Care for the future

Power, Leadership and Resistance related to a successful change path in the care route of hospitals and nursing homes

A.D. Smit

UMCG, Verpleeghuisgeneeskunde
Rijksuniversiteit Groningen, Faculteit Bedrijfskunde,
Master Change Management

Groningen, 20 augustus 2008

Wenckebach Ontwikkelplatform

Universitair Medisch Centrum Groningen

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Auteur	A.D. Smit
Studentnummer	1525050
Afstudeerscriptie in het kader van	Master Change Management Bedrijfskunde, Rijksuniversiteit Groningen
Opdrachtgever UMCG	dr. F. Boersma hoofd Vakgroep Verpleeghuisgeneeskunde
Begeleiders onderwijsinstelling	dr. K.S. Prins, en dr. M.P. Mobach Bedrijfskunde, Rijksuniversiteit Groningen
Begeleider UMCG	mr. R. Hilberts, Wenckebach Instituut

ISBN 978-90-8827-027-7
NUR 801
Trefw Macht, Leiderschap, Weerstand, Veranderproces, Verpleeghuisgeneeskunde

Omslag: Wenckebach Instituut, Universitair Medisch Centrum Groningen

Preface

The thesis in front of you is the outcome of my research conducted from March until August 2008 at the University Medical Centre Groningen. With this research and thesis I finish my MBA study Change Management at the University of Groningen.

This thesis describes which role(s) the variables power, leadership and resistance play and can play to bring about successful changes within the care route of hospitals and nursing homes. The description is based on two real life change efforts (cases) in the previous described care route. The case study findings are outlined in a clear overview per perspective of the interviewed stakeholders. The results do also provide theoretical and practical implications on the influence variables and their contribution to change processes within the care route. The research tries also to fill in the gap of the not available specific research within the Nursing home medicine. Research that links change management, and the three variables power, leadership and resistance, to this particular type of healthcare. So a contribution to the body of knowledge on change management was a predetermined goal.

I would like it to announce that this previous research period was a very interesting and challenging one. It has been an excellent learning experience for me, especially because it took place at a total new and unknown work environment. I learned a lot about healthcare institutions, but conducting the interviews with professional in their field, has been a valuable contribution to me. As well for my personal development as for my knowledge. But overall, it was especially a period with a lot of pleasure. Several people made it possible to conduct this research is such a positive way. Therefore, I would like to announce special thanks to these people.

In the first place I would like to thank my supervisor of the University Karin Prins and my supervisors at the University Medical Centre Groningen, Froukje Boersma and Rudi Hilberts. Their feedback and interesting and valuable points of view made it possible to write this thesis. Secondly I would like it to thank Jan Pols, coordinator of the Wenckebach Institute, for the given chance to do my research at this hospital. But also for the always existing possibility to use the knowledge and critical look of Jan. Furthermore, I would like to it place special thanks to all my interviewees and their organizations, the persons who made my case study research possible. At last, I would also thank my co-students at the hospital for providing a very well work environment and especially fun.

Alexander Smit

August 20, 2008

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Summary

This research provides an answer on the main research question, which has the purpose to find out which variables influence the success of changes within the care route between hospitals and nursing homes. Therefore the development and testing of a conceptual framework which eventually includes the independent variables power, leadership and resistance and the dependent variable successful change was a necessity. Successful change is made variable by focusing on the achievement of predetermined goals a change effort has. Testing of this framework is conducted within the care route of hospitals and nursing homes. All in order to be able to provide a general valid research outcome on what the main stakeholder's view is on when change efforts/projects can be characterized as successful ones and which role(s) power, leadership and resistance (can) play to bring about successful changes within the mentioned care route.

A case study in and around the large city hospital University Medical Centre Groningen and one in and around the peripheral hospital Nij Smellinghe Drachten confirmed that the variables power, leadership and resistance are significant influence variables to come to successful changes within this care route. The study was conducted in and around the hospitals, this means that opinions from general practitioners, nursing homes and their heads of care, medical specialists from the hospital, a region manager and a care insurer were collected. All stakeholders that (can) have influence and involvement during developing and implementing changes and were related to the cases.

Next to the confirmation on the three influence variables, the study shows that power can influence the success of changes because powerful parties can direct changes towards their own (also non nursing home care issues) interests instead of care interests. The stakeholder(s) who are the money provider to change can be seen as the powerful ones. But also hospitals and medical specialists are powerful groups. To achieve successful change, the study showed that working in a power balance seems most appropriate, this has worked. Feeling of mutual dependence and having equal interest is essential. Concerning leadership it is often the initiator of change who acts as the leader. This can be appropriate, but because participation and involvement is announced as important for success, forming kind of project teams to lead the change is even more appropriate. Naming the most appropriate leadership style for successful change is not really possible after the study. Resistance can be managed and is also necessary. Resistance is most of the times present because as well personnel as management have specific interests and are afraid of losing it. Also because people find it often difficult to leave a status quo. These above results will be explained and discussed thoroughly within this thesis, resulting in theoretical and practical implications towards the research subject.

1 Introduction

Care for the Future, these four words are strongly interrelated with the Dutch governmental policy about health care in the Netherlands. This is the case, because it is recognizable that within this sector, changes are upfront in a continuous way. These changes have significant impact on the way the health care is serviced, run and financed. The purpose is to come to an improved quality standard, increased accessibility, more efficiency and permanent financing[1]. In the policy agenda of the Ministry of VWS (2008) the government tries to realize the above mission by focussing on six different, but interrelated themes. These themes are (1) Quality, (2) Safety, (3) Innovation, (4) Working in health care, (5) Prevention, and (6) Participation.

1.1 The care route from hospitals to nursing homes and visas versa

One part of the Dutch Healthcare is the "Nursing Home Medicine", this is the care route between hospitals and nursing homes but also the other way around. Within this field of care it is recognizable, especially the last decade, that change to achieve improved desired states is a constant factor. The cause to achieve the improved desired state comes from four different backgrounds. Firstly, because the Dutch government is stimulating innovative changes in healthcare (Policy Agenda Ministry of VWS, 2008). Secondly, and in this thesis important, because there are flowing ideas from practice towards the care institutions and hospitals and visa versa. Thirdly because of the greying in the Netherlands and its related causes. Plus the always existing expense control (i.e. costs) of changes. And the fourth factor is the increased customer expectations which are formed in our culture (Boersma, 2008).

But, as Boersma and many more specialists within this "Nursing Home Medicine" field argue, overall seen, the level of concreteness and clarity, about how successful change within this care route can be accomplished is missing. Related to this, the field recognizes that same story counts for the future ideas for successful changes. Clarity is necessary, because constant change ideas emerge within the field. These two factors are often appointed as the main reason why change projects have failed during the last decades. As the next paragraph will show, there are a lot of ideas for future change. And conducting these changes without clearness about how to change successfully, will lead to an enormous loss of public money. It is necessary to be a step ahead, to be able to prevent this negative issue.

1.2 Change from practice

From practice, several potential changes which can lead to the above described goals, can be recognized. For example (1) pre-care (Boersma, Bisschop, Croon, 2008), (2) Custom made living, (3) Increased customer orientation (Bisschop, 2008), (4) Further developing Intermediate Care (Bisschop, 2008), (5) staff circulation between hospitals and nursing homes and (6) development of department of specialists (Hilberts, 2008). (7) Collaboration system within hospital (elder)care (Vroom, 2008, Boersma, 2008) to increase the level of care and to be more efficient. (8) Project accompaniment in order to have a view on the different care cultures and significant differences in healthcare/nursing home care. Appendix 1 of this thesis includes a thorough description of these potential changes. These potential changes and especially the missing of concreteness and clarity (which has led to failure) about

[1] Policy Agenda Ministry of VWS; Volksgezondheid, Welzijn en Sport (2008)

managing those determining variables during the process to successful change, has led to the following research.

1.3 Research question

The previous two paragraphs have elaborated on the need for guidance for successful change, in order to prevent more failures of change projects and to be able to come to success in developing and implementing the potential changes from paragraph 1.2. The potential changes which can contribute to an improvement of the field of Nursing Home Care. Important to distinguish is the phase of initiating and developing change plans and the phase of really executing and implementing those plan. In this research, the initiating phase is related to the management level and execution to the level of implementation. This focus is made, because as Lapointe & Rivard (2005) also acknowledge, for success optimal conduction of as well the decision making/initiation process (management level) as the implementation level of the process is a necessity. This distinction will be explained more thoroughly underneath the main research question which is:

Which variables, on the level of management and the implementation process itself, influence the success of changes in the care route between hospitals and nursing homes?

The above research question includes two levels. The management level means, which role the variables play on policy makers, initiators for change and other parties/persons who have power to initiate change. The level of the change process itself, the implementing process, means which role the variables play during this phase of the change. How these contribute to successful change. The focus is particularly on the operational personnel and the level of changeability.

Boersma & Bisschop (2008) do also agree on this. According to them, this is the case because it is incorporated in the way the "Nursing home care" is arranged. A leading position in this type of healthcare is formed by a collaboration of *hospitals* and *nursing homes*. Their management (level) and medical specialists are often the initiators of change. But important, their freedom of movement and decision making is influenced by two other stakeholders. These stakeholders are *general practitioners* and especially the *care insurers*. This latter group is the financial source, the source which has been described earlier. According to several practitioners, it is the influencing factor in the total policy concerning health care.

Next to the management level, Boersma & Bisschop (2008) also announce that success can also be determined by those who have to do the actual/operational work and also implementing changes. One has to think about work pressure and related to this changeability. It is for almost everyone directly related to health care, because health care has changed a lot. Though an important factor which can determine success or failure.

1.4 Key variables and Conceptual model

Within this first chapter and the purpose of this research, successful change is the major dependant variable. To create clearness towards the whole research it is important to define what successful change stands for. Successful change is a change effort that is capable of achieving predetermined plans/goals in order to achieve a new desired future state. The focus of the change effort can be on both the strategic goals as well on the operational improvement of processes. (Oakland & Tanner, 2007; By, 2005).

From oriented interviews and from the contribution of well known researchers on change and successful change, there are three main variables which from the core of this research. The three, power, leadership and resistance, are chosen because in literature it is recognizable that the three variables are often part of the models for change and analysis of change projects. Another reason why these

three are chosen, is that they are interrelated, often in an iterative way, during change efforts. For example, powerful groups are able to initiate change, but therefore they have to lead a change, to guide and direct the effort. As many authors acknowledge, within change efforts, resistance is always there. So, a change initiator, who is also the leader, should manage this resistance (Kotter, 1995). In this way, many examples can be named.

Particularly **power** is chosen because within the research area (healthcare/nursing home care), one can recognize that stakeholders use power sources to influence decisions and to protect own interests. The variable power, is also based on research from Munduate & Bennebroek Gravenhorst (2003) & Raven (1992) who acknowledge the importance and influence force which power has on successful change. The second variable is **leadership**, which is based on the famous influence of Kotter's (1995) work on leading change, is chosen because a change project should be guided and managed in order to create clear goals, willingness and readiness for change. Three important input factor to achieve successful change. The third one **resistance** on change, which is divided from Burnes (2004) and Strebel (1994) is related to clarity in goals and creating willingness and readiness for change, because these factors can decrease resistance. And resistance is, as many researchers acknowledge, an always existing factor during change which can have a negative influence on the change effort, therefore a necessary issue to manage.

According to the above authors, successful change is depended on the way how these three variables are managed within a change project. They also acknowledge that these three variables are very broad ones, therefore focus within the three variables is needed. The conceptual model below shows this focus, together with the visual presentation of the relations that play a role in this research in the care route of hospitals and nursing homes. Later in this paper, specific argumentation to strengthen these relations will be given.

From the previous paragraph and their relationship to successful change efforts, a conceptual framework is developed. The purpose of the conceptual model is to provide support to the problem statement and to create structure towards the objective of the research. The model shows the concepts of the key variables to successful change efforts and the relationship in a graphical way (de Leeuw, 1996).
The figure below shows the conceptual model with the relations.

1.5 Research sub questions

From the research question and the related conceptual model it is recognizable that there are three relations from as one can state, influence factors to successful change. Each of this relation has got the function of a sub-question within the research. Therefore the conceptual model formed the next three sub questions.

1) *How can successful change within the care route of hospitals and nursing homes be characterized and described?*

2) *Which role(s) play the variable power, on the level of management and implementation, to bring about successful changes in the care route between hospitals and nurse homes?*

3) *Which role(s) play the variable leadership, on the level of management and implementation, to bring about successful changes in the care route between hospitals and nurse homes?*

4) *Which role(s) play the variable resistance, on the level of management and implementation, to bring about*

successful changes in the care route between hospitals and nurse homes?

To answer the main and sub questions, a qualitative research will be conducted. Within this qualitative research, case study will be the primary method for gathering the appropriate information and data. The goal of this qualitative research is the development of a concept of conclusions which help us to understand social phenomena in natural (rather than experimental) settings in nursing home care, giving due emphasis to the meanings, experiences, and views of the key stakeholders/participants. The research output will be a description and explanation of what role the key variables play to achieve successful change in the care route between hospitals and nursing homes.

Before the empirical data can be gathered and analysed, it is necessary to built up the theoretical foundation of the key variables and important their relationship to successful change. And managing this process. It is a thorough description of the focus within power, leadership and resistance plus their relation with successful change. The second chapter of this thesis will elaborate on these issues. The third chapter elaborates on the used research methods which played a central role during the empirical study. As well on the operationalization of the research variables. Chapter four, five, six and seven includes the results of the study, it are the results of the two analysed cases in the care route of hospitals and nursing homes. Each chapter elaborates on one of the four research questions The eight and final chapter discusses the results, it provides the theoretical and practical implications concerning this study and it reflects other essential (strong and less strong) elements.

2 Successful change and its management

As the introduction chapter announced successful change is the dependent factor in this thesis, but also that success depends on several variables. As announced these are the variables; power, leadership and resistance. In order to change successfully, organizations have to manage the specific change effort and the influence the variables (can) have. This chapter shows characteristics of how the field of change management can achieve successful changes. There is a lot of choice, there is no one way to success. Therefore the first subject will be the strategic and operational choices which should me made to achieve the appropriate level of success. Followed by a thorough description of the three key variables and how they are related to successful change efforts.

2.1 Change Management and the relation to success

2.1.1 Change a constant factor for achieving success

The last few decades, literature on organizational change have shown a significant shift towards the increased importance of change management within organizations (Burnes, 2004a Beer & Nohria, 2004)). This is the case because organizational change and its management has become a determinist for organizational success. Or in other words, they will determine the survival of organizations. Successful management of change is necessary because organizations are changing faster, in a more fundamental way, through a highly competitive and more frequently changing (business) environment (Kanter et. al, 1997; Kotter, 1995). Change can be seen "as the movement away from a present state toward a future desired state" (George & Jones, 1995).

The difficulty which arises is the fact that change management is not a distinct discipline with rigid and clearly defined boundaries. Theory and practice of organizational change and the management of it, is based on a number of social science disciplines and traditions (Burnes, 2004a:261). Of course this can be an opportunity, because organizations can draw their policy on a wide variety of options. Contrary, organizations have to survive in a complex world and have to choose their core concept out of those disciplines and traditions. Therefore a challenging and difficult task exists. But a necessary one, as By (2005) states, change has become a *constant factor* within organizations, which needs thorough and successful management capabilities. All in order to, as the previous chapter announced, to achieve the predetermined plans which should take an organization to a more appropriate business environment, more profit, improved service levels etc. Change is necessary to achieve success in business and service (By, 2005).

2.1.2 The Open system and alignment perspective

The origins of change management can be found in the occupation and concept of Organizational Development (OD). Many researchers, theorists and authors have elaborated on the subject of OD. Two sources which provide a comprehensive guide to the origins and practices of OD, are the books of Cummings & Worley (2001) and French & Bell (1995). The purpose of OD is getting individuals, teams and eventually the whole organization function better by aligning the external environment into the internal organization. This means that for successful organizational change efforts, the initiator(s) of a change should use an Open system perspective, which means that with change and development a two way related way of thinking have to be adopted. Align all the internal organizational systems (i.e. strategy, culture, technology, structure, organizational learning) with the external environment and the other way around (Worren, Ruddle & Moore, 1999). Eventually this alignment process should

lead to more efficiency, effectiveness and high performance and a high quality of work life (Hirschheim et. al, 2001).

2.1.3 The continuous character

The field of Change management has the view that, in our current environment, the ability and the attention to change continuously is the factor for successful change (Brown & Eisenhardt, 1997). Continuous change is the constant movement towards the fast, radically and unpredictably changing (business) environment (By, 2005). Only by continuous transformation (Burnes, 2004a) organizations are able to keep alignment with the environment and thus able to survive. But the movements are not predictable. This means that the change agents should focus on creating an internal environment were continuous change is a part of the business environment. Whelan-Berry & Gordon state that organizations should continuously be a proponent for change, in order to keep up with the (major) shifts in the environment. Brown & Eisenhardt (1997) announce; continuous change causes the constant innovation of organization's products/services and it is also a starting point of broader organizational change. This shows again the importance of alignment when one is willing to achieve successful outcomes of a change project. All organizational parts are interrelated and are able to force and/or motivate other parts to change.

2.2 Reasons to change

2.2.1 Final goal(s) for change

For successful change efforts, managers (initiators of change) and/or change agents should make appropriate choices and especially decisions about what the outcome of a change project should be. All in order to develop a final goal which can lead as a guide through the change process. But also because this final goal and a new desired state will determine if a change effort is become a success or not (Oakland & Tanner, 2007). To determine the final goal, which is the input for a successful change effort, clearness about why change is really needed should be there (Handy, 1989 & Kanter, 1989).

2.2.2 Basic archetypes of change

As been argued earlier, managers/leaders and organizations can choose out of several approaches/strategies to change. To succeed in this is, the right choice is necessary, because attached to a reason to change a strategy to initiate and perform the change should be available. As Beer & Nohria (2004) state a starting point to achieve a successful change effort is a necessity. It is an overall strategy which should be strongly related to the driver(s) of change.

Beer & Nohria (2004) distinguish between two basic approaches to change, which should be the underlying thought towards a change effort. Table 1 on the next page summarizes the two approaches. "Theory E" approaches to change have the main objective to maximize shareholder value, these approaches involve heavy use of economic incentives. "E" approaches are most often used in situations where an organization's performance has dropped to such a level that its main shareholders demand major and rapid change to improve the organization's financial performance by downsizing, divestment of non-core or low-performing businesses which lead or is caused by restructuring and/or re-engineering. "Theory O", which is more a 'soft' approach. Is also focused at improving the organization's performance. The difference is that this approach is based on incrementally developing the organization's culture and its human capabilities, plus the promotion of organizational learning. For successful changes, change agents can connect their reasons to change to one of these two archetypes. Because it provides attention and focus areas and at the same time, it functions as a guidance for the change process.

	Theory E	*Theory 0*
Goal	Maximize economic/shareholder value	Develop capabilities
Leadership	Top- Down	Participative
Focus	Structure and Systems	Culture
Planning	Programmatic/Planned	Emergent
Motivation	Incentives lead	Incentives lag
Consultants	Large/knowledge-driven	Small/process driven

Table 1: Theory E & Theory O, the overall change strategy
Source: Beer, M. & Nohria, N. (2004)

2.3 Variable power in relation to successful change

From both the introduction chapter as the first part of this chapter, it is clear that success within change will be determined by a particular set of key variables. Variables which play an important role during strategy/plan formulation, but also while conducting the plan of change processes. So, as well on the level of management as on the level of implementing change efforts. On both levels choices about these key variables have to be made. The rest of this chapter elaborates on the three key variables and their relation to successful change, which are derived from practice and literature.

2.3.1 Analyses of power

Analyses of the role that power plays in change in organizations are increasing in force, scale and impact (Munduate & Bennebroek Gravenhorst, 2003). These authors acknowledge that the complexity and diversity of power sources is large. It has become an important, interesting and widely studies issue in the field of organizational change and development (Buchanan & Badham, 1999; Klein, 1998). It has become this important, because power sources and the processes of power can influence and determine the basis for (organizational) change and eventually success (Boonstra & Bennebroek Gravenhorst, 1998). They conclude this, because their research showed that power is related to change strategies and success in change.

For example, stakeholders with power do often hold on to their own beliefs and interests/goals and neglecting overall purposes and other opinions, which can lead to resistance to change. This process can lead to drawbacks in the change process or even lead a change effort to a dead end. Because there is often a lack of faith, commitment and trust. This can be present, because sometimes it is just impossible to influence very powerful groups. Therefore power is sometimes an independent variable to work with or resist to it. This latter has in most situations a negative effect on the change program.

On the other hand, power can have also positive effects on change. Change agents and/or management and/or powerful stakeholders can use their power to influence and change people's attitude and behaviour. Power, in relation with influence tactics, can convince other parties which can lead to a desired new environment and way of working. This is of course the essence of a successful change effort. Another relation between power and successful change, is that power can smooth up decision making processes. These processes are often time and money consuming, plus the fact that inappropriate decision making can lead to

unclear and wrong goals for change efforts. This latter means that the goals become contradicting with the initial goal(s) of a change plan. This example is, according to Boonstra & Bennebroek Gravenhorst (1998), strongly interrelated with resistance and is therefore a key variable for change processes. The role of change agents, also named leaders of changes, play a significant role during the "power game" within change. Because as Munduate & Bennebroek Gravenhorst (2003) argue, the change agents as leaders of change, can influence the people and parties around them. It is influencing them towards a direction. But very important, a change agent has to be able to change themselves, before one can change others towards this desired direction. Otherwise the chance of successful change will decrease strongly.

2.3.2 The Power bases

A lot of research and literature about the subject of the dynamics of power in (organizational) change used the six bases of power from Raven (1965 & 1992). The six bases are also central in this research. It provides a clear distinction between the various sources of power which can influence a particular change effort. Table 2 below incorporates the six bases, as well as their main characteristics. An influencing stakeholder, agent or person within change can possess one or more of these sources to power and can use them to change beliefs, attitudes or behaviours of a target. All to an order that those stakeholders can achieve the most appropriate results from the change effort.

Power Base	***Main characteristics***
1. **reward power**	Providing desired rewards as inducement to cooperate
2. **coercive power**	Providing punishments, threat of negative consequences
3. **legitimate power**	Legitimate right to exert influence over others, private acceptance (inducements to obey)
4. **expert/knowledge**	Having expert/knowledge in a specific domain, have control
5. **referent power**	Refers to identification for similar groups/person, to build strong relationships. Leads to private acceptance.
6. **informational power**	Relevant and validated information which leads to cognitive changes. Often from powerful and/or management groups.

Table 2: The six bases of power in change
Source: B.H. Raven (1965 & 1992)

2.3.3 Managing the power/political dynamics of change

The process of power can be characterized as a political game, which has to be managed thoroughly from the management level (Senior, 2002). Managing this process of power, is an important task for leaders within change projects. Because as the definition of power has shown, power decisions can be influenced. Resulting in negative consequences for organizations, plans and of course, change projects. According to Senior, in order to set up a successful change effort, management/leaders (initiators of change) have to follow four sequential, but when necessary iterative steps. The first one is *to ensure or develop the support of key power groups*, the second is, *use leader behaviour to generate support for the proposed change.* The third step is *use symbols and language to encourage and show support for the change*, the fourth and last step will be; *build in stability by using power to ensure that some things remain the same.* As one can see, power can affect management plans negatively, but at the same time

this management can use power to influence the operational (lower) levels within organizations. Huczynski and Buchanan (2001) do also show these relationships. They argue, power can be used to *influence up* (influence managers by the use of reason), *influence across* (influence co-workers by the use of friendliness) and *influencing down* (influence subordinates by the use of reason) (Kipnis, 1980). In order to direct and guide people to a desired direction, which is a necessity for a successful change effort.

2.4 Variable leadership in relation to successful change

2.4.1 Importance of leadership

From the previous it is several times recognizable which important and determining role leaders and/or managers (can) play during change processes. Kotter (1995) states that; "change requires creating and developing a new system, which in turn always demands leadership". For successful change this is necessary, because according to Kotter, a particular leadership team should and will fulfil the guiding and control function in order to achieve the right results from every step of his *Eight Step model to Transform your Organization* (see Appendix 2 for the model). Guiding a change effort, and using the appropriate leader for it, is according to Kotter a necessity for successful change for several reasons.

Without a good leader who controls, evaluate and drives change the chance of missing the essential steps to achieve the desired state will increase. Missing steps or deleting steps in the change process is often a sign for speeding up the process. More speed can save money and an earlier adaptation to the new desired state. But the mistake is that it can lead to unclearness in vision, goals, people do not recognize the urgency and more internal resistance from operational and management personnel will be the outcome. This will never result in satisfying results for a change. Another essential factor which a good leader should have and especially spread out is *motivation*. Without internal motivation and providing it to the outside world, a change effort will become almost every time a failure. For success, people should help and cooperate with the change initiator, without motivation this process will never start. During a whole change process, communication is a very important issue. A good leader will communicate in a way, as Kotter says, "that the harts and minds of the troops are captured". Only then a change effort can become a success, because cooperation and willingness to change is necessary. Communication is a key source to accomplish this. A last relation between leadership and successful change, lies in own agenda's. The appropriate leader is the one who will always control and guard the overall goal(s) of a change effort, instead of working towards own desired outcomes. Which is an often made mistake and a significant source of failure of change efforts.

2.4.2 Transactional vs. Transformational Leadership

Within this research the focus will be transactional and transformational leadership. James MacGregor Burns (1987) was the first one who made the distinction between transactional and transformation leadership. Transactional is about maintaining the status quo and only change in relation to improve the key characteristics of this status quo. Transformational focuses more about "overthrowing" the status quo. Kotter (1990) introduced a nowadays common used distinction profile of the transactional and the transformation leader.

Transactional leadership is most common in, as it called, a *convergent state*. That is when organizations are operating in stable conditions, which includes a relative predictable internal and external environment and there are established and accepted goals. Indeed, transformational is more useful in a divergent state. That is when environmental changes influence the efficiency and appropriateness of organizational goals, structures and work procedures. Table 3 is summarizing the main characteristics and distinctions.

	Transactional	Transformational
Creating the agenda	Planning and budgeting: develop-ping a detailed plan of how to achieve the results.	Establishing direction: developing a vision that describes a future state along with a strategy for getting there.
People	Organizing and staffing: which individual best fits each job and what part of the plan fits each individual.	Aligning people: a major communication challenge in getting people to understand and believe the vision.
Execution	Controlling and problem solving: monitoring results, identifying deviations from the plan and solving problems.	Motivating and inspiring: satisfying basic human needs for achievement, belonging recognition, self esteem, a sense of control.
Outcomes	Produces a degree of predictability and order.	Produces changes- often to a drama-tic degree.

Table 3: Characteristics of a transactional and transformational leader
Source: J.P. Kotter (1990)

The table showed the differences between the two types of leaders. According to Kotter, they both can lead to successful change, it really depends on the purpose of a change project/effort. But also if the change leader has the capabilities and competences to fulfill the particular leadership role. Without having the appropriate capabilities and competences, which are necessary, a change process is doomed to fail.
On the other side, a hybrid of both the characteristics of table 3 can make a person a good leader for change. This point of view comes from Kanter (1989). She argues that a good leader should have transactional capabilities as well as transformational ones. This is a leader who is able to control the organization through established and detailed rules. But on the other side the leader should be able to challenge the current order and is willing to seize every opportunity. Having these characteristics and using them during change, will lead to an increased chance for successful change efforts.

2.5 Variable resistance in relation to successful change

2.5.1 The right change path

In practice, change processes do relatively often fail (or fail in a particular part), rather than that they totally succeed (Burnes, 2004b). According to Strebel (1994), this is happening because change management is influenced and suffering from competing approaches. Within a change program, he stated, resistance and drivers for change are the key success factors. There should be a change path which is focussing on both the change drivers as well as resistance on change. Change programs primarily based on of the two, are doomed to failure. Paragraph 2.2 already elaborated on the importance on what drives change. The next section will elaborate on resistance. Beforehand it is good to understand that people do not resist whole change efforts, but parts of it (Dent & Goldberg, 1999). They resist because they are afraid of losing status, loss of pay or loss of comfort. But also these parts can have significant effects on the success of change efforts. Because as the above authors mention, to achieve a successful change effort one should start with the knowledge and attitudes of individuals. Attention towards the issues which people are afraid of to lose, should have specific attention. If this attention is neglected, this can result in not cooperating in plans, coalition forming to hold the status quo, strikes and even being violent. It is all about losing commitment and trust in persons and plan, because changes can affect people's individual beliefs and often habits (Ellemers, Kortekaas & Ouwerkerk, 1999; Cook & Wall, 1980). Therefore resistance can be used to sabotage change plans, even the best of intentions (Goldstein, 1988). From as well the management level as the operational level.

That resistance is related to failure is one side of the discussion, because as Ford et al. (2008) argue, resistance can also be a source for change (have a positive impact). It can introduce new points of view or it can provide a change in direction of strategies, which can have a positive impact on the desired future state. Because people identify their self with the issues that they brought in and are willing to change towards it. Which increase the change of successful change enormously, because as the next sub paragraph will show, willingness for change should not be underestimated in order to achieve successful change efforts.

2.5.2 Willingness to change

One focus area concerning resistance, in this thesis, will be on the level of willingness to change. This is the case because the level of willingness to change is an outcome of the four basic forms where resistance can come from (Strebel, 1994). The four are:

1	Rigid structures and systems reflecting organizations, business technology, and stakeholder resources that are not consistent with the forces of change
2	Closed mindsets reflecting business beliefs and strategies that are oblivious to the forces of change
3	Entrenched cultures reflecting values, behaviours, and skills that are not adapted to the forces change
4	Counterproductive change momentum driven by historical or other change drivers that are not relevant to the most urgent forces of change

Table 4: Four basic forms of resistance
Source: P. Strebel (1994)

Because of resistance, and the opportunity to a decreased level of willingness to change, organizations and change agents/initiators can be seen as victims of the irrational and dysfunctional responses of change recipients. Resistance of recipients is often characterized like this (Ford et. al, 2008). When willingness for change is available (within the whole organization), the chance for successful change is much higher than without willingness. Because when stakeholders are willing to change they see and feel the needed urgency for change, they feel connected to change plans and especially they see and feel that they have control over the situation (i.e. the chance that they resist will decrease), all essential factors which have a positive influence on the level of success of a change effort (Wissema, Messer & Wijers, 1996).

The two sources which can be announced to explain the interaction between resistance and willingness to change even more, are people's personal goals and Leader-Member Exchange (LMX) (Furst & Cable, 2008). People's personal goals; because as they have noticed, these goals are often in conflict with the organizational goals. Therefore, a primary goal for leaders and/or change initiators is to "persuade organizational members to direct their effort toward organizational goals". There are several strategies organizations can adopt to reduce employee resistance to organizational change. For example using rewards or sanctions that guide employee behaviours, ask employees to help to design the change (participation), use "power" positions of people to persuade others, and give inspirational speeches to gain employee support.
The Leader-Member Exchange (LMX), adopted from the attribution theory, plays an important role. Because it shows that an employee's reaction/attitude to managerial influence attempts is depended on the interpersonal relation between them. Research on LMX showed that unique interpersonal relationships are developed by interpersonal exchanges. This relationship forms the expected behaviours of both parties. Focus on and development of positive Leader-Member relationships, as well before, during and after change can play a determining role for the success of a change effort (Ferris & Judge, 1991; Furst & Cable, 2008).

2.5.3 Readiness for change

Holt et al. (2007) acknowledge the importance of involvement and commitment. They state that a change strategy should be focused on creating readiness for change, especially at the individual level. Readiness for

change as they call it, is a multidimensional construct, which is a determining factor for successful change. Readiness can decrease resistance to change, because a ready environment for change will provide confidence, commitment and faith towards the whole change process. Armenakis, Harris & Mossholder (1993) developed a model for creating readiness and proposed that "readiness is a precursor for resistance to change". Holt et al. (2007) concluded that readiness for change can be formed when employees belief that (a) they are capable of implementing a proposed change (i.e., change-specific efficacy), (b) the proposed change is appropriate for the organization (i.e., appropriateness), (c) the leaders are committed to the proposed change (i.e., management support), and (d) the proposed change is beneficial to organizational members (i.e., personal valence).

Armenakis et. al (1999) elaborated earlier on the subject of readiness for change. Comparisons can be made, but the interesting factor where they have an extra focus on is the importance of a basic change message. A message that has to be transmitted throughout the organization; in order to inform the whole organization, guide them, let them see that the organization is capable and eventually to decrease the level of resistance. This is important input for a successful change process. The authors based their statement on two models which incorporate elements of both Lewin's work (1947) and Bandura's (1986) social learning theory. The first model argues that creating readiness for change will lead to minimization of resistance to change. The second model has the objective to facilitate the adaptation and institutionalization of desired change. This process leads to increased chance of success. The central element (the "operational mechanism") underlying these two models is the above described change message.

Argued by Armenakis et al. (1999), to use the message in an effective way, such a message should incorporate five components: (1) discrepancy (i.e., we need to change), (2) self-efficacy (i.e., we have the capability to successfully change), (3) personal valence (i.e., it is in our best interest to change), (4) principal support (i.e., those affected are behind the change), and (5) appropriateness (i.e., the desired change is right for the focal organization). The authors state that "the logic of both the models and the message is to convert the constituencies affected by a change, into agents of change".

There is special interest, from both change agents as change researchers, for the influence strategies that Armenakis et al. identify as being useful for spreading out change messages (Armenakis & Bedeian, 1999). These influence strategies (i.e. managing resistance) include: (a) persuasive communication (e.g., speeches by change agents and articles in employee newsletters), (b) active participation by those affected (e.g., vicarious learning, enactive mastery, and participative decision making), (c) HRM practices (e.g., selection, performance appraisal, compensation and training and development programs), (d) symbolic activities (e.g., rites and ceremonies), (e) diffusion practices (best practice programs and transition teams), (f) management of internal and external information, and (g) formal activities that demonstrate support for change initiatives (e.g., new organizational structures and revised job descriptions)

Now the goal of describing and analysing which variables (can) have a significant impact on the level of success of change efforts is succeeded, a thorough description and explanation of how the empirically data is gathered can be done. In other words, the used research method. The next chapter elaborates on this subject.

3 Research method

This chapter will focus on the used research method in order to be able to answer the main research- and sub questions. The next section will elaborate on the research procedure, followed by a description of the respondents of the empirical research. The third part defines the data analyses.

3.1 Research defined

The overall purpose was to get an appropriate view on the role that the earlier described variables, power, leadership and resistance (can) play during changes in the care route between hospitals and nursing homes. To conduct this research appropriately the use of explorative/qualitative research was needed (De Leeuw, 1996). Because this kind of research is particular useful to research within relatively unknown fields, cases and/or relationships. But it is also a possibility to be able to get affirmation on perspectives and hypothesis. A situation is observed and researched and the results are general idea's and an answer on an open question. Experienced persons in the field where the research is conducted, have ideas on how the open question can be answered. But they need affirmation, to be able to create for example a strong negotiation position or to be able to create relationships. This latter is relevant to this research. The first issue, about a relatively unknown field and relationships, is as well relevant, because there has been no earlier research about the role power, leadership and resistance play and should play in order to achieve successful change within the care route of hospitals and nursing homes. Also relevant because business elements are often an underestimated issue in healthcare relationships, though a very important one. And one which is not clearly divided from practice (change projects). Evaluation is often a forgotten aspect.

3.2 Methods

The overall research method during the empirical research was the case study. Case study is a thoroughly studying of particular cases in order to be able to attach general conclusions to the cases (De Leeuw, 1996). The case study research was based on the *Case study protocol* of Yin (2003). Before explaining this protocol, it is useful to mention that the two central research methods were desk research (and attached oriented interviews) and semi-structured interviews. Desk research plus oriented interviews, because it gives the possibility to describe and inform about the needed information of the main stakeholders who are part of a particular case. This detailed information will be subject of the next paragraph. Semi-structured interviews were used, because in common, using interviews gives the possibility to gather more in-dept information from people/stakeholders (De Leeuw, 2003). Especially the *how* and *why* questions played an important role to find out why and how people think in a particular way. A structured part was used, because the structured part had the purpose to guide the interview towards the three main variables of the research. But during the interview, the interviewees should have the feeling that they can tell their story and feelings. For this reason, the unstructured part was used. The used interview questions are incorporated in Appendix 3 of this thesis.

3.3 Operationalizing of the variables

The four variables within the research were; successful change (achievement of the predetermined goals), power, leadership and resistance. Successful change is the dependent variable, the other three the independent ones.

Successful change is operationalized and measured with the definitions of successful change from Oakland & Tanner (2007) and By (2005). These authors state that

successful change is there, when predetermined plans/goals are achieved. And these plans/goals are formed at the strategic/management level and transformed to the operational level. Therefore these two levels played a significant role during the research. An interview question which all the interviewees answered was: *"When, according to you, can a change effort be characterized as a success"?* This was related to the particular case. Through the whole interview, handling the three variables, there was constantly the questions; *"Was this appropriate for success"?* and/or *"How should it had been going/managed in order to achieve a successful change effort"?*

Power is operationalized and measured with the six power bases of Raven (1965 & 1992) which a stakeholder can have. This is used to describe which power position the different stakeholders had and have. Attached to this power base model, power is further operationalized with the four step model of Senior (2002) to manage the variable power in order to achieve a successful change effort. The interviewees answered the question; *"Which role they played during the development of the change project and how they have used their power (if they possessed it"?* This became recognizable because the interviewees marked which power base they have and had during the change project. After this the question arose; *"How should powerful parties manage their power in order to get everyone along with the plans"?* In order to get a view on how powerful parties should handle to achieve successful collaboration and willingness for change. And at the end successful change.

Leadership is operationalized and measured with the research and literature of Kotter (1995) about the essential role leaders should play in order to achieve a successful change effort. This theory states that for a successful change effort, a leader should guide and direct the effort towards it desired destiny. To accomplish this a leader should follow a sequential order of steps in order to fulfil all the necessary input for change. See appendix 2 for the essential steps. The essence of this theory is that change should be done in a planned way and no step should be forgotten. The assumption was there, in the beginning of the research that change is often done in a planned way. This assumption was formed from the oriented interviews concerning the subject. But theory shows that successful change can also be achieved by a more emergent approach to change, that change forms itself by day to day activities and results. To measure if practice needs a more planned way to achieve successful change or a more emergent one (or a mixture), this variable is further operationalized with the leadership theory of MacGregor Burns (1987), Kotter (1990) and Kanter (1989). This theory makes a clear distinction between leaders who focus on more a planned way of change as a transactional leader, and leaders who use a more emergent approach as transformational leaders. During the case study's interviews, the interviewees marked which type of leader, and its characteristics (see section 2.4.2) was there during the case (change project "Intermediate Care" and "Linki Division"). And related to this the question was asked; *"Was this type of leader appropriate in order to achieve a successful change effort"?*. If the answer was no, the question; *"What type of leader is most appropriate to achieve a successful change process with the desired results"?* was asked.

Resistance is operationalized and measured, in the first place, with the theory of Strebel (1994), who put the focus on a right change which should deal with forces of change and resistance to change. This resistance can be managed by creating willingness to change. Willingness to change is often attached to the operational personnel within organizations. Resistance which decreases willingness to change can have, according to Strebel, four sources (see section 2.5.2). The interviewees named if these sources were there during the case and how this resistance spread out and how it should be managed. Added value for willingness to change was there with the Leader-Member Exchange (LMX) theory of Furst & Cable (2008). The added value is, that the level of interaction and personal relationship is important to create willingness for change. The second part which measured resistance was readiness for change. This resistance part is more related to management and the overall view on organizations. The

theory and model to create willingness to change of Holt et al. (2007) and Armenakis et al. (1999) showed that employees personals beliefs and a change message from the management level are essential to create success during the change project.

3.4 Case study protocol

The case study protocol of Yin (2003) exists of four main topics, which are the guidelines for conducting a case study. These topics are; *the introduction* (to inform about the case sample(s), *the used procedure for collecting the data*, *the interviewees of the empirical research* and at last, *the evaluation*.

Introduction: In the field of nursing home care, the choice to use two different changes (change programs) in different environments is made. One case is about the introduction of an "Intermediate Care" program, which took place in a collaboration of the University hospital of Groningen and nursing homes in this city. A hospital with almost ten thousand employees and therefore the largest employer in the north part of the Netherlands. The hospital has got more than 1300 beds and per year approximately 32000 hospital recordings. The financial transactions within all the processes were in 2007 around the 700 million euros. The case "Intermediate Care" includes the following.

The project "Intermediate Care" was a new care form between as the initiators called it care and cure. It is about an after care route for elder people (most of the times 70+). These people can, after a treatment in a hospital, be helped further within a nursing home. This after care starts when direct hospital care is not necessary anymore, but the patients are far from their old level (i.e. health). Further medical specialized attention and treatment is necessary, but hospital beds are too expensive for these situations. With "Intermediate care" nursing homes and their doctors are able to provide this specialized care, which is on a level between hospital care and "normal" nursing home care. It is a specific and difficult part of elder medicine and care. Nursing homes had a lot of the required capacities at home and what was missing should be added. This was necessary to create beds for particular care (recovery and reactivation). All in order to achieve the overall goal to shorten hospital time, to reach a more appropriate level of recovery and reactivation. But also to improve the image of nursing home care, that it could be a start for more innovative changes and that it could motivate personnel because their task became more complex and challenging. A thorough collaboration between hospitals and nursing homes was needed, especially to guide and place patients in this care route.
The second case is about the "Link Division" program which took place in the hospital of Drachten, in relation with its related nursing home. The hospital of Drachten has got almost 1300 employees and there are 340 hospital beds available, with business yields 75000 euro. The case description of the "Link Division" follows on the next page.

The project "Link Division" was a project which started with initiating the first plans at the end of 2001 and the beginning of 2002, at the end of 2005 the project had its close-out. This change project was a collaboration between the hospital in Drachten and the only nursing home within this city, Bertilla. Management of the hospital initiated the plan for change, but the nursing home saw the advantages and necessity for collaboration. The change existed out of the development of a particular division within the hospital which gave the capability to provide (specialized) nursing home care directly within the hospital. So a direct relation to the nursing home (care) became a fact. This change made it also possible to optimize the transfer from nursing home patients to the hospital and the other way around and to increase the care for patients (fast recovery and appropriate multi- disciplinary treatment). Within the division, hospital medical specialists have active contact with specialists of the nursing home. Also because the nursing home doctors work at the division in the hospital. The overall purposes, next to improvement of nursing home care, were to shorten healthcare lists, to shorten the

time hospital beds are possessed, increasing amounts of hospital beds and to have a stronger relation with each other. For the hospital it gave the possibility to grow.
This choice to research a case in Groningen and one in Drachten is made for several reasons. The overall purpose of the research is to come up with general conclusions about changes in the care route of hospitals and nursing homes. To achieve this, data to compare and data that is gathered under different circumstances and in a different environment is an added value, which will increase the validity of the research output. Of course case studies of multiple cases would be the best option, but because of time constraints, analyzing two cases was the maximum.
The choice to select a city hospital and a peripheral one is made because data can be gathered in a environment where competition is a major influence variable (i.e. the city hospital case) and an environment where competition is on a level near to zero. Because in the peripheral case, there is just a one to one relationship between the hospital and one nursing home. This relationship can be characterized as much more informal than in a large hospital with the influence of (internal) competition. Because several hospitals competing on the same nursing homes. Therefore the research will have input from two different work climates. Another important reason why this above selection is made, is because the University hospital argues that the "Intermediate Care" never became a success and the case in Drachten did. Changes do often fail, and to have input from these two different points of view is an added value. Because one is able to think of issues which should have been done in a more appropriate way. Concerning power, leadership and resistance. Which is input for future change programs.

Data collection procedure: As explained in the previous paragraph, the data selection procedure existed out of two different procedures. The desk research and the empirical research. Desk research, to be able to gather information about the change program and about the people/stakeholders who were involved during the change program, but also in the care route. The empirical research consisted of interviews with those stakeholders who were part of change program. In some situations it became clear that the role of a stakeholder was minimal to zero. The interview answers were not deleted, because an elaboration on other changes in the care route took place. The interviewee referred to other, for them well known changes. In this way a common view, which is the purpose of this research, could be created.
The interviews were recorded, in order to be able to find quotes and to hear particular information at a later moment. At the same time, during the interview, quotes and important information/announcements were written down. In order to have specific attention towards particular information and for not missing essential input, especially for the data analysis.
A specific attention was there to a confidence way of handling with the gathered information. For the interviewees the possibility was there to delete theirs or their company name totally. Plus a thorough attention to successful change. At the start of the interviews, the essence and importance of successful change in this research was mentioned. And the request to formulate answers in the light of success in change. This attention stayed there during the interviews. As can be seen in Appendix 3, four tables were used. The tables which are the basis of the three research variables. The interviewee got the time to read the tables and fill them in. To be able to announce which characteristic(s) of the research variables fits in their perspective. After that an elaboration on the given answers took place. This was done in this way, because reading by your own has got better results than hearing it from the one who asks the question. The interviewee can take time for their answer. So it gives the possibility to have a more thorough thought on the issue. Plus, that is appropriate input for the data analysis. It gives the possibility to show the different perspectives in one table.

The interviewees of the empirical research: As explained in the introduction chapter, within the care route of hospitals and nursing homes, five stakeholders can be distinguished. From each case, these five stakeholders were interviewees within this research. From the hospital there were two

stakeholders, the head of the department nursing home care and a medical specialist which is related to this type of nursing home care. The third stakeholder is the head nursing home care in a nursing home. The fourth one is a general practitioner, which is an intermediate for patients in relation to hospitals and nursing homes. The fifth stakeholder is the care insurer, as the financial source for this type of health care. Attached to the general practitioner, there was also an interview with the chairman of the Dutch "general practitioners federation" This variety of persons is chosen in order to be able to give an overall conclusion, from different expert roles, on the role power, leadership and resistance played. It are complex variables, which can interpreted in different ways and can have a different impact from individual to individual. But a change manager has to deal with it and should manage all those different perspectives, or in other words, should have an eye on it. Appendix 4 provides an overview of the interviewees, including general information.

Evaluation: This part of the protocol is about analyzing the findings from the two case studies, to be able to give a clear overview (in the result chapters) what the ideas, suggestions, opinions and thoughts of the interviewees were. All in order to be able to conclude on this by answering the research questions in the final chapter. The next paragraph elaborates more in dept about this process.

3.5 Data analyses

As mentioned, the data for the research consisted of interviews with key stakeholders in the process of changes in the care route between hospitals and nursing homes. On forehand, an outline of the dependent (successful change) and the three independent variables (power, leadership & resistance) and their characteristics from literature was set (see also conceptual model). This outline was the input for analysis. The variables were the input for the four sub-questions. To have an answer on the question which role(s) the variables play in change processes and how they should function to come to success, an outline of the perspectives from all the stakeholders on each of the variables was a necessity. On forehand the subjects of the conceptual model are the predetermined codes, where quotes and explanation should be attached on. All in order to get an overview from what those stakeholders (and their perspectives) have answered.

The results are divided into four chapters, each one consists of a research question. This is done to be able to have a consistent structure throughout the whole thesis. As mentioned, within each chapter the results are outlined by quoting the answers of all the stakeholders (i.e. interviewees). This is done because it provides the possibility to look back at the different perspectives and their particular opinion. These stakeholders can influence a change process, so with the results a change initiator can use this thesis to manage the different stakeholders. So this structure is used for practical reasons, instead of only for answering the research questions. Answering them is though possible with the way the structure in the results chapters has been built up.

The variable **Successful change** is analysed by looking to all the answers on the question, how the interview described when a change effort is a success. From every perspective the answer was quoted. When identical answers were given, the opportunity to attach interviewees to one answer was used. During the rest of the interview, when elaborating on the other three variables, there was constantly the questions; "Was this appropriate for a successful change effort"? or "How should it had been going"? or "Why should this have been managed differently"?. These answers were analysed and quoted within every variable subject. To be able to attach successful change to power, leadership and resistance. This gave the possibility give an overview how power, leadership and resistance influenced the change effort and how stakeholders should handle and manage these variables to be able to achieve successful change.

The variable **Power** is analysed by quoting the answers from every perspective (interviewee) into the section of that particular subject power. For example what kind of power bases were owned by that particular stakeholder. The power bases from every interviewee (perspective) were placed in one table, so in one view it is recognizable where the powerful stakeholders are. But also the question, which stakeholder had the most power (from their perspective) and which influence does power have or when you do not possess it. And how the powerful stakeholders should handle and manage their power to come to a success. The answers and significant differences of the explicit differences between the developing phase and implementation phase were published.

The variable **Leadership** is analysed by looking and quoting which stakeholder(s) were the leaders of the particular case and was this appropriate according to the interviewee. Connected to this, data on which kind of leader should have been most appropriate for the case was gathered. The interviewee filled in the table (from literature) with the characteristics of the type of leaders (transactional, transformational or a mixture. This is analysed by publishing the table with all the perspectives of the interviewees. Again to be able to see in one view, who said and thinks like that way. The answers and significant differences of the explicit differences between the developing phase and implementation phase were published.

The variable **Resistance** analysed by the same way as the previous two variables. A particular focus was there on answers on the subject of willingness to change, therefore the table with sources of resistance (from literature) were used to give an overview of the sources of resistance as well during the developing as during the implementation phase. Another focus lied on readiness to change and the Leader Member Exchange model. This is analysed by quoting the answers on personal relations and management support and change messages. Also to see and publish how, according to the perspectives, resistance should be managed in order to achieve a successful change effort. With this result part, common conclusions can be made. By providing an overview of which role the variables have played and should have played to come to a successful change effort, the purpose to provide a general valid research outcome can be achieved.

4 Results on the variable successful change

This chapter provides the results from the empirical research on the research question; *How can successful change within the care route of hospitals and nursing homes be characterized and described?* The study concerns the case study of the "Intermediate Care" project in Groningen which is related to the University Medical Centre Groningen and the case study "Link Division" in Drachten. The project of the hospital and the related nursing home.

4.1 Description of a successful change effort within the care route

The General Practitioners (GP's) (Croon, 2008; Berghuis, 2008) both made clear that one can talk about successful changes in the care route between hospitals and nursing homes, when *"predetermined overall plans are achieved"*. A focus on appropriate development of plans is a necessity for success. The plan(s) should, according to Croon be; *"reliable, achievable and relevant, otherwise successful changes are doomed to fail in a much earlier state".* The head of nursing home care (Bisschop, 2008b) in the nursing home (who is also a nursing home doctor) stated that *success is achieved when the goal of the project is reached, but also the sub goals*. While it is according to him not necessary to fulfil every sub goal in order to achieve success. *Though this is depended on a particular project and its goal.* Though attention towards sub goals very important is, they make the project workable. The medical specialist of the UMCG (Hegge, 2008) also acknowledged, that success can be determined when a *comparison between the outcome and the initial goal(s) is conducted and it is on the same line.* In order to come to success, it is according to doctor Hegge wise *to create space to be able to change the initial goal when circumstances (during the process of the project) ask for it. Flexibility is important.* The importance of sub goals became also clear, especially that *the sub goals with the highest level of importance should be achieved to come to success.* Though determining these importance levels is a key to success. Head of Nursing home care medicine (Boersma, 2008) announced that *predetermined purposes for change determine success of a change project. But within Nursing home care, success is achieved when overall improvement in the care route is recognizable* and this should be accomplished by improved collaboration between the (professional) involved parties, more efficiency, increased throughput time of patients and of course an increased level of satisfaction for patients.

Care Insurer of Menzis (Tieleman, 2008) who is a contract manager (purchasing hospital care), stated that to talk about successful changes *one have to make the distinction before an effort and afterwards.* On forehand, successful change is when a *change plan fits the overall policy and that a plan is realistic, achievable and risks can be minimized.* And *always think from the clients perspective (in the first place, the goal should be to increase nursing home care).* Do not change, because of change, then the chance of failure increase. *Afterwards a change should be evaluated, because then the costs play a critical role.* Therefore, within the goals of a change plan a thorough *focus on costs* should be accomplished. The change plan *should stay within the budget from the care insurer*, therefore a focus on cost for the hospital as well for the nursing home is essential.

The head of nursing home care (Vroom, 2008) within the nursing home Bertilla, who is also a Management Team (MT) member of the nursing home stated that *defining success is very variable.* Because one can se it from different perspectives, for example patients, money providers and medical specialists. *But in common it is a success when improvement of the care is a fact.* That all the stakeholders are in one line about this improvement. That the *stakeholders feel and show committed, because urgency*

for change is there. An appropriate *change goal is a necessity*, this is good because *it provides clarity and a guideline.* But one should *always be open for unexpected issues.* The medical specialist/nursing home doctor (Kamphorst, 2008) at the Link division within the hospital of Drachten announced that a change project is *a success when all the stakeholders are committed and are willing to debate in order to make the right decision on the project goals.* The stakeholders have to *feel the process like a group process, instead of just a top down change effort*.
The Region manager healthcare/nursing home care Zuidoostzorg (Mollema, 2008) named successful change in the care route in medical terms. He stated that *success is achieved when a current situation which is in pain is transformed and treated to a situation where the pain is gone.* Important to have in mind, is that *for success the focus on patients and social responsibility should always be there and achieved*.

4.2 Success of the change efforts of the case study

On the question when the project "Intermediate Care" or "Link Division" could be characterized as a success, the different perspectives gave a similar view. It is all about achieving the predetermined goals/plans, in order to *shorten the time hospital beds are possessed and be able to treat the patients with specific medical attention which is needed after they have left or should leave the hospital*. Because treatment at home is not possible at that particular time. The head of Nursing home care in a nursing home stated that the project is also a success, *when through collaboration with different parties, there become available routes to start (together) future change projects.* The head of Nursing home care medicine UMCG stated that it has been a success when there should have been *almost a 100 % level of use if "Intermediate Care" and when all the stakeholders (patients, involved organizations and operational personnel) were satisfied.*

5 Results on the role(s) of the variable power

This chapter provides the results of the case studies which role(s) power (can) play during change efforts and how this can influence the success of the particular change efforts. In order to describe which role(s) power has during change, it is important to show how the different parties were/are involved in developing plans and changes. Because during this period, power can be used to defend and/or implement interests and ideas. The first paragraph includes the description of the role(s) power can play, according to the stakeholders (interviewees) of the two case studies. The second paragraph includes a clear overview of the power bases that the stakeholders possess or not.

5.1 Role(s) of the variable power

General Practitioners (GPs)
On the question which role(s) the different parties played during this developing phase, it became clear that the GPs were not involved in developing the "Intermediate Care" program. Overall seen, *the GP is not involved in creating these kind of change plans*. GPs can put pressure on other parties, *but particularly on individual patient level*. Individual care, because they are experts for the care process and are willing to protect their patients. Of course their expertise about care can influence new programs (changes) but on a very limited scale, as one GP said; *"we just do not possess enough sources of power". We are depended on the decisions that the government in relation with hospitals and nursing homes make, they have the power and (can) initiate change*. GPs do have districts and a nation wide association, but they participate only during structural problems instead of during change programs. The GP stated that *investing a lot of time in trying to influence change projects is just not doable*. Because the GP is there to take care of patients and manage their own business (administration and finance). So time to complain, to come up with new plans and work it out and to form coalitions with other GPs (to have more power) is not available. *But also not valuable, because the past has shown that results from the three above actions were not significant. Because the government (financial source) and hospitals, the powerful stakeholders, decide and implement.*
For successful changes in the future, one GPs recommended that *more involvement of GPs should increase the chance of success*. Because Nursing home care is "joint care" and agreement about this type of care, from the beginning of changes on, will enhance the level of Nursing home care. *Especially towards patients, because at an early stage the disadvantages or mistakes of changes , for patients and other parties, can be deleted*. And expertise within the care route can increase, which is a necessary step to take, according the GP. But as the GPs both stated, we do not think that the above recommendation will be achieved. Because *hospitals will keep their control, their standard, interest and influence. The hospitals professionals will not change their attitude that easily. For success this should be a fact.*

Head of Nursing home care in Nursing home (who is also a Nursing home doctor)
The nursing home within this research was not asked to participate during the development of the "Intermediate Care" program. *There were only announcements from the UMCG towards the nursing home, when the plans were already made*. The head nursing home care did not agree with this procedure. He stated that *this "Intermediate Care" has (a lot of) impact on nursing homes (their capacity, staff and expertise). When a change project has this kind of impact, for success and especially early success, more collaboration is a necessity.* It is about a care route between hospitals and nursing homes, which is based *on mutual dependence*. But also because a nursing home can *prepare their selves in a more appropriate way and is able*

to prepare everyone (within the organization) for change and has of course a lot of (practical) expertise at home. .

The problem is that the amount of initiatives, to provide information, for collaboration and changes, from the UMCG is far from enough. It is in most of the cases, that *the nursing home should ask and should have the initiatives.* This is most of times *possible by using the own created networks with people from the hospital of from other nursing homes.* According to the nursing home, *they do not have powerful bases to use to put pressure on the hospital and the provider of money* (the Care insurer). *This makes it hard to force collaboration and involvement*. Also because *there is less stimulation from the government to collaborate*. And the nursing home itself has *not a lot of money for change. Hospitals do, and because they are related to the Dutch politics, they have a far more powerful position to initiate change and implement it.* The nursing home has, next to expertise, only referent power. *By using their network of nursing home doctors and medical specialists, they can try to influence decisions from hospitals. By forming a coalition to announce that win-win situations should be achieved, for as well patients, hospitals and nursing homes*. But it is still a difficult and often a process with low results.

Head of Nursing home medicine UMCG

The head nursing home medicine UMCG did not participated during the development and actually implementation of the "Intermediate Care" project, for the reason that she was not working in this hospital and because the function profile did not exist at the time. But afterwards she evaluated and talked a lot about the project, *because she (still) sees it as a huge change and chance for the care route.* Nowadays *the head is involved in almost every plan for change and she introduces them.*
From her evaluation on the "Intermediate Care" she concluded that the communication within the hospital medical departments was way to minimal. *Specialists were not informed well about the opportunities and procedures.* But also after the start there *was to little (no) attention to the early wins of the project, the progress it made*.
Potentially involved people *were not convinced, because they did not know*. The same counted for nursing homes. *There was not a thorough thought out implementation plan and it is really a question if the experts informed and involved nursing homes*. The answer will strongly direct to no, because *most nursing homes did not know early enough about the change project.* For successful change, *this communication process, a lot of attention towards progress the project has made, a good implementation plan and involvement of nursing homes is essential*, according the head of nursing home medicine. And think *in the first place from the perspective of the patients and then attach financial issues to it.* While finance is a critical success factor. *Without enough money, changing is almost impossible.*
For present change plans and to make sure that the above attention is made, the nursing home medicine *has two power bases. Her expert role and the knowledge she has because she is and has worked a long time as a nursing home doctor*. She knows the care route very well. And because she *has a leading function* in a powerful hospital she has got also *informational power*. She knows *opportunities, collaboration lines, financial information and ideas for future plans within the care route between hospitals and nursing homes.* Using this information she also possess referent power.

Concerning other parties with power, it became clear that *managers/departments in hospitals play a major role for success in change projects.* When they have *influence and are important, a top-down approach becomes working.* Because they are powerful, they can force and guide other parties. It is often difficult to work with, *because the powerful parties will not easily step aside from their way of working and thoughts.* For successful changes, it would be good to *participate with managers/professionals who have a "great eye" for patients interests, instead of putting other interests first.* This latter is an often and very dangerous mistake which is recognizable in practice. But of course this will never be admitted. Managers are able, because of their powerful position, *to guide medical specialists towards desired environments.* So *involving these managers, who*

are open for change, can be a very useful intervention to achieve successful change efforts.
Concerning other parties, it became clear that involving nursing homes (their doctors and management) is also a necessary step. *General Practitioners can be seen as independent parties and are not directly related to change project from hospitals or from nursing homes. So really letting them participate is not necessary, though informing them is.*

Medical specialist UMCG
During the "Intermediate Care" project, this medical specialist was not asked to be an active participant in a kind of project team during the development of the project. This developing phase, the idea for the change, lied in the hands of the head of the department Geriatrie. But as the specialist announced, *of course you are a medical specialist and these persons are valuable ones for healthcare issues.* This was also the case during "Intermediate Care". Within the department discussion was there, but the decisions were made by the head of the department. In other projects, when the medical specialist has a more active position to the project (for example initiating one), it is clear that this medical specialist *does not like to force others*. It became clear, that *for successful change efforts, force will not be the appropriate power source.*

For success, one should *create commitment, cohesiveness and trust and by forcing others this is very hard to achieve this.* Because *resistance comes up*, people within the care route do not like it lose control and that freedom will be lost. *Sometimes change situations need forced power, otherwise the change effort will become stuck in the middle.* The medical specialist *does have the possibility to force others*. And then *in relation to knowledge/expertise and informational power (which the medical specialist named as equals) and to legitimate and referent power.* Because a medical specialist *has a lot of inside information, but has also a professional perspective(position) whose contribution has/can have an added and often a determining value*. Also because these professionals know a lot about practical issues, issues *which should have a main priority in order to achieve a successful change effort*. The medical specialist does also *have the power to use a kind of reward power, especially in the sense of confirmation. In order to get people a long and convince them*. On the other hand, having money to change and money providing is a departmental issue. *A medical specialist can not use it by their self. Therefore communication, valuable and achievable plans should justify financial spending. This is a very important one, because without financial safety, a project is doomed to fail.* Because a lot of stakeholders do look differently to the purposes of the money. Therefore, *a change project should have a thorough attention to justify the purposes of the money. For medical specialists it can be very useful to know a lot of financial structures.* Because the *primary money provider*, which party this is (it can differ from project to project*), is the most powerful party to achieve a successful change effort.*

Concerning General Practitioners the medical specialist also acknowledged that *they are not or to a very limited level a participant during the development and implementation of change efforts* in the care route. For success *it is not a necessary step*, also because this party is not always *willing or able to participate*. But *this interest differs from GP to GP and from change effort to change effort. So a change initiator should translate the change effort interests in relation to need if GP's should be involved or not. Especially because GP's have all own interests, which can be in conflict with change purposes.*

Care Insurer Menzis
In common and also during the "Intermediate Care" project, the care insurer was a money provider. *Two percent of the money available for hospitals is for innovation/change projects*. So the hospital is asking the care insurer to step in a project. *The care insurer is not willing to force other parties (hospitals/nursing homes) to change, because these healthcare institutions should have the passion and active role to change.* These institutions should come with change plans, *they can create a basis.*

While the care insurer can be very useful as a control/independent party. Nowadays, the care insurer (can) play a more pro-active role to initiate change, *because of their experience in healthcare and especially because their knowledge about legislation and related healthcare costs (valuable to control).* Which are critical success factors to create a successful change effort.
Overall seen, the care insurer has *reward power*, because *they can provide money for appropriate and added value plans*. They are able to *force*, because *without their help some plans are really not achievable.* But they should always *make the balance between interests of healthcare (institutions) and the wishes of the people/patients who are the customers of Menzis. Commitment towards healthcare institutions as well to customers is important.*
The care insurer has got *legitimacy power*, because they function as *a legislator. Rules and regulations are in favour of the care insurer to let other parties follow to act legally.*
Because the care insurer has a broad view on healthcare and the developments because they *operate in a wide variety of healthcare issues and especially because they have the task to control the laws and finance, they have expert/knowledge power*. But there is *not that much organizational knowledge about healthcare institutions, this is an improvement issue for the future. Referent power is also there, because Menzis can identify their self with patients and patient organizations, which all can form a strong coalition. Patient organizations can be very powerful stakeholders, as well as management boards of hospitals and the medical specialists*. For successful changes, *alignment between these parties is essential*. Then *basis for change can be created.*

Informational power is strong, because Menzis insures 75% of North Netherlands and has a strong collaboration with patient organizations. Menzis can influence especially the management level of care institutions, because the collaboration is with them and not with for example medical specialists. To achieve successful changes this is a good issue, *because there is a fit between expertise and information.* Furthermore, *to achieve success and especially to deal with powerful stakeholders, an independent party should be incorporated in the change project. Especially during the developing phase, but also during the implementation phase it can have an added value. To coordinate interests and to follow a particular change line. A consultant for example or members of patient organizations. All to defend healthcare interests and issues.*

Head of Nursing home care in Nursing home (who is also a Nursing home doctor & MT member)
During the development of the change project, this stakeholder was an active participant but particularly as MT member, *but the role as medical specialist is always involved and will be used for the project.* It was especially a change project which was initiated on the level of the CEO of the hospital and the management of the nursing home. It was about transferring the nursing home care to the hospital. All in order to train people, to find and select the appropriate people. During the implementation there was more discussion about healthcare policy, facilitating issues and the relationship (especially towards patients). *As well during the developing as during the implementation, this stakeholder has a lot of experience and expertise about nursing home care and processes, therefore it is essential to let these important persons participate during the whole change process.*
Concerning power, it became clear that the nursing home feels that they are in relation to the hospital, *on the same level of power. Especially because there is a clear one on one collaboration system (i.e. there are no other nursing homes involved).* A relationship with *mutual dependence on the care issues and therefore common interests.* Power was not and is not the critical reason for the success of change efforts. But on the other hand, *financial issues have always and will always have a large weigh factor within healthcare (i.e. hospitals).* Therefore *the nursing home tries always to defend their (patient) interests.* Management and the head of nursing home *used reward power, by aligning people by providing improved work conditions and improved future perspectives. Forcing can also be used, but especially within the own organization.* They can force operational personnel *by stating that if they do not change along they should leave. But towards hospital management*

it is not an issue, then they are one the same power level. Legitimate power and being an expert, are the most powerful sources. Especially because this stakeholder is as well a medical specialists as MT member, so *experience on both these issues has worked as valuable interventions to convince other parties* during the change project. *Information power was and is also available, because the nursing home has information on daily processes which can be transformed to financial consequences in relation to healthcare treatment.* The money provider is a very powerful party. The hospital also, because the nursing home needs their collaboration, but as said before it is also the other way around. General Practitioners were not involved during the "Link Division", this is a common picture in relation to change projects.

Medical specialist/Nursing home doctor hospital Drachten

This stakeholder was not an active participant during the "Link Division" project, because this medical specialist was not working there at the time. But soon after the start he did. In common, *the medical specialists of Zuidoostzorg are active participants during the development and implementation of change plans.* Medical specialist are *a source for innovative ideas*. But this can only work *when consensus about particular plans/ideas is present. Consensus is a very important factor for successful change.* Medical specialist have *an important role,* because they debate and people (i.e. change initiators like management, CEO, head nursing home care) are *listening about their opinion on health care issues as well as on (internal) organizational issues.* Therefore, *medical specialists have a powerful position.* They can *force (in a limited way), they have a strong position because of legitimacy and because they are the professional expert with a lot of specific information and therefore have referent power.* These power bases are used and explored to direct change plans and to come up with plans. For example *by participating during several debate groups (for as well medical issues as organizational ones), by using informal contact (helps very well to come to success, because then consensus can be achieved in a smoother way). Sometimes the use of formal letters is a fact, often in corporation with the management level of the hospital or the head of nursing home care within the nursing home.* One stands strong and is able to convince and direct others. But never forget that *it will be the money who directs the nursing home care.* So *the financial source will be the powerful stakeholder and for us the task to convince them and create consensus. For successful change, all the stakeholders should be open for negotiation, but also be clear about opportunities and issues which are not achievable. And never forget the focus on the patient.*

Region Manager healthcare Drachten

This stakeholder was not actually a member of the project team that developed and implemented the plans for the "Link Division". But at the time he was a management team member at the nursing home Bertilla, therefore he was very close to the whole process. In his function of region manager he has evaluated and controlled the working, results and relationships of the "Link Division". *Evaluating, controlling and facilitating* by change projects is a role the region manager plays, and according to him, *an essential role for successful change efforts. Because every change effort is different and needs control.* But also because *a region manager can take a more independent role and has an overall view.* It is an advisor within change. And as an advisor you have to get *people/parties along, you have to convince, inform them and provide urgency for change. These issues are input for success in change.* The region manager is able to work on these issues, because he knows involved parties personally and *he has reward power (to achieve win-win situations), coercive power (position), legitimate power, expert/knowledge power, referent power and informational power.* Especially to be able *to influence the financer, these sources are very important, because success depends on if the finance is available.* But in the first place also to *create commitment and a feeling of one team towards change plans and its goals.*

As said the financer was and is a powerful party for change projects, but concerning the "Link Division, *the municipality played a major role.* Especially related *to get a building permit and of course for commitment. Commitment will open doors and is input for even more and further change to improve.* During the "Link Division" case, *the hospital was not the powerful party.* The board of the hospital as well as the board of the nursing home *saw the urgency to change and knew the mutual dependence. Reason to show who has more power was not an issue.* According to the region manager, *it was a pity that General Practitioners were not involved.* But he acknowledged that it is often because *the own negative attitude the GP's show.*

To increase the whole care route they *should have played a far more active role and therefore it is a good thing that Zuidoostzorg starts a project which are in collaboration with the General Practitioners.* Because also for them *there is so much to win.* In conclusion he stated that, *to achieve success*, involved parties should *always focus on the patient, instead of using power sources to reach own goals.* This is *a very hard challenge, but a challenge we are willing to overcome.* Therefore, the need for good collaboration, especially between the policy makers of involved organizations, a necessity. *We were lucky that this was the case during the "Link Division" project.*

5.2 Overview power bases that stakeholders possess

Power Base	General Practitioner	Nursing home (doctor)	Head Nursing home medicine UMCG	Medical specialist UMCG	Care Insurer "Menzis"
1. **reward power**				xxxxxxxxxx	xxxxxxxxxx
2. **coercive power**				xxxxxxxxxx	xxxxxxxxxx
3. **legitimate power**				xxxxxxxxxx	xxxxxxxxxx
4. **expert/knowledge**	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
5. **referent power**		xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx
6. **informational power**			xxxxxxxxxxx	xxxxxxxxxx	xxxxxxxxxx

Table 5: overview of the power bases which the different stakeholders possess in relation to the case "Intermediate Care"

Power Base	Head Nursing home care Bertilla Drachten	Medical specialist hospital Drachten	Region manager healthcare
1. **reward power**	(xxxxxxxxxx)		xxxxxxxxxxx
2. **coercive power**	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx
3. **legitimate power**	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx
4. **expert/knowledge**	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx
5. **referent power**		xxxxxxxxxxx	xxxxxxxxxxx
6. **informational power**	xxxxxxxxxxx	xxxxxxxxxxx	xxxxxxxxxxx

Table 6: overview of the power bases which the different stakeholders possess in relation to the case "Link Division"

6 Results on the role(s) of the variable leadership

This chapter provides the results of the case studies which role(s) leadership (can) play during change efforts and how this can influence the success of the particular change efforts. The first paragraph includes the description of the role(s) leadership can play, according to the stakeholders (interviewees) of the two case studies. Furthermore there is a specific attention to the most appropriate leadership style, in order to achieve successful change efforts. The second paragraph includes a clear overview of which leadership style is most appropriate.

6.1 Role(s) of the variable leadership

General Practitioners (GPs)
While the GPs were not involved during the project, they both *stated that the hospital and its experts were the leader of the project*. Both the GPs announced that one party who has the leadership role is appropriate. *A leader who provides clarity, order, a party which has sources to make decisions and to have a responsible person and/or group. Which is very important to create a successful change environment, especially when things run not that well.* But the leader(group) *should always involve the GPs (and the other parties), because nursing home care is a joint program and a particular future vision should be spread to all the involved stakeholders. Only collaboration, and intensive, will lead to success.*

Head of Nursing home care in Nursing home (who is also a Nursing home doctor)
This interview showed that it was clear that the hospital had an interest to change (in order to shorten the time that expensive hospital beds were possessed) and *therefore took the leadership role*. According to the nursing home, *this was not the right way to act*. The consequence was that *involvement was down to zero and the hospital forced nursing homes to work the way the hospital would like to.* The view the nursing home has, in order to achieve successful change, is to *create a project team which has the leader role, during the whole project. A project team with staff and specialist from as well the hospital as the nursing home.* Using this, it is *possible to defend and to create collaboration on both its interests and borders to work in. One can learn from each other.* So project team should function as well *during the developing as during the implementation phase*. Because you will *create a legitimate team which can motivate, inform and stimulate the operational personnel and decision makers (finance providers for example).* And then you can *change in more planned way, with control and the right people on the right place.* With "natural enthusiasm" as a result. Means that people were willing to change, understand the vision and are motivated.
Developing a good project team and to come to a status of equality, is often a long road. One should *not be scared to follow this long road. Some times it is necessary to take one step back in order to take two forward. So do not give up to early.*

Head of Nursing home medicine UMCG
The leader of the "Intermediate Care" was the head of department Geriatrie of the UMCG. Especially during the developing phase for the project. It was obvious that the hospital and elder care had specific interests for "Intermediate Care" (read the case description). *During the implementation phase of "Intermediate Care", naming the leader is more difficult*. Because this *process went not well and there was no real leader who performed this implementation process*. Overall seen, during the project, there was just *to little control on the change process and the steps which should lead to success and especially collaboration*. (within the hospital, but also towards and with nursing homes). *This can be happened or by to narrow attention from the leader or the involved parties did not get*

or took an active role during this control function to achieve the goals and guide the process of change.
A good leader for the "Intermediate care" project would be a person who has, *in the beginning, a lot of attention for goals which should be achieved and that these goals are transformed and related to a particular vision.* For a project where *the goals are clear and reasonable, detailed planning should be used. But if not, more space to fill in the vision later on the road should be possible*. However, in every project *the leader should name, and this is possible, what the minimum is what should be achieved.* This should take for *coordination and predictability. Concerning personnel, it is really important that willingness to change is created*. This can be achieved by *appropriate participation, communication, so people will get attached to a vision and believe it is theirs*. Connected to this, the *leader(s) should motivate and inspire the involved parties and people, because then collaboration (which is essential) can grow to a desired level.*

Medical specialist UMCG
This stakeholder could not be totally clear about who was the leader of the project, because multiple stakeholders were involved, for example management and their always existing interests. But probably it was the head of the department Geriatrie who was the leader and initiated the change. *It was more a team effort, which is of course very good for achieving success.* During the implementation, this medical specialist *was not sure if there still was leadership, which of course was not an appropriate element. The more people involved from a department, the better. But one person as the leader is appropriate, it can guide the change.* But one should, with every change effort, *look to the change interests and the stakeholder interests and then appoint the leadership role to it.* Often it is *the initiator of change who will be appointed as the leader*. Also because *they see the urgency and are committed to it.*
Then it is the leader's task to *find their supporters, without environmental support a change effort will be very difficult, the powerful you are. Forming a project team with those involved stakeholders could be an appropriate option,* because interests could become earlier to one line and it can be good for managing resistance. *The team and its members can correct each other more easily.*
Concerning the type of leadership *it is most appropriate to start with a leader who has the focus on transactional characteristics, because in the development phase of a change, clarity in goals and to future plans is a necessity.* Especially *to convince other stakeholder, especially the money provider. Without a clear plan, a reliable and achievable one, a change effort will not receive its needed resources.* During the *implementation phase, a transactional leader should still be there*. All in order *to control the change line where from the change effort started from*. The difficulty is that the stakeholders in this care route *can hardly be forced.* Doing *this will create resistance*. Therefore, to come to a success, *the leader(s) of the change should let stakeholders (also operational personnel) participate from the beginning, but without losing control.* This can be *achieved by letting the leader make the decisions.* From the beginning on, because *letting them participate to late is a major source for time loss during the change, because then resistance (about interests) can increase to a high level.* Therefore, *the change leader should have and use the transformational intervention*, *especially when the main purpose of the change is clear and when the implementation starts*. To accomplish this, *appropriate communication channels are a necessity*.

Care Insurer Menzis
Because Menzis was only a money provider during the "Intermediate Care" program *it is difficult to be clear who the responsible leader was.* Probably *it was the council of administration* of the UMCG. *In common it is often the case that middle management within hospitals are the leaders and initiators of change projects. For successful changes this is an appropriate way of working, because this middle management has an appropriate position and is therefore capable to link strategy to healthcare interests and to organizational possibilities*. Viewing the type of leader, for the "Intermediate Care" program and also in common, *a transactional leader is the best for changes within the care route of hospitals and nursing homes.*

Because it provides in an early state clarity, a basis for change and speed to develop and implement the change effort. All issues on which a transformational leader put less attention. *A transactional leader is appropriate because their way of working is translatable to costs, which is for the care insurer of course very interesting. The chance on increasing costs with transformational leaders is much higher and though dangerous to step in. Of course every change project needs transformational issues, but for success these should be there in a pre-development phase.*

Head of Nursing home care in Nursing home (who is also a Nursing home doctor& MT member)
Concerning the "Link Division", there was one person from Bertilla (MT member and medical specialist) who participated, together with the management of the hospital, during the development of this particular project. *It was clear that it was a common change plan and that both parties were the leaders and were responsible. With of course the support of both the CEO's.* Leadership during the implementation process lied in the hands of the medical specialists of the nursing home, *because they should provide the care processes in the hospital.* According to this stakeholder, *the leadership role was appropriate. To achieve successful change efforts, there should be support from top management and because a common interest is recognizable, both parties should have participants who are the leaders and are responsible.* The best option for change projects in this care route, *is to form a project team.* During "Link Division" they did this, *this was an advantage. For future projects, this should be again the case. Important to not forget, is that also medical specialists should be involved, from the beginning on. Especially when care specific elements are not totally clear or when these elements are essential for the purpose of the change effort.* So, management should always make this consideration.

Concerning the type of leader, this stakeholder was clear that *the best option to achieve a successful change effort is and was to use transactional and transformational leadership in the developing phase/beginning phase of a change project.* This in order to be open for the opinions of medical specialists which can direct the purposes of the change effort. Within this, *transactional leadership is necessary because time is not endless and because a leader should provide clearness about finance and goals, especially in the beginning. The rest of the change process needs transformational leadership, because all the stakeholders should become committed, motivated and attached to the change project.* Because professionals are involved, *often people who are hardly to direct, will the transformational style has got its advantages over the transactional one.* Because this style leaves space for change within the change project. One should always be open to this possibility. *Otherwise it is very hard to let the stakeholders stay committed, especially when the day-to-day activity shows new elements.*

Medical specialist/Nursing home doctor hospital Drachten
From this perspective it was not clear which party was the leader. *It was more a project from the top of both the hospital and the nursing home.* To achieve the most appropriate results for a project like the "Link Division", but also in common change projects, *a transformational leader is the best option. But creating clearness and order towards outcomes should always be a major task for a leader, as well during the developing as during the implementation phase.* Because this will guide people and make them committed to change. The transformational issue are related to this, these issues *create vision and the leader should motivate stakeholders* during the whole change project. Only then success can be achieved, *because vision and motivation can create commitment for change, which is essential. In care, everyone should participate and be involved. The level of participation differs of course from project to project. That is no problem and to find a balance in it, is an important task for the leader.*

Region Manager healthcare Drachten
It was clear that the CEO's of the hospital and the one of the nursing home were the (responsible) leaders. To

achieve a successful change project, *this was an appropriate situation. Because both persons saw the urgency for change, were committed to it and both had the right vision to strengthen the care route between the hospital and the nursing home.* The leaders *were transformational leaders and this is also the appropriate style to reach success*, according the region manager. Because *healthcare needs a lot of creativity for change, because money plays this important role.* And when a vision is connected to commitment from the involved parties, a change project *will guide and controls itself.* Of course *it is good to form a project team from involved persons out of both the organizations.* This was present during the "Link Division". Furthermore, improved communication to the inside of the nursing and hospital organization played an important role to an increased level of motivation.

6.2 Overview of most appropriate leadership style

	Transactional = 1	**Transformational = 2**	**General Practitioners**	**Nursing home (doctor)**	**Head Nursing home medicine UMCG**	**Medical specialist UMCG**	**Care Insurer "Menzis"**
Creating the agenda	Planning and budgeting: develop-ping a detailed plan of how to achieve the results.	Establishing direction: developing a vision that describes a future state along with a strategy for getting there.	1	1	1&2	1	1
People	Organizing and staffing: which ind-ividual best fits each job and what part of the plan fits each individual.	Aligning people: a major communi-cation challenge in getting people to understand and believe the vision.	1&2	1	2	1&2	1
Execution	Controlling and problem solving: monitoring results, identifying de-viations from the plan and solving problems.	Motivating and inspiring: satisfying basic human needs for achievement, belonging recognition, self esteem, a sense of control.	1	1	2	1&2	1
Outcomes	Produces a degree of predictability and order.	Produces changes-often to a dramatic degree.	1	1	1	1	1

Table 7: overview of what type of leader, according to different stakeholders, was most appropriate for the case "Intermediate Care" or when relevant for change projects in the care route of hospitals and nursing homes.

	Transactional = 1	**Transformatio-nal = 2**	***Head Nursing home care Bertilla Drachten***	***Medical specialist hospital Drachten***	***Region manager healthcare***
Creating the agenda	Planning and budgeting: developping a detailed plan of how to achieve the results.	Establishing direction: developing a vision that describes a future state along with a strategy for getting there.	1&2	2	2
People	Organizing and staffing: which individual best fits each job and what part of the plan fits each individual.	Aligning people: a major communication challenge in getting people to understand and believe the vision.	2	2	2
Execution	Controlling and problem solving: monitoring results, identifying deviations from the plan and solving problems.	Motivating and inspiring: satisfying basic human needs for achievement, belonging recognition, self esteem, a sense of control.	2	2	2
Outcomes	Produces a degree of predictability and order.	Produces changes often to a dramatic degree.	2	1	2

Table 8: overview of what type of leader, according to different stakeholders, was most appropriate for the case "Link Division" or when relevant for change projects in the care route of hospitals and nursing homes

7 Results on the role(s) of the variable resistance

This chapter provides the results of the case studies which role(s) resistance (can) play during change efforts and how this can influence the success of the particular change efforts. The first paragraph includes the description of the role(s) resistance can play, according to the stakeholders (interviewees) of the two case studies. Furthermore there is a specific attention to managing resistance. The second paragraph includes a clear overview of which sources of resistance (can) influence the level of success of change efforts.

7.1 Role(s) of the variable resistance

General Practitioners (GPs)
Because the GPs were and are not involved in the development and the implementation phase of almost every change project, they were not able to give a valid opinion about the sources of resistance. *The past and healthcare has formed GPs as stand alone parties, which are though very important for health care*. Because of this position, an environment is created where *GPs follow decisions in health care. Resist towards these decisions is not what GPs do*. For two reasons, *first because GPs have often no direct interests in changes in the care route of hospitals and nursing homes. Second because GPs are one man companies, which have to managed.* So time to show resistance is not available and because a lack of sources of power is a fact, *resistance will be thrown away easily. Spending time and effort to spread out resistance is lost time, one* GP acknowledged.
The advise which the GPs both gave was that resistance should be managed with *being clear and the use of participation of the parties who have interests*. In order to *create willingness to change and to prepare these involved parties.*

Head of Nursing home care in Nursing home (who is also a Nursing home doctor)
During as well the developing as during the implementation phase, the sources of resistance during change, comes from the cultural aspects which have formed behaviour and attitude. People within the nursing home find it in the beginning difficult *to leave the status quo*. Especially in the beginning, because *nursing homes and its staff are in common willing to change*. But there is *always the threat of uncertainty and losing particular interests, as with every change*. Managing this is very important. Several points of attention which can lead more easily to successful change were given. *From the beginning on, management support throughout the whole organization must be recognizable.* There must be *an environment of a shared vision and especially a positive vision for as well the health care as for the nursing home and its operational staff.* This will take time, but it is a necessary step to achieve success. *There must become an organization which is one team towards the change project.* This can be accomplished *to use as well top down as bottom up relationships. Top down creates clarity, direction and guidance for change*, by using presentations with visual material people can identify their self with the change and their work. *Top down can also be used as a source to force people to follow (or have to leave the organization). This forced aspect should always be there, because the management level develops the strategy. This strategy should be followed. During implementation there is more resistance recognizable then during the developing phase. There will be more internal protest by using verbal actions, gossip and announcements of the negative sides (spoken by the operational personnel).* The intervention to use, to overcome this, is *"relevant participation".* The whole organization should *participate during change, to some degree then.* One should *participate in their own domain.* Therefore, *the leadership team and management should*

set and create borders to work in and hold people to it. Especially within nursing homes. .

Head of Nursing home medicine UMCG
Concerning the subject of resistance, the head nursing home medicine of the UMCG was clear that *the management level of the hospital and nursing homes were and are ready and willing to change*. But looking to *the operational staff within these organizations, it is a contradicting view. Operational staff is not that willing to change she argued, because of the increasing work pressure (on primary work) which is recognizable*. And because they are *not willing, they are not ready. While management is*. This is contradicting and *a source for resistance and then the hierarchical structures will determine what will happen.. A good leader-organizational member relationship is necessary for successful change and a manager pay attention to it*. All in order to form a team towards a change effort. *The chance for success is then at the highest levels*. The difficulty though is that *parties have their own interests, way of thinking and way of working which can be and was a major source of resistance during the "Intermediate Care" project and probably future projects*. For the future, change managers should have a *thorough attention for win-win situations and communicate them in order to decrease resistance.*
Comparing the developing and implementation phase and related to resistance it became clear that the above story counts for both phases. *Focus on communication and participation.*

Medical specialist UMCG
With the IC project, this stakeholder stated that *the nursing homes (as well on the management as operational level) did not had to change a lot and therefore were willing to change. Communicating how much, what to change and what the benefits are, is an important step during a change project*. At this moment, nursing homes *are willing and ready to change, especially when change plans are challenging and interesting and have benefits from different perspectives*. And when it will be conducted in kind of projects. *Because they feel commitment and of course a strong position*. But the willingness to change is in common *determined by the characteristics and vision of a management and the head of nursing home care within nursing homes*. Especially the head nursing home care, because this is often *the person with the contacts to other medical professionals (within hospitals and/or nursing homes). The level of autonomy this person has, can be a determining factor to change and to be willing and ready to change. Within hospitals the same story counts.*
But overall seen, medical institutions (hospitals/nursing homes) with all those professionals, *are difficult organizations*. Because all the *professionals have all a professional autonomy, but they are incorporated in a wider organization where strategy and hierarchy is an important issue. Professionals have their own ideas and way of thinking and they do not like it that others guide and force them. This is an important source for resistance*. As became clear, inappropriate leadership, which has the focus on forcing others *and not use the intervention participation to inform, attract and get everyone on one line, will have a much larger change on resistance (from as well other external stakeholder as from operation personnel).* Within the hospital, the feeling is there that there is a *large distance between the top management level and the medical professionals and operational personnel. Whereby the professionals work in a kind of autonomy, but this differs a lot.* This has also resulted in a culture where *people do often walk away from particular responsibilities. An important source for resistance.* Viewing resistance practical, it is almost a fact that *change is directly related to resistance (always there when change happens)*. It is recognizable that *resistance often comes from very small (relatively unimportant) issues which results in verbal resistance because there is doubt, loss of power or loss of safety.* It leads also *to quite protest*. This happens *as well during the development phase as during the implementation phase.* During the implementation phase, *the resistance from operational personnel increases at that time. But of course there are the interests for patients and there is a hierarchical system which helps to decrease the amount of resistance.* Related to the "Intermediate Care" project a source of resistance, during the implementation

phase, *was the time for change. Probably there were not enough patients available for entering the program*.

Care Insurer Menzis

The care insurer has not a close enough relation to the internal organization within hospitals and nursing homes to state clear if hospitals and nursing homes are now and were in the past willing and ready for change. It seems that as well management as operational personnel are willing to change, *because it seems necessary within healthcare. What often is missing is urgency to change, which is an essential aspect in order to change successfully.* Focus on this urgency issue is though very important. Because Menzis is a kind of alone and independent party and because they were and are not active participants during developing and implementing changes, it was not possible to name the exact sources of resistance. *Though it is very important to manage resistance, from the beginning on. This is especially a task for the change initiator and/or leader of change*. Menzis sees that the parties *with the most resistance are hospitals and medical specialists, because they want to use their power to hold on their interests.* Towards the care insurer *there is (often) resistance to them because the care insurer holds on to regulation/laws which do not fit with the plans of hospitals and/or medical specialist and plans who are financial not achievable and reliable. Debating and discussing are valuable interventions to come to a solution, but to a curtain end.* Communication is essential. A common problem that is recognizable, is that this *resistance comes out at a late stage during the change. This costs so much time and money*. The advice from Menzis is, to *let Menzis participate in a kind of work group. This gives the possibility, in an early stage, to debate with hospitals, nursing homes and medical specialists about change plans, if they are achievable and valuable. Two critical issues for success.* In a work group*, the care insurer can provide its corporation and can take care of the legal, financial consequences and is able to minimize risks for failure.* This can *smooth up the developing phase and gives a possibility that the implementation can start earlier. Because it is often the care insurer who stops a change project, just when the change initiator wants to implement their plan. Often because the costs become to high and because of conflicts with regulations.*

Head of Nursing home care in Nursing home (who is also a Nursing home doctor& MT member)

Concerning resistance the picture was clear. As well management as the operational personnel saw the chance, the urgency and especially the positive consequences that the "Link Division" could have in the future. Therefore there was almost no resistance within the nursing home recognizable, as well during the developing as during the implementation phase. This can be explained by the fact *that there was and is a good relationship between management and operational personnel within the nursing home.* A relationship based on *openness, trust, commitment and participation*. These four factors can *be important influencing interventions* to manage resistance during the whole change process. But the involved nursing home persons who were also innovative and open for change. *This is of course essential, they should be willing to change and then the task for the organization is to make them ready. Especially by informing and communication which has a future (as well short as long term) perspective.* The only resistance was recognizable between specialists from the nursing home and from the hospital, specialists who should work together. So this was during the implementation phase. *Both parties had their own work systems and hierarchical systems, which conflicted a little bit.* This resistance is managed by appointing persons who should lead this working together. By appointing persons which *were higher in the hierarchical standard.* These persons started *open conversation and by discussing how everybody could work the best, solutions were tried to be incorporated.* This has worked, *but it is a question if the collaboration between nursing home and hospital specialists will ever be total positive. It is just the character of these persons and therefore always a challenging task for managers and/or a head of nursing home care.*

Medical specialist/Nursing home doctor hospital Drachten

Because the medical specialist was not an active party during the actual development and implementation of the "Link Division", there was no valuable opinion on the sources of resistance. Though this stakeholder made it clear (in common) that for successful change, *resistance should be managed. Because readiness and willingness is essential for change. This can be achieved by clear vision which is translated into clear goals. Resistance* will become part of a change project when the change has got *an unclear character*. When this latter is the case, hospitals and nursing homes are not willing to change. Otherwise they are. *Then there is a good collaboration level between management, medical specialist and operational personnel, which will increase on a successful change effort enormously.*

Region Manager healthcare Drachten

From the interview it became clear that both the hospital as the nursing home (as well management as operational personnel) were willing and ready to change. *Both parties understood the necessity to collaborate* and that the "Link Division" could have an added value for the whole care route. The culture within the nursing home and the hospital has a strong focus on patients health. *A necessity for achieving the success. This culture had formed good formal and informal relationships between the management level and operational level. But also by just being clear and as honest as possible.* For this reason their was almost no resistance to the change project. Of course there was resistance, *because people are always scared to lose a job or function and because the nursing home had a feeling that the hospital saw them as a lower level than they are.* But this flawed away, very quickly, because *the project team communicated that it was all about a win-win situation, that there was job security for the people, than an improved work environment would come available, that the focus was on quality for patients and that there were keep on growing possibilities for the organization as well for personnel.* These interventions were used as well during the developing phase as during the implementation phase of the project, it has lead to a successful change effort.

During the development phase, there was more resistance from the management level. Especially in the beginning, *because as well the hospital as the nursing home wanted to protect their way of working, way of thinking and culture. And because the past had shown that the relationship between the hospital and nursing home was not always good, were people not always happy with the change.* Because they thought that the hospital wanted *collaboration for their sake and not for patients and/of nursing home.* This resulted in discussion and a slow process of negotiation. *Eventually this has strengthen the relationship and collaboration, because both interests and especially the interest of healthcare won. This is the base of successful change projects.* Therefore, a nursing home or a less powerful party, *should be concise, assertive and sometimes aggressive. Be competitive, even if you feel not that strong. Resistance can be overcome by using these interventions, and if persons really do not want to participate one has to straight and hold their vision.* This can lead to a dead end or, concerning personnel, firing. For successful change, *one vision, commitment and collaboration is a necessity.* In practice it is often happening that medical specialists (professionals) resist against plans and changes, *because they find it very hard to leave their way of thinking and working. In these situations, the change agent should ask the help of other professionals, their superiors or the board of management. They can use their top-down power and especially because they "speak the language" of the professionals who resist.*

7.2 Overview of sources of resistance

The tables below provide the overview of the sources of resistance, according to different stakeholders, which were recognizable during the developing and implementation phase of the case "Intermediate Care" or when relevant for change projects in the care route of hospitals and nursing homes. *Not of application means no opinion because of no involvement or no experiences.*

	Source of resistance	General Practitioners	Nursing home (doctor)	Head Nursing home medicine UMCG	Medical specialist UMCG	Care Insurer "Menzis"
1	Rigid structures and systems reflecting organizations, business technology, and stakeholder resources that are not consistent with the forces of change	not of application		xxxxxxxxxx	not of application	not of application
2	Closed mindsets reflecting business beliefs and strategies that are oblivious to the forces of change	not of application		xxxxxxxxxx	not of application	not of application
3	Entrenched cultures reflecting values, behaviours, and skills that are not adapted to the forces change	not of application	xxxxxxxxxx		not of application	not of application
4	Counterproductive change momentum driven by historical or other change drivers that are not relevant to the most urgent forces of change	not of application			not of application	not of application

Table 9: developing and initiating plans for change

	Source of resistance	General Practitioners	Nursing home (doctor)	Head Nursing home medicine UMCG	Medical specialist UMCG	Care Insurer "Menzis"
1	Rigid structures and systems reflecting organizations, business technology, and stakeholder resources that are not consistent with the forces of change	not of application		xxxxxxxxxx	xxxxxxxxx	not of application
2	Closed mindsets reflecting business beliefs and strategies that are oblivious to the forces of change	not of application		xxxxxxxxxx		not of application
3	Entrenched cultures reflecting values, behaviours, and skills that are not adapted to the forces change	not of application	xxxxxxxxxx			not of application
4	Counterproductive change momentum driven by historical or other change drivers that are not relevant to the most urgent forces of change	not of application			xxxxxxxxx	not of application

Table 10: implementation phase

The tables below provide the overview of the sources of resistance, according to different stakeholders, which were recognizable during the developing and implementation phase of the case "Link Division" or when relevant for change projects in the care route of hospitals and nursing homes. *Not of application means no opinion because of no involvement or no experiences.*

	Source of resistance	**Head Nursing home care Bertilla Drachten**	**Medical specialist hospital Drachten**	**Region manager healthcare**
1	Rigid structures and systems reflecting organizations, business technology, and stakeholder resources that are not consistent with the forces of change		Not of application	xxxxxxxxxxxx
2	Closed mindsets reflecting business beliefs and strategies that are oblivious to the forces of change		not of application	xxxxxxxxxxxx
3	Entrenched cultures reflecting values, behaviours, and skills that are not adapted to the forces change		not of application	xxxxxxxxxxxx
4	Counterproductive change momentum driven by historical or other change drivers that are not relevant to the most urgent forces of change		not of application	xxxxxxxxxxxx

Table 11: d*eveloping and initiating plans for change*

	Source of resistance	**Head Nursing home care Bertilla Drachten**	**Medical specialist hospital Drachten**	**Region manager healthcare**
1	Rigid structures and systems reflecting organizations, business technology, and stakeholder resources that are not consistent with the forces of change	xxxxxxxxxxxx	not of application	
2	Closed mindsets reflecting business beliefs and strategies that are oblivious to the forces of change		not of application	
3	Entrenched cultures reflecting values, behaviours, and skills that are not adapted to the forces change	xxxxxxxxxxxx	not of application	
4	Counterproductive change momentum driven by historical or other change drivers that are not relevant to the most urgent forces of change		not of application	

Table 12: implementation phase:

8 Discussion

This chapter elaborates on the interpretation of the results of the previous two chapters, which will lead to the answers on the main research questions. Furthermore, the theoretical and practical implication of this research will be outlined. The end of this thesis will provide a reflection on the research, this exist out of analysis concerning reliability, validity and the strong and less strong issues of this research.

8.1 Interpretation of results

Having the research results outlined in the previous chapter it is now time to interpret these results, by using the main research questions. Viewing the main research question, about *which variables (can) influence the success of change efforts in care route*, one can conclude that power, leadership and resistance are variables which can have this influence. Variables which should be managed and used in a certain appropriate way, because only then a successful change effort can be achieved. Concluding it has become clear that as well power, leadership as resistance are related to the level of success of change efforts within the care route between hospitals and nursing homes. Also because all the interviewees agreed on the importance and influencing role the variables can have, during the whole change effort. No one mentioned that one of those variables is not an influencing factor for successful change efforts. Therefore every interviewee elaborated, most of them very thoroughly, on the three variables, their role(s) and the relation to successful change efforts. Answering the four research questions will provide a clearer picture of the role(s).

1) *How can successful change within the care route of hospitals and nursing homes be characterized and described?*
In general, there was a common opinion on how this question should be answered. The interviewed stakeholders described successful change in a certain way that it is a change where the plans/goals which are made on forehand by the change initiator are achieved. Attached to it, it became clear that several interviewees directly related their description to improvement of healthcare. But not all, which can be an interesting outcome. Because this can be in line with other interests (that involved parties can have), contradicting to healthcare issues which should be the primary issue in order to achieve success in change. Furthermore, the data showed that plans/goals should be clear, reliable, achievable, relevant and should have a minimal amount of risk. Essential characteristics to achieve successful change.

2) *Which role(s) play the variable power, on the level of management and implementation, to bring about successful changes in the care route between hospitals and nurse homes?*
From both cases and from almost all the perspectives it has become clear that power is a source for stakeholders to influence decision making about developing and purposes for change plans. This is especially on the management level. With power bases one can try to protect their own interests and therefore direct and guide a change effort to a certain desired state. Within organizations and especially during implementation processes, power is also a pressure source. Power provides a stakeholder a particular strong position to influence for example operational personnel, to do what management/change initiators want them to do. But overall seen, the study provides the information that money and the stakeholder(s) who possess the money are the powerful parties. For successful change it is necessary that this money providing stakeholder gets committed to a changeplan. and is willing to corporate. Concerning the powerfulness of the stakeholders, the research shows that

in common, General Practitioners are powerless parties to influence change efforts and were not involved in developing and implementing the changes. Most stakeholders found this situation appropriate, it does not influence the success of the change effort. While the GP's stated that they should be more involved, because nursing home care is a joint program and because they have practical experience. Within the "Intermediate Care" case, the nursing home felt their self far less powerful, in relation to the nursing home in the "Link Division" case. A reason for this is probably that within the "Link Division" case relations are based on mutual dependence, while this was not present with the "Intermediate Care" case. Stakeholders like the head nursing home care in the hospital and a region manager healthcare have important roles, they have overview and can have a control function. To protect the healthcare interests. But the head nursing home care has far less power bases than the region manager. Contrary, medical specialists are together with Care insurer/money provider the powerful stakeholders. Because they are medical specific important, but also organizational. So as well for the management level as for implementation. But the "Intermediate Care" case showed that not all medical specialists are asked to participate to develop change plans. This can mean that superiors of the specialists are even more powerful and probably know that medical professionals can be a difficult group to work with. Power will always play an important role, to overcome the negative influence power can have, stakeholders should create common interests. Interests on nursing home care issues. Achieving this will lead to an increased chance for successful change. Contrary, the research showed also that not all the stakeholders have to be involved, or that power should be used to come to a successful change effort.

3) *Which role(s) play the variable leadership, on the level of management and implementation, to bring about successful changes in the care route between hospitals and nurse homes?*

Appropriate leadership is a necessity for successful change, because leaders have the function to guide, control and initiate and translate the change from the management level (strategy) to the implementation phase. It are often the initiators of change who are the leaders to conduct the change. Leaders should keep the change on course. Leaders have also the task to get stakeholders along, to create commitment and to get the interest for change to one line. This is a difficult task, because multiple interests are involved. Therefore, it is probably why most of the stakeholders agreed on the value a project team with all the involved stakeholders can have. That using this is most appropriate to achieve successful changes. During the "Link Division" case this was used, during the "Intermediate Care" case not. Can be a reason on the level of success. Concerning the type of leadership style, the research shows that most of the interviewees related to the University Medical Centre Groningen stated that to achieve a successful change effort (also what should have been used during the "Intermediate Care" case), a transactional leadership style with transformational characteristics is most appropriate. In order to achieve clarity, direction and order. And with transformational issues to use a vision to motivate others and to create commitment and cohesiveness for the change. The "Link Division" case shows the opposite. That transformational leadership was and is the most appropriate style, added with transactional issues. So the study provides no significant view on the most appropriate leadership style.

4) *Which role(s) play the variable resistance, on the level of management and implementation, to bring about successful changes in the care route between hospitals and nurse homes?*

The research data shows that every stakeholder acknowledge that resistance plays a role during change efforts and most of them also in relation to the level of success. For example that resistance exists because persons are afraid to lose power, interests, position and/or influence. Often, people are afraid of leaving the status quo, as well on management level (for example the medical specialists) as during implementation (resistance by operational personnel). The study provides no one sided view on the sources of resistance, as well during the developing as implementation phase. This is not rare,

because every change can be different and because every stakeholder can have different interests which can form resistance. The study shows that resistance on the implementation level plays not a that significant role for the success of the change effort. Because there is always the hierarchical system, and the operational personnel (as well in hospitals as in nursing homes) confirms their selves early to a change. They have to. Of course managers/leaders of change have to manage resistance, to decrease the chance for it. Interventions which were named to achieve an as low as possible resistance level are; participation (of operational personnel), having a clear vision, a lot of communication, provide urgency and create appropriate internal and external relationships. Especially relationships between hospitals and nursing homes, relationships based on openness and trust to create commitment for change and their interests. The "Link Division" case has shown that having this kind of relationships is an added value to have a low level of resistance and to achieve successful change. But nursing homes should also protect their own interests, concerning nursing home care, because hospitals are often willing to change when it is in their favour. The stakeholders who had a view on the level of willingness and readiness for change, concerning nursing homes and hospitals, were positive about these two important issues. Especially when plans are interesting and value adding for the care route. Healthcare is a field where change seems a constant factor and therefore are open and ready for change. Especially when projects with the other stakeholders can be started, then the chance for successful change can increase.

8.2 Theoretical implications

Contrary to previous research within nursing home care, this research adds a new perspective on change processes within this particular nursing home care. This study provides an overview of how multiple variables can have a significant impact and/or influence on the success of a change effort within this health care field. This is a new perspective because the study shows the importance of managing influence variables within change projects well. How these variables can have influence and how they should be managed is the added value of this thesis, related to previous research within nursing home care. This missing element of managing change within the nursing home care, can be explained by the fact that this occupation does not have the attention and knowledge about business world variables concerning change processes. Within the business world, change management is a part of total management, but within nursing home care it is not. This thesis relates the business world theory on change management, particularly about power, leadership and resistance, to the field of nursing home care. And this study shows that organizational business theory on change processes can be translated to the field of nursing home care. Which is a trend which is asked for, because nursing home care changes a lot and because the application for conducting this research has become a fact. There is an upcoming interest for change management and business knowledge within the nursing home care. This research has shown that this correct, because the research variables which have a significant in business world, do also have a significant important role during change processes within the nursing home care.

This research illustrates also that power, leadership and resistance are important variables to achieve successful change efforts, but they should not be researched as individual variables and that discussing them separately is difficult. Theory and practice shows that powerful groups are often in a leadership role and have a task and resources to overcome and manage resistance from other stakeholders. This is one example of the relationship, but theory and practice show many more. The focus of this research was not to sum up these relationships and how these relationships influence the success of change projects. But along the way, these relationships were recognizable. A future research proposal could be to study the interrelatedness of the variables power, leadership and resistance and to what level they influence the success of change efforts within the nursing home care. Within this

future research there must be attention to the stakeholders with who own the financial resources. The study illustrates that the parties with the financial power, are very powerful. Looking to the six power bases which operationalized the variable power, financial power was not a base. Within the research financial power is related to reward power, it is the closest to each other. But when one is straight, to announce which party has financial power and how it can influence a change effort to become a success, the power base model of Raven (1965 & 1992) should be expanded with the base financial power. Because when the stakeholder with this kind of power does not corporate, the rest of the involved parties are almost out of order.

The research provides an overview of which power bases the different stakeholders had during the cases and just have in common (related to change projects), which type of leader was (is) most appropriate for the researched cases and which sources were the basis for resistance. These three variables and its bases/sources/characteristics are researched in a common perspective. This means that the results show if a stakeholder possessed for example particular power base and the description explained how it was used/can be used. What not has been researched, are the differences in weight. For example if one stakeholder stated that he possessed reward power and another one did the same, it is understandable that one party can be more powerful over the other. Future research can put a focus on this issue, by studying the amount of power a stakeholder possessed (attaching a weight factor to a base/source and which influence this got on developing and implementing a change project and evaluating its outcomes.

From the research it becomes clear that almost every interviewee named that involvement, confidence and especially commitment towards plans, other parties and within their organization is a base for successful change. The involved parties for a change should see themselves as a team with the same goal. It became also clear that achieving this feeling of one team, consisting out of different organizations and specialists, is a difficult task.

Within business, but also in health care, there is very little research on team level commitment. For example how to achieve it. Only on individual level research about commitment is recognizable, but commitment at team level has added value (Serva, Fuller & Mayer, 2005). Simons & Peterson (2005) and Chowdhury (2005) name the advantages. Commitment plays a determining role concerning interpretation of others and mutual commitment is valuable for internal information transmission, open discussion and decision making processes. All issues which can have significant importance to achieve the goal(s) of a change effort. Future research on how commitment can be created on a team level (with parties with different interests) can have an interesting contribution for managing change projects in order to achieve successful results.
As announced, the focus within this study lied on power, leadership and resistance. An important part of resistance was willingness to change. The research data showed that without willingness to change, an effort is far more easily doomed to fail that with it. Within this research, willingness to change is measured with the theory on resistance by Strebel (1994) and the LMX model. Metselaar and Cozijnsen (2002) do also acknowledge the importance of willingness to change in order to achieve a successful change effort. They elaborate in more depth concerning the willingness, especially in situations where resistance to change is large. Where this situation has to be transformed into willingness to change. They use the DINAMO model, which has a focus on attitude, subjective norm and perceived behavioural control. So, next research on willingness to change within the nursing home care, can be conducted by using this DINAMO model together with the theory of Strebel (1994) and the LMX model, in order to create a thoroughly view on willingness to change.

Managing change efforts is a complex task with a lot perspectives and influence variables. The previous implications showed that power, leadership and resistance could be expand far more. But there are more variables which could possible influence the success of change efforts. These factors, which are not part of the research,

are for instance culture (Burnes, 2004 & Schein, 1984) and learning (Argyris & Schon, 1978). Culture in the sense that a strong culture is difficult and slowly to change and that the current culture is often in conflict with the purposes and forces of change efforts. Reasons which can cause for failure during change projects. Concerning learning, it is for example in relation willingness to change. Because when an organization has the status of an learning organization, it has the possibility to transform itself continuously to the environment by the help of involvement of all the organizational members. Which is a positive issue to achieve success during the change effort.

8.3 Practical implications

An often mentioned attention from the results of this study is that every change effort is a different one. Because every change effort has/can have different interests. Before elaborating further on the differences on change efforts, it is necessary to mention the start focus of change projects in the care route of hospitals and nursing homes. The initiators of change (for example hospitals, nursing home and/or their specialists and/or project teams) should start their effort with a focus of how a change project can have added value to the type of healthcare (i.e. for patients). Because that is the core business of healthcare institutions. It seems superfluous to mention this, but the research showed that a lot of different interests can play an even more significant role in order to achieve successful change efforts. Interests which can neglect healthcare/patient interests. Think of money, personal/hidden agendas, competition and status. The leader of change should protect the basic interest. This can be done by naming and especially communicating the urgency for change, but also by involving those stakeholders in the beginning of a change project. In this way, an early recognition of the different "sub-interests" can be available and therefore can be managed. When there is still a total conflict, the leader of change is able to abandon the effort. This early involvement is important, because starting to change and involving the stakeholder later on in the process, increases the chances of drawbacks and/or time loss because stakeholders can resist by not showing corporation, which is a necessity for successful change efforts.

Coming back to the different characters change efforts, but also their change environments, can have, it is important that initiators of change projects in this healthcare field should not think that managing change efforts in care route of hospitals and nursing homes can be formed in a "one best way" for all change efforts. Not during a developing as during the implementation phase. This is an often made mistake in the field of change (Burnes, 2004b). As Burnes concludes in his research, organizations should avoid it, to view change situations like this. Instead, organizations and the leaders of change should identify and look for best suited approaches, every time. Lack of interest about this theme, is for Burnes as well as for Beer and Nohria (2004) the reason to announce that almost two-third of change processes/plans fail. So this research is no guarantee that the role(s) the three research variables played, will happen during other change efforts. But, because the results show a lot of agreement on for example the powerful position of the money providers to conduct a change effort, or the importance of involvement, participation, communication, clear goals and a mixture of a transactional and transformational style, provides a strong intention that focusing (by the leaders of the change effort, during the whole change) on such interventions will contribute to an increased chance for successful changes.

An outcome of the study is that stakeholders who initiate change should have a thorough focus on developing appropriate plans with change goals. For the purpose to create clarity, to inform others, especially to convince other stakeholders (for example money providers, medical specialists and managers) and to be able to control if a change is a success or not. A useful intervention for change agents can be to make the plan and its goals all SMART. This is common in project management. The leader of the change effort should make the plan and goals *Specific,*

Measurable, Acceptable, Realistic and Time related. And because to change, multiple stakeholders are involved, the change initiator can create an added value in the developing phase of the plan by conducting stakeholder management. Because creating consensus along these stakeholders is a step to success. Stakeholder management can provide an overview to come to this state of consensus and is therefore input for the SMART deliverables.

That a mixture of a transactional and transformational style was announced several times is not rare. Because over the past twenty years, it seems that the emergent approach (which has a close link to transformational leadership) and strategies overwhelmed the planned (related more to the transactional) approach as the most appropriate one. But as the research of Burnes (2004b) identified, planned and emergent should not be seen as competitive approaches to change. If situations ask for both planned as emergent aspects, these two strategies can work alongside each other (Mintzberg, 2003). The can form a hybrid strategy to change (i.e. complementary to each other). In order, under control of the change leaders who should develop a change plan, to form change strategies which are a 'one best way for each' change project within the care route. .

Power, leadership and resistance can have and do have an import role when a change initiator/manager would like to achieve a successful change effort. Like there were theoretical implications on resistance, there are some practical ones for power and leadership. Before one can go deeper into different types of power within change and try to manage them where it can, it is for those persons who develop and manage the change process, useful to understand the concept of power. From the earliest stage the change get its form and purpose. As Burnes (2004a: 185) argues, in essence power is easy to understand and to define. He names power, "the possession of position and/or resources which can help to influence decisions". But the difficulty lies in the relation to authority. Often, these two concepts are used interchangeable, which is not correct. Robbins (1987: 186) elaborated on this distinction. "Authority is the right to act, or command others to act, toward the attainment of organizational goals". This right has got legitimacy which is based on the authority figure's position in the organization or relation. Contrary, power is an individual's/group capacity to influence decisions. The overall distinction is that the ability to influence decisions can be the case because of one's legitimate position, but such an individual/group does not require authority to have certain influence.

Concerning leadership, the distinction between transactional and transformational leadership can, for managerial positions, be a good tool to appoint a particular leader for a particular project. This tool inhibits different characteristics a leader can and should have in order to follow a particular leadership strategy. So the distinction provides a control mechanism for those persons who have the task to appoint leaders for change. In order to achieve successful change, Munduate & Bennebroek Gravenhorst (2003) state further that it is possible to connect transactional and transformational leadership to types of change processes. They refer it to the planned and emergent way of changing. According to them, the two main processes (derived from Weick & Quinn, 1999) are Episodic change (i.e. discontinuous, intermittent, short time span development of radical change with large impact and using the planned Three Step model of Lewin) and Continuous change (i.e. emergent, evolving, incremental, sequence of events to improve, constant adjustment and growth, people oriented and using the freeze, rebalance and unfreeze model). These authors combine transactional leaders with the Episodic change, while transformational leadership is interrelated and successful for Continuous change. This gives the possibility to view a change process from a leadership point of view, because when leadership and its type for the effort is present, a connected process to change is demonstrable.

This research studied which role power, leadership and resistance played during two cases from a "professional" perspective. This means that the interviewees were stakeholders working in and around the care route of hospitals and nursing homes. The research had no focus on

interviewing patients. This is not done, because of several reasons. Because there are that many researches within hospitals, there is a kind of gentlemen's agreement of not intervene in one's recovery and/or treatment process. But also because the chance of non-response is high, in common because patients are not always willing to corporate and because available time. A last reason, is that patients of do not know about the changes and do not the underlying thoughts of changes. So a first task is to inform patients about the ins and outs of the change plan, before a thorough interview can take place.

Though patients, also according the interview data, are the persons who have to see and feel the consequences of changes within the care route. They can function as a kind of control function. So when change initiators really would like to know the opinions of patients, it can be achieved by developing a clear, for everyone understandable and especially short list of questions. So a quantitative way of researching which is initiated by the hospital and/or a particular doctor. It can be important to make it personal and especially recognizable for patients what their opinion means for the hospital and/or doctors.

The results of the research showed that most of the stakeholders stated that especially nursing homes, but also the hospitals are willing and ready to change. A characteristic of healthcare is that it is a continuous evolving environment, especially within University hospitals. Because a core element within such an institution is to connect scientific research to healthcare issues, this means a constant chance and focus on change. Therefore, as well management as medical specialists should have their eyes open for chances to change. Day to day work can provide tremendous information for further optimizing the process of nursing home care. Weick (2000) explained this emergent approach more thoroughly, by acknowledging that it is about "ongoing accommodations, adaptations, and alterations that produce fundamental change without priori intentions to do so". He stated that it most occurs when people reaccomplish routines and when they deal with contingencies, breakdowns, and opportunities in everyday work.

8.4 Reflection

This final section evaluates the research by focussing on the reliability, validity and other strong and less strong characteristics of this research.

Reliability
The number of interviewees and their position within the care route of nursing homes and hospitals is enough to conclude that the data out of the two case studies are reliable, but overall seen not to the highest level. Because it is succeeded to interview all the stakeholders who were appointed before the empirical research. The stakeholders who (can) have influence on change projects and also during the cases. Furthermore, because all of the stakeholders were experienced persons in their profession and because the (first) focus was on the specific cases, it can be announced that their data is based on reliable experiences and opinions. And the interview data showed a lot of similarities from different perspectives. This can mean that the study findings are reliable. A third reason why the data is reliable, is because the interviewees found it an interesting subject and a good one for research. They were cooperative and it was recognizable that the interviewees though about the interview subjects. This increased the reliability because they were willing to provide their view on the situation, because they believed that the subjects are important for future changes. So they were willing to help to come to successful changes, or plans to manage it. There was some kind of own interest and therefore their information was well-thought-out and should have value to the research report. Such a report can set up an appropriate change plan.

It can be concluded that the reliability has not reached the highest level because some stakeholders did not really participated during the development and implementation

of cases. They were at the sideline, which of course provides a degree of reliability because they could have a more objective look from their perspective and experience. Another danger which can decrease the reliability, is that interviewees do not say anything they think. Especially because they do not want to put others in a dark light, which can have negative influences for the future. And because the cases are happened a time ago, the interviews are always answering some parts within their common view. Which can have, on the other hand, a positive influence on the generalizability of the data (so it is two sided). The results of this research can be used as representatives for other future change projects, because the two cases were large, had a large impact and involved a lot of parties and persons with their perspective. And because one project has become a failure and one a success and one project conducted out of a large hospital with a lot of competition and one in a peripheral hospital without strong competition is input for a high score on generalizability. But never forget that every change project is different and that the possibility arises that the variables play a different role. This research makes it possible to have attention points for future change projects, it gives the possibility to make a best way for that particular situation.

In the future, it is possible to conduct a more reliable study on the variables power, leadership and resistance by using a quantitative research approach. Then one can work with questionnaires. With statistical techniques one is able produce a very reliable research. But it will not be this appropriate for case study research, because with case study research it is almost impossible to let every research stakeholder fill in the same questionnaire. This is the strength of quantitative research.

Validity

Because the research variables are wide concepts, it was appropriate to delimit the variables to the research. This made it possible to be clear and to research which role power, leadership and resistance can have in order to bring about successful change. To rely on and trust the theory on those variables and their relation to successful change and especially by using (during the empirical research) the tables of power bases, the characteristics of leadership style and the sources of resistance, the research can be characterized as internal valid. Research has proved that the founded theory is significant related to bring about successful changes. A critical element to this, is that there should there could have been more attention on how power is used by the stakeholders. And especially in relation to successful change, so how power bases can influence the success of changes. Now the main description is about who owns power and that power is important within change. Of course the research showed, for example, that creating commitment and consensus with powerful parties like the money provider, is essential to achieve a successful change effort. But to strengthen this relation between power and success, the previous element could have been added. Before starting the interviews, the researcher has used a try-out interview in order to acknowledge if the interview subjects and its questions (the structured part) were clear and understandable.

Concerning external validity, the research and its outcomes is valid for the specific two cases. But also to other change efforts. Because the interviews gave a lot of information about the appropriateness of the cases. This of course can contribute to future change efforts. But viewing this critically, the outcome of this research is no guarantee for future change efforts in nursing home care. Because it is very hard to cluster types of change projects, every change is different. To increase this external validity, more research on the role power, leadership and resistance in nursing home care should be conducted, research on many more different change projects. Which gives maybe the possibility to cluster types of change in the care route and to make a more valid overview of the three variables.

The factor time

An important limitation of writing a master thesis is the factor time. Within the time available, it was impossible to do more than two case studies. Case studies with interviews with the different stakeholders like in this thesis. It is a limitation because as said before, every change

project is a different one. The more studies of different projects and interviewing more equal stakeholders from different projects, makes the research more reliable then it is. Of course, the variables can have to a certain level, the same influence. Repeating this study should explore this statement. Until the rule of information saturation becomes clear, this means that the output of the research shows common perspectives in certain situations. Then a reliable common view can be given.

But one should never underestimate our fast changing world, a situation which can affect the way change projects are conducted. Because the possibility of new research techniques can become available, but also collaboration systems and rules and regulation within the research area can differ. One should not forget that this research is a measurement at one moment in time. Therefore an appropriate option would be to research how the three variables and their influence on the success of change projects change and evolve over a certain period of time. So, longitudinal research about which role power, leadership and resistance play in relation to the success of change projects in the care route of hospitals and nursing homes can have an added value.

Interview procedure
During the interviews it was good thing to use the tables from the theoretical section of this thesis. The tables are the basis of the delineation of the three research variables power, leadership and resistance. The tables were the input for the information the researcher would liked to receive out of the interviewees. It was also an appropriate procedure because the interviewees could take their time to read the tables and fill them in. This procedure provided clarity, it showed what the researcher wanted to know and how the results of the research should get its form. Furthermore, the filled in tables were excellent input for further conversation and discussion. It worked as a control mechanism, because the important subjects could not be skipped of forgotten. Then the real added value of interviews could work appropriately.

Another advantage during the interviews was that almost all the interviewees were sufficient familiar with definitions and theory on business processes and the three variables. This saved a lot of explanation time and it gave the possibility to use the definitions from my literature research.

An issue which could have been gone better, related to the whole research and to the interviews, was to have more knowledge about specific medical elements. Especially in nursing home care medicine. During the interviews, the interviewees talked and named often medical treatments and procedures. So to be more confident when you interview medical specialist, it can be useful to do a more thorough study of the specific medical elements. This can be done in the form of an internship on for example the department nursing home care medicine, before you as a researcher conduct the empirical research. Then there is more time to focus on medical issues, for example by using more oriented interviews/conversations with your supervisor of the medical institution.

This previous has of course not led to a limited research outcome. Because with this thesis, nursing home medicine departments as well as (hospital/nursing home) managers, change initiators and change leaders are able to manage important influence variables in order to achieve successful changes in the care route of hospitals and nursing homes.

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Appendix 1 Possible changes in Nursing home care

Pre-care (Boersma, 2008; Croon, 2008)
To optimize the nursing home care, especially towards the goal of decreasing the time that hospital beds are possessed and the goal of increasing the attention for faster recovery, pre-care can be a good change. Pre-care means that people (especially elder ones) who have not and will not get an appropriate condition and should have a surgery, will be prepared within a nursing home in order to have an as good as possible health situation when one is entering the surgery. All in order to decrease the recovery time a (elder) patient has. Because research has shown that an appropriate condition will lead to a faster recovery. This means a lot of collaboration between hospitals (medical specialists who diagnose and develop a plan for surgery) and nursing homes (who have to treat the patient, according a detailed developed medical and physical plan).

Custom made living (Bisschop, 2008)
This suggestion for future change projects is about the opportunity that the people who have to live in a nursing home, can be their own boss on how to live and what to do. Especially in the sense of how to decorate a house, how and what to eat, but also for medical interests. When one will pay for nursing, they can hire private nursing. But also extra medical check ups and recovery training. Custom made living can increase satisfaction because people can decide over their selves and can live a life as they want. As far as possible of course. This is in line with our community where individualization and more and more specific demands are recognizable. All in order to fill in people's dreams, living standards and assumptions. By introducing custom made living, these traditions can stay. This can be very important, because an assumption about nursing homes is that when people have to live in it, the value of life will decrease dramatically. And with custom made living this can be rejected. But people have to pay for it and a lot is the picture.

Increased customer orientation (Bisschop, 2008)
Collaboration system between hospitals, nursing homes and general practitioners (Bisschop, 2008, Boersma, 2008)
Staff circulation between hospitals and nursing homes (Hilberts, 2008)
These above suggestions for future change projects have all one important aspect in common, which is an increased level of collaboration between and within hospitals and nursing homes. A collaboration which should lead to an increased health care level for patients, a smoother nursing home care process for those patients and more positive view from the outside to nursing home care. This latter issue should be achieved by in increased customer orientation. This is in strong relation with the suggestion for custom made living. It is all about fulfilling as much of the wishes of the patients as possible. Because also within a nursing home, quality and the satisfaction of life should be high. A lot of patients/elder do not believe this and are afraid to move to nursing home. Hospitals and nursing homes should take a more active role in providing information about nursing home care. About the possibilities, the advantages and the focus on quality of life. That the hospitals and nursing homes pay a lot of attention to it. Patients should have a choice, or the family should make it. This choice should be made on relevant and future oriented information.
This previous part is before a patient will live in a nursing home. The second and third suggestion for change projects is for the care itself. Bisschop (2088) suggested a IT collaboration system that relates hospitals with their medical staff, nursing homes and their medical staff and general practitioners. This is necessary because (elder) patients need more and more multidisciplinary care, which means that more medical specialist treat ((pre) care and after care) one patient. A lot of communication is necessary

and this is a part which can improve a lot. To often there is no rejection, which can lead to failures, longer treatment time and often decreasing health level of patients. With a collaborative system the involved parties can align all the multidisciplinary parts and there is clearness in the documentation. Practical seen, it is sometimes the case that medical specialists are not clear (even because of a bad handwriting) in their communication (often a letter), about the necessary treatment within a nursing home. A system can provide these time consuming issues, because a direct link to specialist can be made. These direct links are also very useful to use when specialist, nursing homes and/or general practitioners need help.

Collaboration system within hospital (elder)care (Vroom, 2008)
Development of department of specialists (Hilberts, 2008)

These suggestions of Vroom and Hilberts are also strongly interrelated to the multidisciplinary focus which more and more (elder) patients need. They argue that coordination and alignment is a necessity to increase the health care level for patients. Because the treatment for patients in bad condition should be made as easy as possible. But also because it is now the fact that a lot of medical specialist are only focused on their domain and do not see (clearly) future other treatment. Specific routes for treatment, along the different medical specialists, should be made in order to shorten treatment as far as possible and to decrease the chance on wrong or contradicting treatment. This latter is sometimes the case because, one particular treatment (from one specialist) can have negative influence on other treatments or even decrease the overall medical status of a patient. To coordinate this process of a patient, the suggestion came to hire an experienced nursing home doctor or medical specialist who is able to connect the lines of the treatment a patient needs. This person can coordinate and develop the routes a patient should follow and protect the patient against the different treatments and their possible negative influences. This person should also take care for communication between the medical specialist within the hospital.

Hilberts (2008) suggested to overcome the difficulty of multidisciplinary, is to form a department elder care which has all the medical specialist in-house. This means that they are working strongly together on one department and as a team they will treat a patient. Hilberts announced that this is an opportunity to increase the care level, because our community is greying. Future medical care should have more and more attention to these elder patients with often the need for multidisciplinary care.

Appendix 2 Eight step model of Kotter

1. Establishing a sense of urgency
2. Forming a Powerful Guiding Coalition
3. Creating a Vision
4. Communicating the Vision
5. Empowering Others to Act on the Vision
6. Planning for and Creating Short-term Wins
7. Consolidating Improvements and Producing still more
8. Change
9. Institutionalizing New Approaches

Appendix 3 Outline for semi-structured interviews

Interview vragen "Intermediate Care" Groningen

1. **Wanneer kan een veranderproject als een succes worden gezien?**
2. **Hoe omschrijft u het veranderproject "intermediate care"? Wanner kan/kon het als een succes worden getypeerd?**
3. **Welke rol speelde u als ziekenhuis of medisch specialist of huisarts of zorgverzekeraar tijdens het ontwikkelen van de "intermediate care" verandering in het zorgtraject (v/d verpleeghuiszorg) tussen ziekenhuizen en verpleeghuizen? En tijdens implementatie?**

- Werd/wordt u betrokken bij overleg voor bedenken van plannen/veranderingen en uiteindelijk invoeren van veranderingen?
- Welke positie was er in overleg?
- Ooefenende u druk uit, gaf u ze zelf richting aan gewenste verandering en op welke manier(en)?

4. **Welke machtspositie heeft/had u als partij? (tabel invullen):**

De factor macht:

Machtsfactor	*Karakteristieken*
1. **beloning**	Geven van beloningen als stimulans om mee/samen te werken.
2. **dwingen**	Kunnen geven van straffen, dreigementen en/of negatieve consequenties als gewenst gedrag/houding niet getoond wordt.
3. **legitimiteit**	Legitiem recht om invloed over anderen uit te voeren. Vooral als stimulans om andere partij te laten gehoorzamen. Laten accepteren wat jij als legitieme partij wil.
4. **expert/kennis**	Controle en sterke positie in onderhandeling hebben door het bezit van specifieke kennis, dus expertrol bezitten.
5. **referente macht**	Je identificeren met soortgelijke groepen/personen om sterke relaties en coalities te vormen. Leidt tot vergrote onderlinge acceptatie.
6. **informational power**	Het bezitten van relevante en valide informatie wat leidt tot of kan leiden (bij inzet ervan) tot cognitieve veranderingen. Vaak in bezit van machtige groepen en/of management groepen.

5. **Wat zijn volgens u andere partijen met een sterke machtspositie en hoe moeten betrokken partijen omgaan met hun machtspositie, als er samengewerkt moet worden? Hoe verliep de samenwerking bij het "intermediate care" project?**

Type leider voor verandering:

6. **Wie of welke partij was de verantwoordelijke/de leider van het veranderproces "intermediate care"? Was er verschil tijdens de fase van ontwikkelen van plannen en tijdens de daadwerkelijke uitvoering van de veranderplannen?**

7. **Wat voor soort type leider was het meest geschikt voor het veranderproces "intermediate care"? (tabel invullen)**

	1	2	Vul 1 of 2 hier in
Maken van de verander- agenda	Planning en financiering: leider maakt een gedetailleerd plan van resultaten die behaald dienen te worden.	Leider geeft een richting voor toekomstperspectief: door een visie te ontwikkelen dat de gewenste toekomstige staat weergeeft. Samen met een strategie om daar te komen. Maar niet totaal gepland.	
Personeel/ Mensen	Organiseren en bemanning: leider bepaalt welk individu het beste bij een taak/baan past en in directe relatie met de geplande verandering.	Leider bindt mensen aan de visie: een belangrijke communicatie uitdaging om het personeel te laten geloven en begrijpen waar de visie voor staat.	
Uitvoering	Controle en probleem-oplossing: leider monitort resultaten, identificeert afwijkingen in vergelijking met het oorspronkelijke plan en lost problemen hiermee op.	Leider heeft de taak om te motiveren en te inspireren: zorgen voor satisfactie van de standaard behoeften van personeel/betrokkenen zodat er gepresteerd, herkenning en erkenning is, het gevoel van eigenwaarde belangrijk is, plus dat er onder het personeel een gevoel van controle is.	
Uitkomsten	De leider moet een goede omgeving van voorspel-baarheid, duidelijkheid en orde creëren.	Leider is vooral bezig en produceert vooral veranderingen met een grote, vaak dramatische impact voor vele betrokkenen.	

8. **Was de juiste leider aanwezig, hoe functioneerde de leider(s)?**

Weerstand:

9. **Waren volgens u verpleeghuizen/ziekenhuizen (management/hoofd verpleeghuiszorg en operationeel personeel) bereidt en klaar om te veranderen? Hoe is de situatie op dit moment?**
10. **Hoe was de werk en persoonlijke relatie tussen het managementniveau en het operationele personeel, vooral in verpleeghuizen? Welke rol heeft deze relatie gespeeld tijdens de ontwikkeling en implementatie van de verandering?**
11. **Voor u als ziekenhuis of medisch specialist of verpleeghuis of huisarts of zorgverzekeraar, waar kwam de (meeste) weerstand vandaan, als er gekeken wordt naar de ontwikkelingsfase van de "intermediate care"?. Hoe uitte de weerstand zich?**

De bronnen van weerstand tijdens ontwikkelingsfase:

1	Aanwezig zijn strikte structuren en systemen die de organisatie, de technologie en de stakeholder's (hulp)bronnen om mee te werken bepalen en beïnvloeden, maar deze structuren en systemen zijn in conflict met de verandering en haar krachten.
2	Afgeschermde, eenzijdige denkrichtingen die het geloof in de organisatie en de strategie bepalen, maar die duidelijk tegen over een veranderplan staan.
3	Verankerde culturen die de normen, waarden, gedrag en vaardigheden vormen, maar die niet overeenkomen of veranderd worden ten aanzien van de krachten van een verandering.
4	Averechts gekozen tijdstip om te veranderen, wat bepaald wordt door historische en/of andere redenen om te veranderen die niet relevant zijn voor de huidige en meest urgente verandering.

12. Voor u als ziekenhuis of medisch specialist of verpleeghuis of huisarts of zorgverzekeraar, waar kwam de (meeste) weerstand vandaan, als er gekeken wordt naar de implementatie van de "intermediate care"? Hoe uitte de weerstand zich?

1	Aanwezig zijn strikte structuren en systemen die de organisatie, de technologie en de stakeholder's (hulp)bronnen om mee te werken bepalen en beïnvloeden, maar deze structuren en systemen zijn in conflict met de verandering en haar krachten.
2	Afgeschermde, eenzijdige denkrichtingen die het geloof in de organisatie en de strategie bepalen, maar die duidelijk tegen over een veranderplan staan.
3	Verankerde culturen die de normen, waarden, gedrag en vaardigheden vormen, maar die niet overeenkomen of veranderd worden ten aanzien van de krachten van een verandering.
4	Averechts gekozen tijdstip om te veranderen, wat bepaald wordt door historische en/of andere redenen om te veranderen die niet relevant zijn voor de huidige en meest urgente verandering.

13. Op welke manier(en) is er omgegaan met de weerstand? (tijdens de ontwikkelingsfase en implementatiefase).Kan en moet het anders in de toekomst?

Toekomst:

14. Wat zijn volgens u mogelijke veranderingen die het zorgtraject tussen ziekenhuizen en verpleeghuizen kan verbeteren en/of efficiënter kan maken?

Interview vragen "Schakelafdeling" Drachten

1. **Wanneer kan volgens u een veranderproject als een succes worden gezien? Wanneer was de schakelafdeling een succes?**
2. **Welke rol speelde u/speelt u als verpleeghuis/verpleeghuisarts/medisch specialist/regio manager/zorgverzekeraar tijdens het ontwikkelen van de schakelafdeling in het ziekenhuis/veranderprojecten? (zie de subvragen hieronder)**

- Werd/wordt u betrokken bij overleg voor bedenken van plannen/veranderingen en uiteindelijk invoeren van veranderingen?
- Oefenende u druk uit, gaf u ze zelf richting aan gewenste verandering en op welke manier(en)?

3. **Welke machtspositie heeft/had u als partij om belanghebbende personen/partijen mee te krijgen met veranderingen? (svp tabel invullen, kruis zetten indien van toepassing):**

De factor macht:

Machtsfactor	*Karakteristieken*
1. **beloning**	Geven van beloningen als stimulans om mee/samen te werken.
2. **dwingen**	Kunnen geven van straffen, dreigementen en/of negatieve consequenties als gewenst gedrag/houding niet getoond wordt.
3. **legitimiteit**	Legitiem recht om invloed over anderen uit te voeren. Vooral als stimulans om andere partij te laten gehoorzamen. Laten accepteren wat jij als legitieme partij wil.
4. **expert/kennis**	Controle en sterke positie in onderhandeling hebben door het bezit van specifieke kennis, dus expertrol bezitten.
5. **referente macht**	Je identificeren met soortgelijke groepen/personen om sterke relaties en coalities te vormen. Leidt tot vergrote onderlinge acceptatie.
6. **informatie**	Het bezitten van relevante en valide informatie wat leidt tot of kan leiden (bij inzet ervan) tot cognitieve veranderingen. Vaak in bezit van machtige groepen en/of management groepen.

4. **Wat zijn volgens u andere partijen (in het zorgtraject van ziekenhuis en verpleeghuis) met een sterke machtspositie?**
5. **Kunt u aangeven of en hoe huisartsen betrokken worden bij het ontwikkelen van veranderingsplannen?**
6. **Hoe moeten betrokken partijen omgaan met hun machtspositie? (omdat er bijvoorbeeld samengewerkt moet worden en er doelen vanuit de zorg zijn)**

Type leider voor verandering:

7. **Wie of welke partij was de verantwoordelijke/de leider van het veranderproces van de schakelafdeling? Was dit een juiste situatie voor succes?**

8. Wat voor soort type leider was het meest geschikt voor het veranderproces van de schakelafdeling of is het meest geschikt voor veranderingen? (svp tabel invullen, combinatie van leider 1 en 2 kan ook)

	1	**2**	**Vul 1 of 2 of beide in**
Maken van de verander-agenda	Planning en financiering: leider maakt een gedetailleerd plan van resultaten die behaald dienen te worden.	Leider geeft een richting voor toekomstperspectief: door een visie te ontwikkelen dat de gewenste toekomstige staat weergeeft. Samen met een strategie om daar te komen. Maar niet totaal gepland.	
Personeel/ Mensen	Organiseren en bemanning: leider bepaalt welk individu het beste bij een taak/baan past en in directe relatie met de geplande verandering.	Leider bindt mensen aan de visie: een belangrijke communicatie uitdaging om het personeel te laten geloven en begrijpen waar de visie voor staat.	
Uitvoering	Controle en probleem-oplossing: leider monitort resultaten, identificeert afwijkingen in vergelijking met het oorspronkelijke plan en lost problemen hiermee op.	Leider heeft de taak om te motiveren en te inspireren: zorgen voor satisfactie van de standaard behoeften van personeel/betrokkenen zodat er gepresteerd, herkenning en erkenning is, het gevoel van eigenwaarde belangrijk is, plus dat er onder het personeel een gevoel van controle is.	
Uitkomsten	De leider moet een goede omgeving van voorspel-baarheid, duidelijkheid en orde creëren.	Leider is vooral bezig en produceert vooral veranderingen met een grote, vaak dramatische impact voor vele betrokkenen.	

9. Was de juiste leider aanwezig, hoe functioneerde de leider(s)?

Weerstand

10. Waren volgens u verpleeghuizen/ziekenhuizen (management/hoofd verpleeghuiszorg en operationeel personeel) bereidt en klaar om te veranderen? Hoe is de situatie op dit moment?

11. Hoe was de werk en persoonlijke relatie tussen het managementniveau en het operationele personeel, vooral in verpleeghuizen en in ziekenhuizen?

12. Voor u als regio manager, vanuit welke belanghebbende(n) kwam/komt de (meeste) weerstand vandaan, als er gekeken wordt naar de ontwikkelingsfase van de schakelafdeling c.q. veranderprojecten?

13. Hoe uitte de weerstand zich? (bijv. door klachten, slechte werkprestaties, gemopper)

14. De bronnen van weerstand tijdens ontwikkelingsfase (svp tabel invullen, kruis zetten indien van toepassing). Weerstand ontstond door…….

1	Bestaande structuren, systemen en procedures die in conflict waren met de verandering en haar krachten.
2	Eenzijdige denkrichtingen van betrokkenen die duidelijk tegen over het veranderplan stonden.
3	Verankerde culturen die de normen, waarden, gedrag en vaardigheden vormen, maar die niet overeenkomen of met de nieuwe veranderde situatie?
4	Een verkeerd gekozen tijdstip om te veranderen, wat bepaald wordt door historische en/of andere redenen om te veranderen die niet relevant zijn voor de huidige en meest urgente verandering. (bijv dat er geen geld is maar er toch veranderd wordt)

15. Waar kwam/komt de (meeste) weerstand vandaan, als er gekeken wordt naar de implementatie van de schakelafdeling c.q. veranderprojecten?

16. Hoe uitte de weerstand zich? (bijv. door klachten, slechte werkprestaties, gemopper)

17. De bronnen van weerstand tijdens implementatiefase (svp tabel invullen, kruis zetten indien van toepassing). Weerstand ontstond door…….

1	Bestaande structuren, systemen en procedures die in conflict waren met de verandering en haar krachten.
2	Eenzijdige denkrichtingen van betrokkenen die duidelijk tegen over het veranderplan stonden.
3	Verankerde culturen die de normen, waarden, gedrag en vaardigheden vormen, maar die niet overeenkomen of met de nieuwe veranderde situatie?
4	Een verkeerd gekozen tijdstip om te veranderen, wat bepaald wordt door historische en/of andere redenen om te veranderen die niet relevant zijn voor de huidige en meest urgente verandering. (bijv dat er geen geld is maar er toch veranderd wordt)

18. Op welke manier(en) is er omgegaan met de weerstand? (tijdens de ontwikkelingsfase en implementatiefase). Was dit de juiste manier?

19. Heeft u specifieke aandachtspunten waar veranderaars aan moeten denken die noodzakelijk zijn om tot een succesvolle verandering te komen?

Appendix 4 List of interviewees

Nr.	Interviewee	Job	Project	Date
1.	**D. Croon**	General Practitioner	Intermediate Care	**18-06-2008**
2.	**E. Berghuis**	General practitioner/Chairman of DHV (district union)	Intermediate Care	**18-06-2008**
3.	**A. Bisschop**	Head of Nursing Home/ Nursing home doctor	Intermediate Care	**25-06-2008**
4.	**H. Hegge**	Medical specialist UMCG	Intermediate Care	**27-06-2008**
5.	**F. Boersma**	Head of Nursing home care department UMCG	Intermediate Care	**30-06-2008**
6.	**M. Tieleman**	Care Insurer Menzis	Intermediate Care	**28-07-2008**
7.	**V. Vroom**	Head Nursing home care Zuidoostzorg Drachten/doctor/Management team member nursing home Bertilla Drachten	Link Division	**08-07-2008**
8.	**H.J. Mollema**	Region manager (Drachten) Zuidoostzorg/Management team member nursing home Bertilla Drachten in the past	Link Division	**17-07-2008**
9.	**E. Kamphorst**	Medical specialist at the Link Division at the hospital in Drachten	Link Division	**23-07-2008**