organisation in the IG/WG meetings.

Stakeholders reported that the “generous lead-time” allocated to the design process allowed groups to work together effectively, consider the model and incorporate the views of others. One respondent reported, “one of the advantages…as opposed to any other joint initiatives…is that there has been a very long lead up phase”.

Finally, stakeholders identified “time away to focus on the design process” as a significant facilitator to their contribution in the design process, with the added benefit of giving stakeholders the opportunity to “build links and network”. Implementation and Working Group members reported that they were given “adequate time” to meet and work together on their HARP CDM tasks.
Key Findings

What barriers influenced the engagement process?

- Considerable time commitment affected involvement;
- Prior experience and existing expertise required greater consideration;
- Greater communication between working groups was needed;
- Volume of documentation hindered access to information.

Understandably, the reality of “lack of time” was still the most regularly quoted barrier to full engagement with the Southern Health HARP CDM design process. This was a shared concern amongst all involved, and the primary barrier quoted in regard to involvement in both the two-day forums and IG/WG activities. Although a few participants valued the opportunity to back fill their positions, this was not practicable for many who maintained their existing workload.

Participant observation findings noted that existing HARP project staff were concerned with the lack of acknowledgement of their previous experience with HARP projects. This issue was explored during the interviews. This stakeholder group perceived there to be a “lack of utilisation of past experience and prior learnings”. They considered that knowledge and experience gained from existing HARP projects, and highly relevant to the design of the HARP CDM model of care, was not always acknowledged or incorporated into the design process. The relevant stakeholders expressed a desire for “key learnings (to have) a higher priority and greater input”. Non-HARP program staff and external stakeholders (who appreciated involvement in the process) did not report this as a barrier. In response to the concerns voiced by HARP project staff, and to assist with the general change process, a change management consultant was engaged by Southern Health to address this issue. Responding to this issue in a timely manner is an excellent example of the value of an action research framework. This methodology provides opportunities for ongoing reflection and adjustment during the design phase rather than leaving this till project completion.
Working group participants recognised that decisions made outside the working group meeting times, or within other working groups, affected their part of the model and noted that lack of information sharing between IG/WGs was problematic. Task-oriented groups are very effective in generating widespread involvement and enthusiasm for change processes. However, they also run the risk of working unilaterally and may require clear procedures to ensure that their activities are communicated to the wider organisation and reviewed periodically, to ensure that they are kept on track.

Time pressures also influenced the effective dissemination of information from IG/WG members to the personnel within the organisations that they represented. Feedback from stakeholder interviews suggested that they did not follow a consistent, documented reporting procedure regarding their HARP CDM activities. *Lack of time* was regularly quoted as the reason for this omission.

A related barrier was the volume of documentation generated within the project and the time required for reading, management and distribution. A typical comment on this issue was “part of the challenge has been that they (Southern Health) have put out a lot of documentation ... it was taking me hours and hours to read”. Some interviewees suggested the utilisation of different technologies via the Southern Health web page and intranet, to maximise access to information and resources related to HARP CDM activities.

Southern Health was recognised by stakeholders as defining “*clear goals and objectives*” in regard to direction on roles and responsibilities. However, a few participants were not aware that the Deakin R&E team were asked by management to actively participate in the discussions of Working Group One. In this respect, a small group of stakeholders were confused about the role of the team during those particular working group meetings.
Analysis of Key Learnings

What has been learnt about the Engagement Process?

The data collected indicates that the stakeholder engagement process has, overall, been highly successful. The majority of interviewees were satisfied with the Southern Health HARP CDM design process and identified a greater number of factors that facilitated the engagement process compared to those that may have hindered it. A number of key learnings emerge from the data. These are:

- Utilisation of both internal and external expertise was a significant contributor to reported high levels of stakeholder satisfaction.
- Commitment of time was a critical element of successful engagement.
- Acknowledgment and utilisation of prior experience and existing key learnings provides multiple benefits to the organisation.
- Broad stakeholder representation and consultation was highly valued.
- Dissemination of information regarding HARP CDM to others is an important element of effective change implementation.

Stakeholders across all groups indicated that they appreciated the efforts of the professional facilitator during the two-day planning forums, as well as the supportive environment of the IG/WG meetings. Effective facilitation has been identified as a major factor in the promotion of stakeholder engagement during the design of any large-scale health initiative and can reduce staff resistance to change. Added benefits include facilitating a personal commitment to the outcome and drawing on the experience and expertise of those involved (Kanter et al., 1992).

Successful organisational change efforts are characterised by the skilful application of a variety of approaches, most significantly supportive facilitation, participation, education and communication, in order to articulate a shared vision for the initiative (Kanter et al., 1992). Supportive facilitation of stakeholder discussions ensures clear communication within a supportive and collaborative environment and works to
establish widespread understanding of the vision underpinning change (Gulliver, Towell, & Peck, 2003). Organisational literature denotes attention to the feelings and responses of the people within the organisation as one of the major factors in enhancing their engagement with the process and thereby ensuring successful transition (Kanter et al., 1992; Dodds et al., 2004).

During the middle of 2006, a change management consultant was employed. The consultant involved in the HARP CDM redesign process provided an opportunity for stakeholders to voice their thoughts and concerns regarding the initiative in a neutral environment, and was particularly successful in responding to concerns voiced by existing HARP project staff in regard to lack of consideration of existing key learnings and experience. Interestingly, the consultant was described as “an ally” by one of the more disaffected stakeholders, demonstrating the importance of the relationship. Resoundingly, the responses of interviewees indicate that the employment of a professional facilitator and external change management consultant during the forums was an important investment in the design phase, a strategy that encouraged extensive communication and relationship building.

Commitment of time was a critical element of successful engagement

During the initial planning forums, Southern Health clearly outlined the time demands that would be placed on stakeholders and attempted to ameliorate time pressures by arranging two-day forums away from work demands. These efforts were well-received by forum attendees and “time away from existing workload” to focus on the development of the HARP CDM program was regularly reported as a facilitator to their contribution, extending opportunities to build partnerships and networks, and providing the opportunity to focus on the task at hand.

The success of the ongoing process of the design and implementation of the Southern Health HARP CDM program requires continued significant, long-term commitment of time and other resources by all stakeholders. Southern Health has responded to this issue via a number of strategies, such as back filling work commitments and providing time to focus without distraction on the issues at hand in two-day forums.
It should be noted, however, that such time commitment was not always feasible and for some stakeholders was a barrier to involvement.

A major enabling strategy associated with successful change is the provision of adequate time. The design of long-term, sustainable change initiatives, whereby all aspects of the change are thoroughly considered, require substantial time and resource input from stakeholders (Jerrell, Wilson, & Hiller, 2000; Kanter et al., 1992). Generous lead-time for the design of HARP CDM was considered a positive factor in the design phase, allowing for the gradual evolution of the model, whilst considering and incorporating the opinions, suggestions and feedback of stakeholders. Planning for the implementation stage of the HARP CDM program and other future initiatives may consider how to maintain extended periods of time away whilst minimising the additional pressure it places on some participants.

Acknowledgment and utilisation of prior experience and existing key learnings provides multiple benefits to the organisation.

As successful stakeholder engagement relies on organisational administrators responding to the concerns, resistance and feedback raised by stakeholders, one of the aims of the stakeholder interviews was to highlight areas of concern. Stakeholders involved in current HARP programs expressed concern that their existing knowledge was not adequately recognised or elicited, especially during WG meetings.

Best practice literature recommends drawing on the prior experience and skills of those involved in similar initiatives (such as existing HARP projects) to ensure that key learnings are elicited and that mistakes are not repeated (Kanter et al., 1992). A further benefit of consultation with this important group of stakeholders is to engage the staff members that are most closely affected by the change initiative and consequently most at risk of feeling disaffected or threatened. This strategy results in more efficient avenues for change, a sense of ownership of the plan and investment in achieving the outcomes (Argyris, 1998; Clegg-Smith, 2003; Deal & Kennedy, 1988; Kanter et al., 1992).
Consistent with the literature, the balance between utilising current knowledge and introducing new ideas and innovations is sometimes difficult to strike. In line with an action research framework and change management best practice principles, the concerns of some HARP program staff were identified in a timely manner and addressed by the change management consultant, providing the staff with an opportunity to express their concerns to management via an intermediary.

*Broad stakeholder representation and consultation was highly valued*

Selection and involvement of a broad range of key stakeholders from the early stages of the Southern Health HARP CDM initiative was an important principle underpinning the design process. Interviewees recognised and appreciated the range of stakeholders who represented a “good mix of people and disciplines” involved in the HARP CDM design phase. Advantages of broad consultation include presenting a clear picture of the needs of an organisation and ensuring organisational culture change that is inclusive and effective (Barreira et al., 2002, Torrey et al., 2002). Disadvantages of broad consultation include the significant commitment of time and resources required to involve all stakeholders. However, the experiences of previous unsuccessful change initiatives assert lack of consultation as a major determinant of failure (Goding, 2005).

Both generic organisational change literature, as well as literature specific to experiences of change implementation within health care settings, emphasise open communication and collaboration with stakeholders as a fundamental ingredient to success (Argyris, 1998; Clegg-Smith, 2003; Deal & Kennedy, 1988). Evaluations of health service initiatives demonstrate that reduced stakeholder engagement can directly affect successful implementation (Callaly & Arya, 2005; Dodds et al., 2004; Philips, Ahlberg, & Huzzard, 2003).

When considering health services within an organisational change paradigm, a number of unique challenges arise. A public health service provider such as Southern Health is inherently complex, encompassing a diverse population across a wide geographic area, delivering health services directly as well as linking to external service providers. Therefore, the design process of the HARP CDM initiative
required not only well-grounded internal change, but also strong partnerships and engagement with external stakeholders. Evaluations of organisational change models identify involving both internal and external stakeholders in the planning phase as a key feature in the success of change (Barreira et al., 2002, Torrey et al., 2002).

Previous studies that focus specifically on implementation of change initiatives within the health sector specify involvement and engagement of key stakeholders, such as GPs, as essential to success (Argyris, 1998; Callaly & Arya, 2005; Clegg-Smith, 2003; Deal & Kennedy, 1988). The positive response from external stakeholders, who represent the majority of GPs involved in the Southern Health HARP CDM design phase, is an indicator of this successful approach. GPs have considerable cultural authority to promote (or limit) the impact of any proposed change due to their direct contact with patients at a primary care level (Callaly & Arya, 2005; Clegg-Smith, 2003). Therefore, it is suggested that their successful engagement is a positive indicator with respect to the success of the Southern Health HARP CDM health care initiative.

**Dissemination of information regarding HARP CDM to others is an important element of effective change implementation**

Transparent, well-documented communication is essential to promote stakeholder engagement in any large-scale initiative. Southern Health has maintained a strong culture of communication during the HARP CDM design process. However, implications from interviewee feedback suggest the need for a range of strategies from Southern Health that target the efficient delivery of HARP CDM information to attendees, ensuring clear lateral communication between working groups, and encouraging the subsequent vertical dissemination of information to others within their organisation.

Lateral communication between working groups is an essential element of the overall communication process. One participant suggested the provision of a “*key individual*” to work across and inform all groups. Other alternatives include the development of standardised protocols to support communication within and between implementation and working groups (for example, the development and distribution
of regular one page summaries, which outline the salient points of group activities) and scheduled meetings with a steering committee (usually composed of management and other key stakeholders) are common overseeing methods (Kanter et al., 1992). Technological opportunities that promote lateral communication could include the distribution of summary documents from other task groups either via email or desktop icons.

When considering vertical methods of communication to others regarding HARP CDM activities, best practice literature emphasises the importance of extensive communication and full disclosure to all those involved in, or affected by, a new initiative; as an essential component to giving individuals a personal stake in the outcome and overcoming concern regarding change (Gulliver et al., 2003). Southern Health management have clearly stated that it is the responsibility of two-day forum attendees and IG/WG members to ensure that information is adequately disseminated regarding their activities within the HARP CDM design process. However based on the feedback from interviewees, this did not always occur. Hence, it is recommended that more formal procedures be developed.

When considering dissemination practices, stakeholders used varying methods to communicate to others. Presentation via “staff meetings” and “email” were the most common means of communicating information about HARP CDM activities to their colleagues. However, some stakeholders used multiple forms of communication and it is unclear from the findings how many stakeholders did communicate their activities to other staff within their organisations.

Participants appreciated “comprehensive minutes from (IG/WG) meetings.... and forums” which assisted dissemination practices. However, others reported a “lack of time” and “lack of interest/relevance to others” as barriers to ongoing communication of HARP CDM activities, which could result in an interruption to dissemination of information to personnel not directly involved in the design process. Typical participant suggestions for structural documentation improvements included “briefing notes” and “one-page summaries” as alternatives.
Despite a strong commitment and effort regarding communication, the implications of the feedback suggest that Southern Health would benefit from adopting more formal procedures which target the delivery of information to attendees, ensure open communication between IG/WG, and support a clearer strategy for the subsequent dissemination of information to others within their organisation. In light of some of the concerns expressed by stakeholders, a comprehensive communication strategy was recently tabled by the change management consultant which focused primarily on internal communication strategies.

Stakeholders suggested a variety of innovative strategies to manage the volume of documentation and aid communication with others in their organisation regarding their HARP CDM activities. Notably, one stakeholder suggested a “document tracking system” to manage different versions. Another suggested harnessing technological options such as introducing a HARP CDM icon on stakeholders’ PC desktops that linked to current minutes, summaries of activities, meeting schedules, newsletters and general information.
Conclusion

Southern Health has been highly successful in engaging a broad range of stakeholders in the system redesign of HARP CDM. The application of best practice principles ensured that many pitfalls common to such initiatives were avoided. The barriers that were identified by stakeholders, such as the time commitment required and managing the volume of documentation, as well as the experiences of existing HARP project staff, are consistent with barriers experienced in the majority of large-scale initiatives discussed in the literature.

The collaborative and consultative approach adopted in design of the Southern Health HARP CDM program is in line with best practice principles for the development and implementation of integrated services within the health sector. Southern Health have invested considerable effort and resources to ensure broad consultation at the local level as well as input from various levels of management, to ensure that competing agendas for design and implementation are considered.

Southern Health has fostered stakeholder engagement through a variety of best practice strategies such as providing committed, consistent leadership for change, articulation of a shared vision, opportunities for reflection on the change experience and a supportive culture of communication within the organisation (Gulliver et al., 2003). Ongoing recognition of stakeholder efforts, stable leadership and active involvement of senior level management has demonstrated Southern Health’s clear commitment to the program, which has helped to ameliorate some of the pressure on staff. Experiences from previous such initiatives in health services emphasise the important of a stable, committed core leadership, which drives the change initiative over time (Arfken, Klein, Agius, & Di Menza, 2003; Guydish, Stephens, & Muck, 2003; Zukoski & Shortell, 2001).

Research in the area of organisational change consistently highlights the value of open communication, establishing common goals and stakeholder engagement. Top-down, non-consultative approaches to organisational change have been shown to be unsuccessful, especially if imposed by non-clinical administrators (Goding, 2005).
Southern Health has consistently followed the former approach, resulting in overall stakeholder satisfaction with the HARP CDM engagement and design process. It is recommended that a similar model be adopted during the implementation stage and for any future initiatives.

As with any study examining organisational change the data has some limitations. For example, consistent with a qualitative methodology approach, not all stakeholders involved in the design phase were interviewed and nor was the selection random. It is possible that other themes might emerge if more stakeholders were interviewed, however, interviewees included representatives from all stakeholder groups, and it is likely that a saturation point had already been reached during analysis.

Limitations of participant observation include the volume and complexity of data which, in this case, exceeded the capacity for complete and comprehensive note-taking. Another potential limitation is observer bias in what data is collected, and its interpretation. These limitations were minimised by embedding both data collection and data analysis firmly in the evidence from the literature.

Nonetheless, results indicate that Southern Health has the capacity to move into the implementation stage confident that stakeholders are committed to the successful design of the HARP CDM program. However, sustainable stakeholder engagement relies on organisational administrators responding to the opinions, feedback and concerns raised by stakeholders from all levels (Kanter et al., 1992; Lin et al., 2005). Therefore, it is recommended that stakeholders are provided with an opportunity to discuss the feedback from this report, and that management are given an opportunity to respond to feedback. This strategy is an important component of action research methodology, which incorporates stakeholder feedback to inform design, implementation and ongoing program improvements. Action research has previously been successfully utilised in health care settings, linking the development of the care model to stakeholder feedback, thereby reducing resistance to change (Hart & Bond, 1995; Siegfried & Sainsbury, 2001; Tobin, Dakos, & Urbanc, 1997).
Key Recommendations

One of the goals of this evaluation report was to provide Southern Health management with feedback and suggestions from stakeholders. In framing the following recommendations, the Deakin University R&E team considered both the successful elements of the Southern Health HARP CDM design process and those elements that were identified as requiring attention.

The following recommendations can be applied to the remainder of the design phase, the implementation phase of the HARP CDM program and to any future large-scale change initiatives that may be undertaken by Southern Health. Drawing on findings from the data and best practice principles it is recommended that:

1. Management continue the strategy of utilising both internal and external expertise to assist the HARP CDM design and implementation process

Professional facilitation of stakeholder forums encouraged full engagement with the design process and was well received by participants. Provision of an external change management consultant enabled staff to work with management on issues related to workforce development and organisational change. Management maintained strong links with researchers who possess specialist competencies in organisational theory, action research methods and knowledge of the relevant health care literature.

2. Management continue to prioritise adequate lead time when engaging in system change

An important element of success was management’s recognition of the time commitment required from participants, and allowing reasonable time for stakeholders to contribute to the lead-up and planning commitments associated with a large system redesign such as HARP CDM.
3. **Key learnings from existing staff involved in similar projects are acknowledged and utilised**

Many of the stakeholders involved in HARP CDM had prior experience with HARP projects and were keen to make an even greater contribution to the redesign process. Whilst these stakeholders were involved in many of the working groups and forums, greater utilisation of their learnings could capitalise on positive experience and ensure that mistakes are not repeated.

4. **Broad representation and consultation is maintained**

It is recommended that Southern Health maintain the strategy of broad representation and consultation with stakeholder groups both from within and external to the organisation. Stakeholder groups include government, peak bodies and community agencies, health service staff, consumers and their families.

5. **HARP CDM management further formalise the communication strategy**

It is recommended that Southern Health consider a range of strategies that ensures clear communication between IG/WG, targets the delivery of information to attendees (i.e., reduce the volume of documentation), and defines a formalised strategy for the subsequent dissemination of information to others within their organisation.

6. **Southern Health ensure a stable presence of HARP CDM management**

Given the integral importance of relationships and partnerships between stakeholders, it is highly recommended that where possible, a stable presence of management and stakeholders be encouraged, providing stability of vision and investment in the initiative.
References


Appendix

Participant Observation (PO) was conducted during the following forums:

Cape Schanck planning forum, September 2005;
Stakeholder Forums: December 2005 and April 2006; and
Implementation group meetings, March and May 2006;

Please Note: Participant Observation was not conducted during the working group meetings as senior management had requested that the research team actively participate and contribute to the working group meetings.