



H-PASS

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Training Monitoring Report



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Table of abbreviations

Acronym	Description
GA	Grant Agreement
SC	Steering Committee
HWF	Health Workforce
HRH	Human Resources for Health
MS	Member States
TtT	Train the Trainers
DCA	Digital Change Agent
CME	Continuing Medical Education

Applicable and reference documents

The following documents contain requirements applicable to the generation of this document.

Reference	Document title
GA	Grant Agreement
CA	Consortium Agreement

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1. Executive summary

This report presents the main findings of the monitoring, assessment, and evaluation activities conducted during the pilot implementation of the H-PASS (Health Professionals' and the "DigitAl team" Skills advancement) project. The project aims to strengthen the skills, resilience, and digital readiness of the health workforce (HWF) in response to the evolving demands of digitally enabled healthcare systems.

The analysis is based on data collected across six pilot countries (Cyprus, Greece, Hungary, Italy, Lithuania, and Romania), combining output indicators, participant feedback, and pre- and post-training assessments in line with a common evaluation framework based on the Kirkpatrick model. The report provides an overview of key results, identifies trends in learning outcomes and participant experience, and highlights considerations relevant for future programme development and large-scale implementation.

You can find the H-PASS dashboard with key project indicators and results under the below link and QR code.

H-PASS dashboard: <https://hpass.healthworkforce.eu/training-monitoring-report-executive-summary/>



For easy overview we are presenting the key project indicators below in table format too:

H-PASS output indicators

Indicator	Target value/Result
Number of health professionals completed training in digital skills (including TtT sessions and pilot trainings):	450/814
Number of health professionals completed training in digital skills (H-PASS without TtT):	350/603
Number of persons completed TtT sessions:	100/211
▪ number of health professional completed the Train-the-Trainer training for H-PASS trainers:	54
▪ number of H-PASS alumni completed in the Digital Change Agent training:	157
Number of health professionals receiving ECTS, CME credits or microcredentials for H-PASS training (100% CME credits, 0% microcredentials, 0% ECTS):	400/ 541

Breakdown by country	Number of health professionals completed training in digital skills (Target value/Result)
Cyprus	75/48 (*couldn't be fulfilled due to the demographic characteristics of the piloting country)
Greece	75/119
Hungary	75/127
Italy	75/142
Lithuania	75/83
Romania	75/84

Breakdown by professions	Number of health professionals completed training in digital skills (Target value/Result)
Medical doctors	135/111 (*couldn't be fulfilled due to the target-group-reach of the piloting partners, as well as work characteristics and training preferences of the target group)
Nurses	135/240
Pharmacists	80/88
Allied health professionals	158
Other	6

Breakdown by age groups	Number of health professionals completed training in digital skills
18–24	41
25–34	131
35–44	133
45–54	193
55–64	82
65 or older	14
No data	9

Breakdown by gender	Number of health professionals completed training in digital skills
Female:	498
Male:	105

Breakdown by thematic components	Number of persons who completed training on specific themes (themes defined in training plan)
C1: Digital technologies in healthcare:	603
C2: Leading digital change:	603
C3: Communication:	603
C4: Teams:	603
C5: Conflict:	603
C6: Culture:	603
C7: Health care-system awareness:	418
C8: Developing healthcare solutions:	418
C9: Managing healthcare developments:	418
C10: Data in the Healthcare system:	455
C11: Safety:	455
C12: Working with Data:	455

H-PASS training outcome indicators

Indicator	Target value/Result
Improvement in digital skills among training participants (based on pre and post-training surveys)	75%/ post: 99,1%
Improvement in transversal skills among training participants (based on pre and post-training surveys)	75%/ post: 99,6%
Improved capabilities for teamwork for teamwork in digital setting (based on post-training surveys)	75%/ post: 99,3%

Increased use of digital tools in clinical work (based on post-training survey)	75%/ 82,9%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/ 79,2%
Utilisation of acquired digital and transversal skills in practice (based on post-training survey) - At least 50% of training participants report change in teamwork patterns, better organised workflows and workload among health professionals or improved task-shifting after the training.	50%/ 80,68%

TtT training (DCA) outcome indicators

Indicator	Target value/Result
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/ 88%
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/ 88%
Utilisation of acquired digital and transversal skills in practice (based on post-training survey) - Improved capabilities for leadership in digital settings among participants of train-the-trainer courses	50%/ 92,06%

Training impact

Indicator	Result
Overall satisfaction rate of the H-PASS training (evaluated with 4 or 5 on a five-point scale)	92,9%
Overall satisfaction rate of the H-PASS training (evaluated with 5 on a five-point scale)	56,4%
Overall satisfaction rate of the DCA training (evaluated with 4 or 5 on a five-point scale)	88,2%
Overall satisfaction rate of the DCA training (evaluated with 5 on a five-point scale)	56,7%
Average increase of digital and transversal skills and attitudes targeted in the H-PASS training (based on pre-post self-evaluation)	8,16%

Average increase of digital and transversal skills and attitudes targeted in the H-PASS training (excluding non-change and decreasing results) (based on pre-post self-evaluation)	15.8%
Proportion of H-PASS participants reporting change in teamwork patterns, better organised workflows and workload among health professionals or improved task-shifting after the training. (*outcome indicator)	80,7%
Proportion of DCA completers who took specific actions in their professional or work environment to enable digital innovation or to improve teamwork and collaboration	58,7%

2. Introduction

2.1. Project description

Health workforce (HWF) education is a key component in human resources for health (HRH) management and development to keep health professionals' knowledge, competences and skills fit to practice. The digital transformation resulted in new ways of care provision, modified care pathways and scopes of practice and altered professional-client or team relationships by the growing use of digital solutions. This acceleration of technology brings an inevitable opportunity to improve healthcare team competences, skill-mix, task shifting, upgrade qualifications and upscale HWF skills.

Responding to the “Call for proposals to provide training for health workforce, including digital skills” of the EU4Health Programme, the "Health Professionals' and the “DigitAl team” Skills advancement" (H-PASS) project aims to support EU Member States (MS) in developing digital and transversal skills for health professionals to support team resilience and to adapt to the challenges of digital transformation.

The aim and scope of the H-PASS project

The main objective of H-PASS is to design and pilot a training programme with thoroughly developed modules and appropriate synchronous and asynchronous activities, training materials and tools concerning transversal skills that ensure up-to-date and evolving knowledge and respond to skills gaps. H-PASS particularly develops digital skills of the clinical staff in an innovative environment. By targeting various health professions: medical doctors, nurses, and pharmacists as well as training the trainers for more effective change management and educating digital change agents, more advanced digital maturity, literacy, readiness and integration in healthcare can be realised. H-PASS performed pilot implementations in Cyprus, Greece, Hungary, Italy, Lithuania and Romania. Pilots tested and validated the new training programme and the innovative learning environment, and incorporated lessons from 6 EU MS. H-PASS dedicated a significant attention to stakeholder involvement and engagement at various levels (e.g. national, regional and EU), intends to monitor the synergies with other EU initiatives, and to enable maximising the uptake, impact and continuation of the H-PASS training in the EU.

The project includes two types of train-the-trainers (TtT) courses; in particular, training the central trainer pool of H-PASS (Train the trainer session I.) and Train the trainer courses for health professionals at country level (Train the trainer session II.), that we called the Digital Change Agent training (DCA). TtT1 of the H-PASS programme trained a central pool of trainers, with each consortium partner preparing 2–3 trainers to deliver the pilot training in six Member States. This session focused on both training content and educational methods, while also enabling trainers to test materials and develop a shared understanding of the programme; we ran a prototype version of the training to deliver this task with the participation of future trainers. TtT2 expanded the H-PASS training courses' impact by training Digital Change Agents among healthcare professionals, H-PASS alumni, emphasising leadership, change management, and networking to support the uptake and sustainability of H-PASS modules across the six pilot countries.

2.2. Aims of the Training Monitoring Report

This document serves three main objectives. First, it provides an overview of the characteristics of health professionals participating in the H-PASS training programmes, with a focus on the project's key indicators. Second, it presents a detailed summary and analysis of the training evaluation data collected during the H-PASS pilot phase, with the same project-indicator-focus in mind. Third, it includes the necessary contextual information to support the interpretation of the findings, including a description of the assessment and evaluation framework, as well as the data collection methods and analytical approach applied.

2.3. Data sources and collection for output and outcome indicators

Project indicators and monitoring

Within the project we monitored output indicators, whereas, we have collected the number of training participants completing the training by piloting country, by profession connected to the project's target groups, by age group and by gender. We have created an indicator table template that includes these information along with completion/drop-out information, we also registered H-PASS certification and CME credit information here. The templates were shared with the partners through cloud service that they could continuously update in their own country folders, making both the completion and the tracking of these administrative documents easy to follow-up at different stages of the piloting process.

Data from these separate data templates were gathered and closed for analysis for the purposes of this monitoring report on 25.03.2026. The Cypriot and Greek pilots were still ongoing at this point, accordingly final data can be included only in the Final Report of the project.

Assessment and evaluation framework

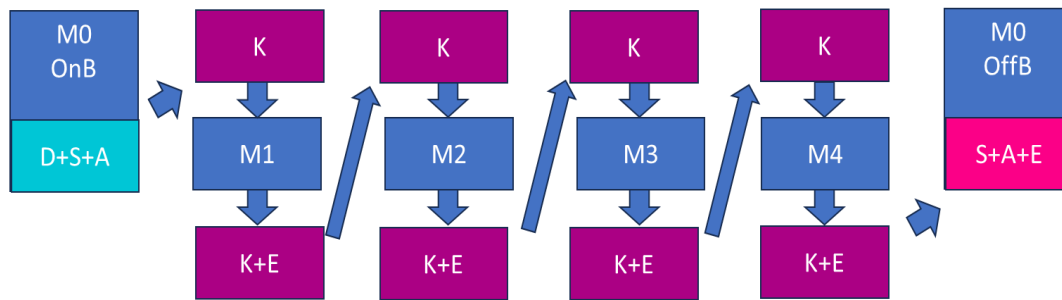
The assessment and evaluation concept was designed based on Kirkpatrick's four-level model. Level 1: Reaction – measures how participants react to the training (e.g. satisfaction); Level 2:

Learning – analyses how well participants truly understood the training (e.g. increase in knowledge, skills or experience); Level 3: Behaviour – assesses whether participants are using what they learnt at work (e.g. change in behaviour); Level 4: Results – determines if the training had a positive impact on the business/ organisation.

Reaction and learning can be measured parallel with the training, while evaluation of behaviour change and application requires a follow-up period. With regard to the concept of H-PASS programme, evaluation at organisational or system level cannot be linked to the programme. The overall objective of training evaluation is to provide trainers and content developers information to assess the quality of their performance and to provide further guidance for improvements. Evaluation of H-PASS training courses are planned in four phases:

1. Pre-course activities: Sociodemographic questionnaire to be filled in before starting the training. Participants also complete a self-assessment questionnaire in order to map the pre-course competence-level.
2. Evaluation linked to training components: Participant feedback questionnaires to be circulated after finalising each training module. Questions dedicated to participant experience, perceived utilisation of knowledge, education methods and trainer performance will collect information.
3. Post-course evaluation: Post-course evaluation includes an overall feedback questionnaire enabling to provide qualitative answers on the highlights and the shortcomings of the training. Post-course competence assessment (with the same questions taken pre-course) can provide information about learning that took place in the training period.
4. Follow-up: Participants will be contacted via email 1-3 months after the training and will be requested to provide a brief, written summary on how they can use the acquired skills at the workplace. This common evaluation scheme to be applied for every delivering institution and professional group in the programme, allowing slight differences according to local specificities. As digital maturity and target group needs might be different, evaluation does not aim to compare training courses in different countries.

Through collaboration of all partners a core assessment and evaluation framework (Figure 1.) and guidance was developed. This framework builds on predefined learning outcomes, as well as on the project indicators. Demographic data, skill and attitude pre- and post-training assessment, as well as the module and training evaluation elements, were centrally designed and mandatory by the partners to follow. Partners could, however, organize the knowledge assessment of their training as per their own judgement, in line with their local accreditation requirements, while making sure that they assess the knowledge materials they delivered locally (taking changes in the training into consideration).



OnB / OffB: On- and Offboarding

D: Demography questionnaire

K: Knowledge testing

S: Skill self-evaluation

A: Attitude self-evaluation

E: Module/Training evaluation

Figure 1. General structure of the training evaluation and assessment during the pilot phase

The general training concept (modules and components) based on the pre-defined learning outcomes had to be translated of course into assessment and evaluation considerations (Figure 2.) and adapted on the local level. Due to adapted local lexical materials or not implemented Modules, different requirements of knowledge-assessment, local assessment and evaluation was slightly different in all countries.

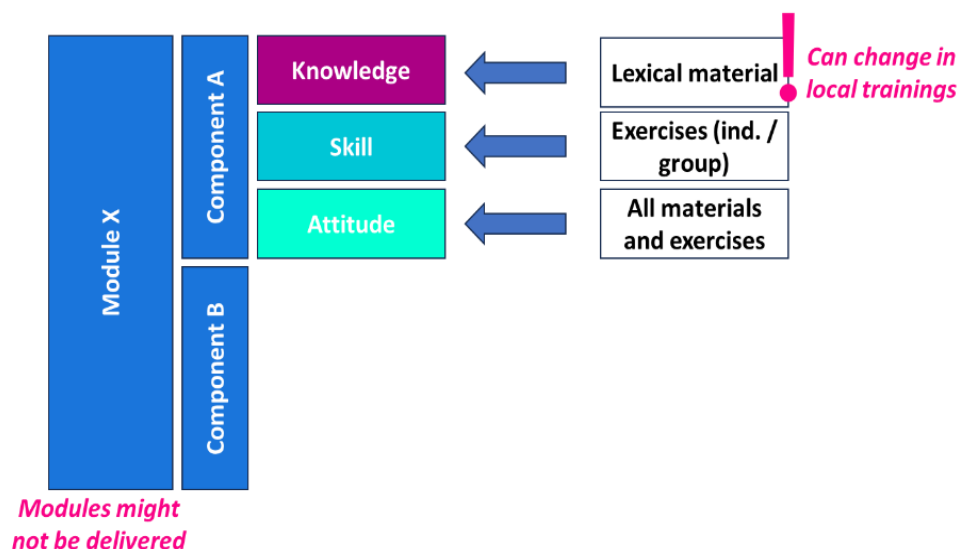


Figure 2. Assessment and evaluation considerations during adaptation on the local level

The assessment and evaluation concept included a follow-up phase as well. Participants of the primary H-PASS training courses, as well as those who also enrolled in the Digital Change Agent training, were also contacted via an additional survey 1-3 months after the training, to assess how they can use the acquired skills at the workplace in line with Kirkpatrick model's level 4 assessment concept.

This common evaluation scheme was applied for every delivering institution and professional group in the programme, allowing for slight differences according to local specificities. As digital maturity and target group needs might be different, evaluation does not aim to compare training courses in different countries.

Surveys and data

Accordingly, pre- and post-training surveys and module evaluation surveys were centrally co-created with the piloting partners, and pre-post assessment questions were suggested and tested for assessing knowledge improvements; however, decisions about the specific knowledge assessment questions were delegated to the piloting partners. These surveys (Annex 1.) were shared for translation and guidance for adaptation was provided (Annex 3.). Guidance stated that the original structure and content of the surveys can't be changed, only extended by locally relevant questions.

Data was collected in centrally tracked Google Surveys and could be transferred into a common data template (Annex 4.), building the base of a common H-PASS database. A guidance for data preparation (Annex 5.) was also provided for the partners.

Connected documents:

- Welcome survey
- Module 1-4 evaluation surveys
- Closing survey
- Follow-up survey for the H-PASS training
- DCA Pre- and Post-Training Survey
- Follow-up survey for the DCA training
- Assessment and evaluation guide
- H-PASS evaluation master template
- Data preparation guide

The surveys were filled out by more participants than those who in the end completed the course, as they were shared with all who entered the training courses, except for the follow-up surveys that were shared only with those who earned the H-PASS certificate.

2.4. Data analysis

Data analysis happened with the help of IBM SPSS Statistics and diagrams and figures were created with MS Excel based on the SPSS data. The data was analysed both on the whole consortium-level and on country-level as well.

The collection of consortium-level survey data was closed on 13 March 2026. This dataset served as the basis for the analysis of output and outcome indicators, as well as for the preparation of the present consortium-level report and the country reports for Italy, Hungary, Lithuania, and Romania.

As pilot trainings in Cyprus and Greece continued until the end of the project period, local-level data collection for these countries was extended and closed on 25 March 2026 for the purposes of their respective country reports. Output indicator data at consortium level were subsequently updated based on the dataset provided on 25 March 2026.

Follow-up surveys for both the H-PASS pilot courses and the Digital Change Agent (DCA) training were conducted on a separate timeline, with data collection closed on 10 March 2026.

During the consortium-level analysis of the assessment and evaluation data, several differences in data collection approaches and technical conditions across pilot sites were identified. These variations are primarily related to local implementation contexts, technical features of e-learning platforms, or minor methodological adaptations. While they introduce certain analytical limitations, they do not affect the overall validity of the evaluation. Where possible, adjustments were made during the data processing phase in order to harmonise the datasets and ensure comparability (see country-level differences in Annex 2.).

The data collection process across multiple pilot sites demonstrates the practical complexity of coordinating large-scale evaluation activities in international training programmes. Even with the support of guidance documents and consultation mechanisms, minor variations in implementation, technical platforms, or local administrative requirements may lead to differences in data structure or completeness.

These differences do not compromise the overall validity of the evaluation but require careful harmonisation during the analysis phase. Addressing such inconsistencies is a standard component of consortium-level data analysis and helps ensure that the most accurate and reliable interpretation of the results can be achieved.

3. Training Statistics - Consortium-level

The consortium-level overview of the course builds on all the surveys of the H-PASS assessment and evaluation framework, along with the data of the official indicator tables. Its purpose is to report about the characteristics and impacts of the pilots delivered within the project's timeframe.

3.1. Demographics of the H-PASS training courses

The age distribution of participants (Figure 3.) in the H-PASS Project training programme shows that the majority of respondents belonged to mid-career professional groups. The largest proportion of participants was observed in the 45–54 age group (32%), indicating strong engagement of experienced healthcare professionals in the programme. Two additional age groups—25–34 years and 35–44 years—each accounted for 22% of respondents, together representing nearly half of all participants and suggesting that early- and mid-career professionals were also substantially represented. Participants aged 55–64 years comprised 16% of the sample, demonstrating continued interest in professional development among senior healthcare staff approaching later stages of their careers. Younger professionals were less represented, with only 6% of participants belonging to the 18–24 age group, which reflects the programme's primary target audience of established health professionals rather than students or entry-level staff. The 65+ category represented 2% of respondents, indicating only minimal participation from professionals beyond the typical retirement age. Overall, the age distribution suggests that the H-PASS pilot trainings predominantly reached mid-career healthcare professionals, which aligns with the project's aim of strengthening digital and transversal skills among active members of the health workforce who are directly involved in healthcare delivery and organisational change.

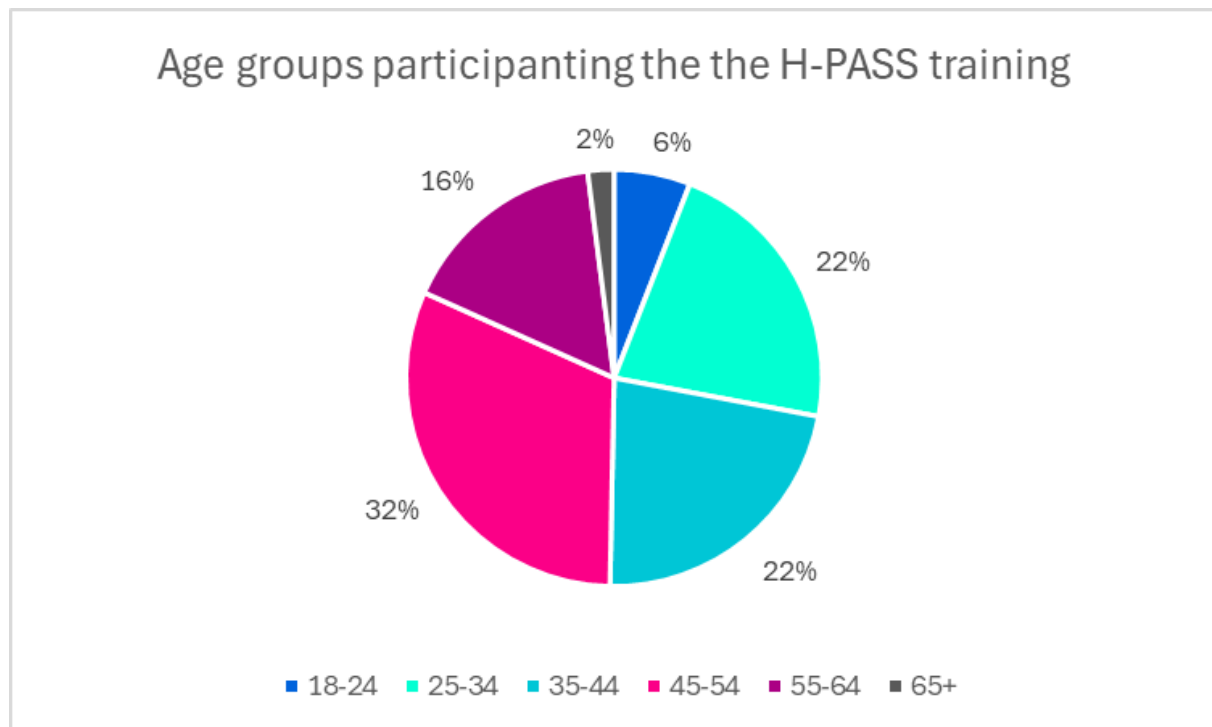


Figure 3. Age groups participating in the H-PASS training (n = 640)

The gender distribution of participants (Figure 4.) in the H-PASS Project pilot training shows a strong predominance of female respondents. According to the collected data, 79% of participants identified as female, while 21% identified as male, indicating a markedly uneven gender distribution among participants. This pattern reflects the broader demographic structure of the healthcare workforce in many European countries, where several key professions targeted by the programme—particularly nursing and pharmacy—are traditionally female-dominated. The high proportion of female participants therefore suggests that the training programme successfully reached core segments of the existing health workforce. At the same time, the participation of male professionals, although considerably lower, demonstrates that the programme also engaged healthcare workers across gender groups. From an evaluation perspective, the gender composition of the sample should be considered when interpreting training outcomes and self-assessment results, as professional roles and gender distribution may be interconnected in healthcare settings. Overall, the observed gender distribution aligns with expected workforce patterns and indicates that the H-PASS Project pilot trainings primarily attracted participants from professional groups where female representation is historically high, as we will see in Figure 4.

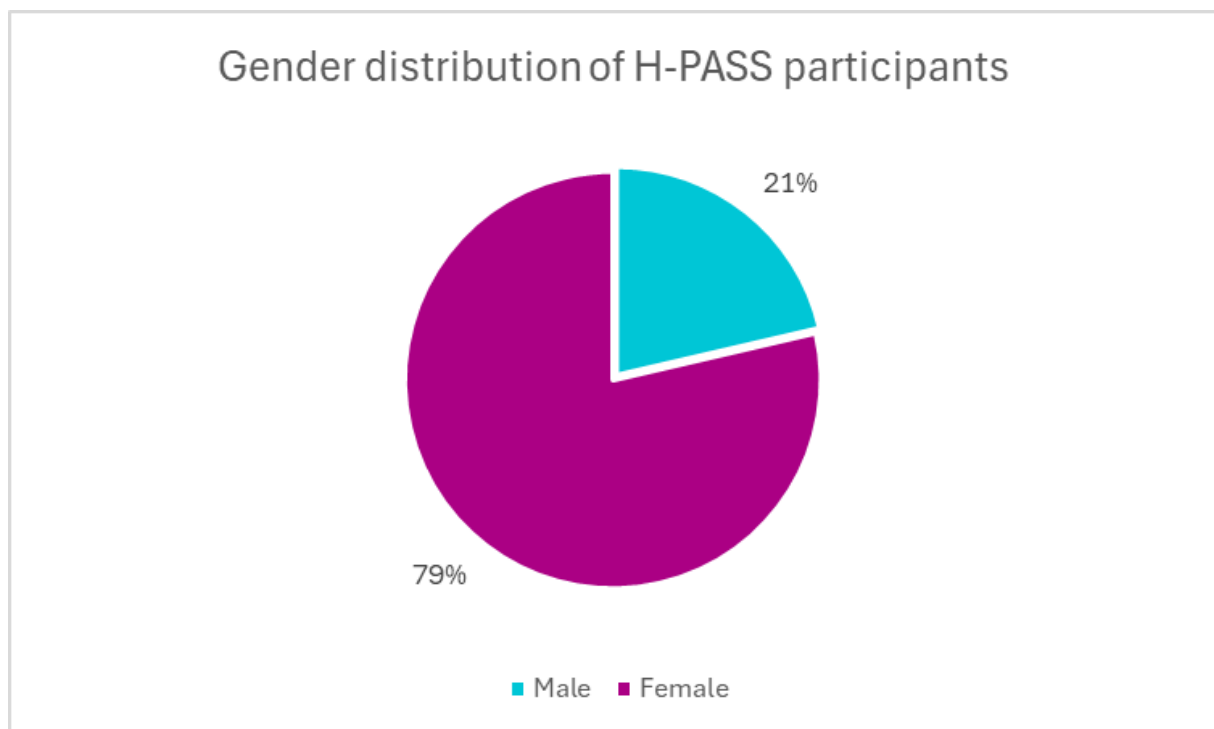


Figure 4. Gender distribution of H-PASS participants (n = 641)

The educational background of participants (Figure 5.) in the H-PASS Project training programme demonstrates a highly qualified participant group, reflecting the professional requirements of healthcare occupations. The largest share of respondents, 45%, reported holding a Bachelor's degree, making it the most common level of education among participants. A substantial proportion, 38%, indicated having a Master's degree, highlighting the advanced academic preparation typical of many healthcare professionals involved in the programme. In addition, 10% of respondents possessed a Doctorate or PhD, suggesting

participation from highly specialised professionals and academic staff. Smaller proportions of participants reported High School or equivalent education (6%) or Vocational Education and Training (VET) (1%), indicating that the programme also reached some participants with more practice-oriented educational backgrounds. Overall, the distribution confirms that the majority of participants held tertiary-level qualifications, which is consistent with the educational pathways of professions such as physicians, pharmacists, and many nursing roles targeted by the training. From an evaluation perspective, the high educational attainment of the sample may also influence participants' baseline digital literacy and learning outcomes, which should be considered when interpreting the results of the training assessments.

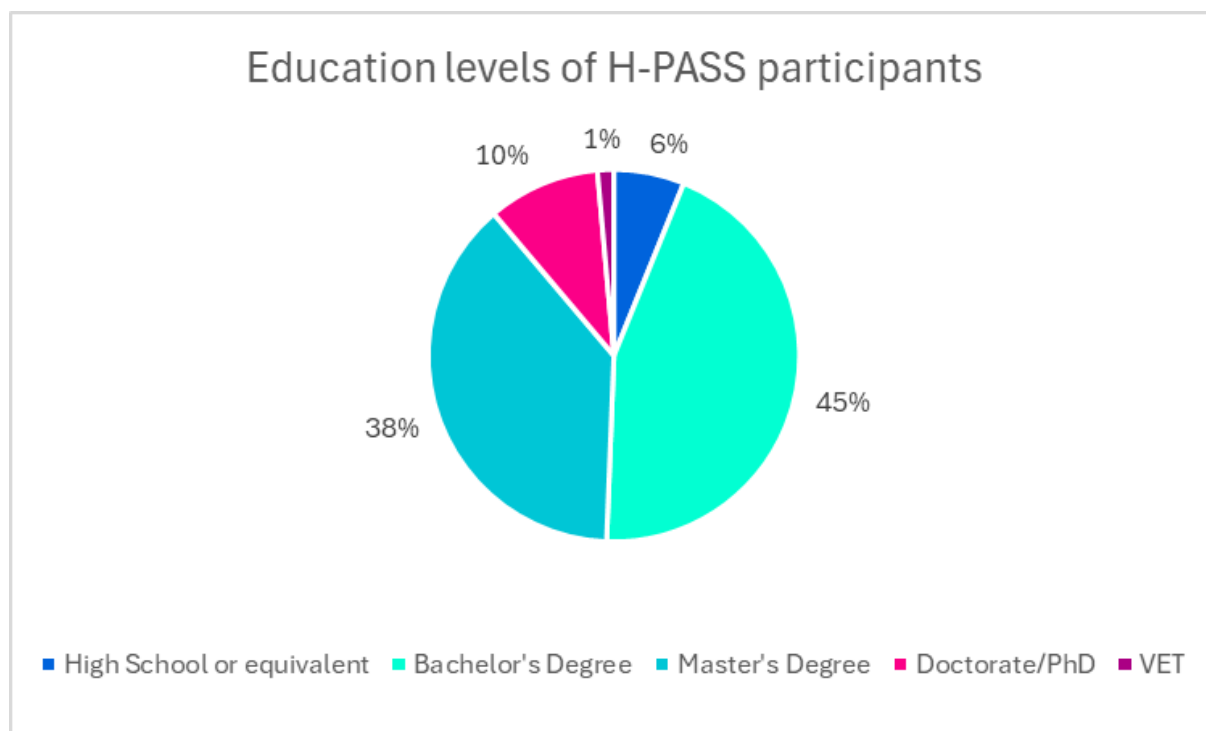


Figure 5. Education levels of H-PASS participants (n = 634)

The distribution of professional roles among participants (Figure 6.) in the H-PASS Project pilot trainings highlights the multidisciplinary composition of the target group and complements the demographic patterns observed in the previous figures. The largest group of respondents consisted of nurses, representing 39% of participants, indicating particularly strong engagement from this professional category, while also reflecting the fact that nurses constitute the numerically largest healthcare professional group in Europe. This finding is consistent with the gender distribution presented earlier, where a large majority of respondents were female, reflecting the traditionally high representation of women in the nursing profession. Physicians accounted for 18% of the sample, demonstrating that medical doctors also demonstrated considerable interest in the programme, though to a lesser extent compared with nursing staff. Pharmacists represented 15% of respondents, confirming that the training successfully reached another key professional group involved in medication management and increasingly in digital health services. Smaller but still relevant proportions of participants were technicians (5%), administrative staff (5%), and allied health professionals

(5%), indicating that the programme also engaged individuals supporting clinical and organisational processes within healthcare institutions. Additionally, 13% of respondents selected “Other” professional roles, suggesting participation from a diverse range of additional health-related professions that were not explicitly listed among the predefined categories. Taken together, these findings confirm that the H-PASS pilot trainings attracted a broad and interdisciplinary audience, aligning with the project’s objective of strengthening digital and transversal skills across entire healthcare teams rather than within a single profession.

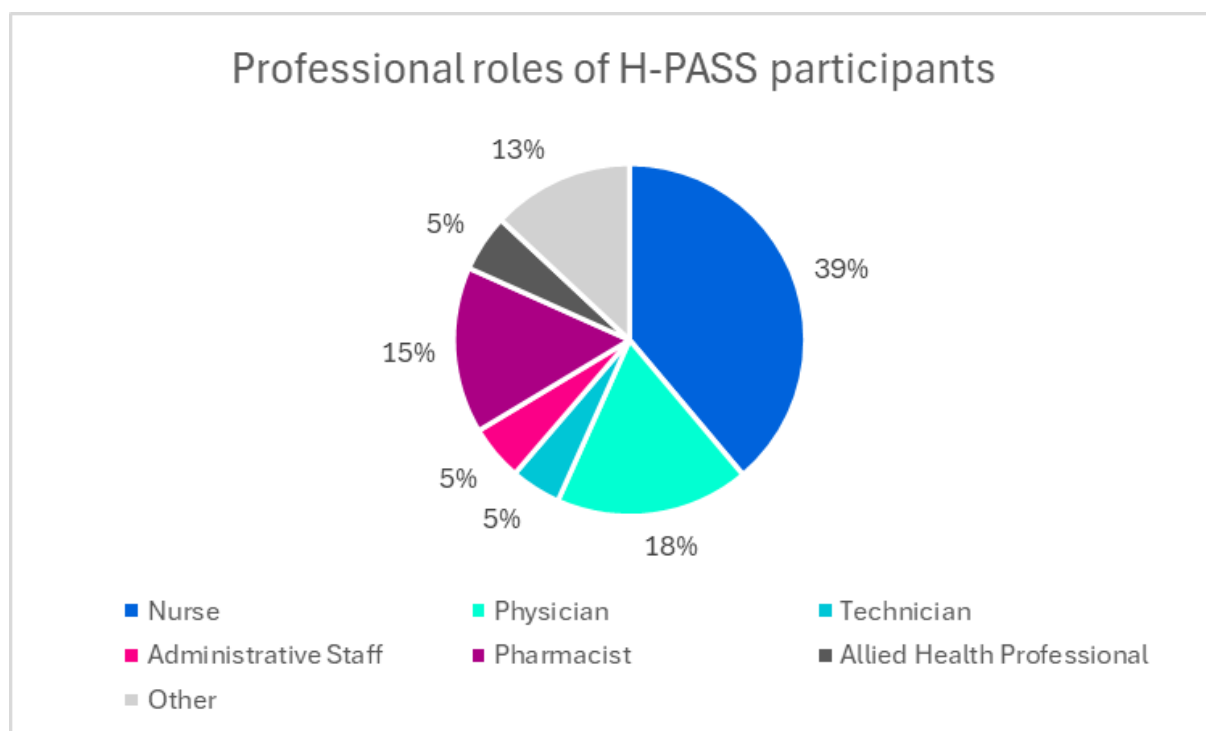


Figure 6. Professional roles of H-PASS participants (n = 628)

The distribution of professional work experience among participants (Figure 7.) in the H-PASS Project pilot trainings further illustrates that the programme predominantly reached experienced healthcare professionals. The largest proportion of respondents, 41%, reported having more than 20 years of professional experience, indicating a strong presence of highly experienced members of the healthcare workforce. A further 27% of participants reported 11–20 years of experience, suggesting that a significant share of respondents were well-established professionals in mid to late stages of their careers. Together, these two groups represent more than two-thirds of the sample, confirming that the training primarily attracted participants with substantial professional backgrounds. Participants with 1–5 years of experience accounted for 19%, while 9% reported 6–10 years of experience, demonstrating that early-career professionals were also represented, although to a lesser extent. Only 4% of respondents indicated less than one year of work experience, reflecting the fact that the programme was mainly targeted at active healthcare professionals rather than newly entering

staff. These findings are consistent with the age distribution presented earlier, where the largest groups of participants were in mid-career age categories and with the higher levels of tertiary education.

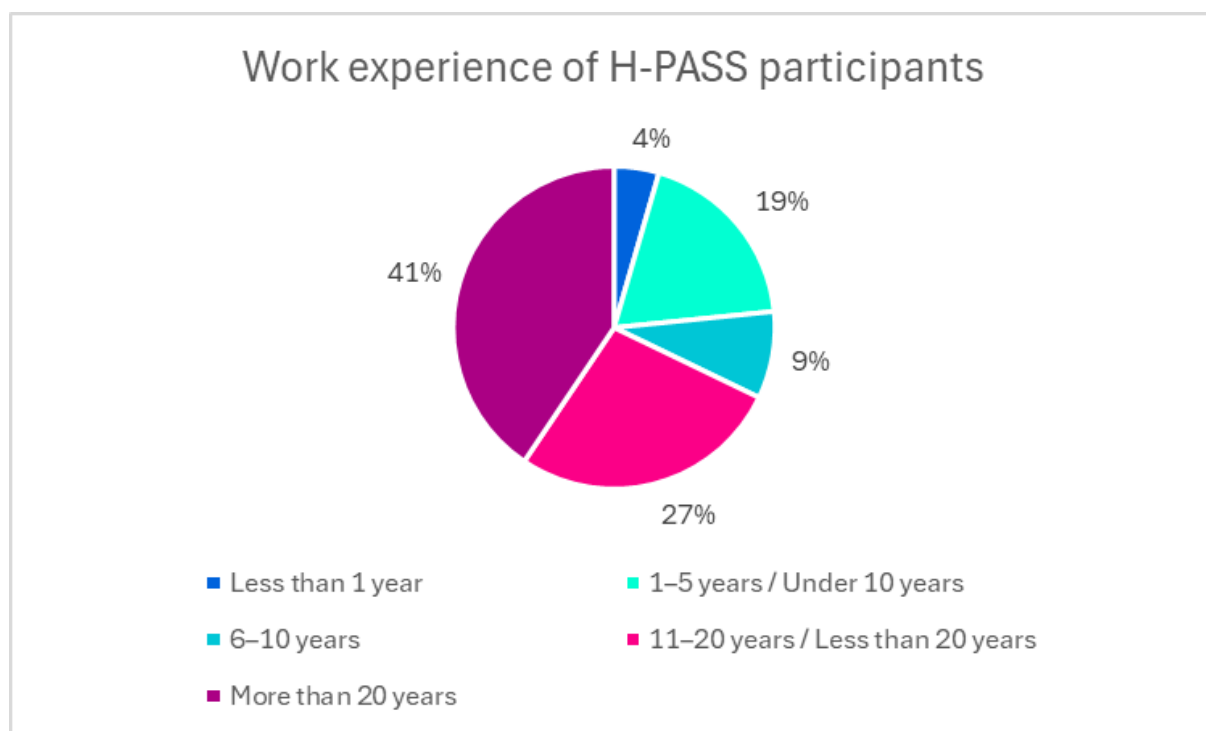


Figure 7. Work experience of H-PASS participants (n = 641)

The distribution of participants by workplace facility type (Figure 8.) indicates that the H-PASS Project pilot trainings primarily engaged professionals employed in the public healthcare sector. The large majority of respondents, 79%, reported working in public institutions, while 16% were employed in private healthcare facilities and 5% selected other types of organisations (these data are provided in the relevant country-level analysis section; however, on aggregate, the number of other categories was insignificant by proportion). This strong representation of public-sector professionals is consistent with the organisational structure of healthcare systems in the piloting European countries, where a significant share of healthcare services and workforce are employed within publicly funded institutions. From a programme perspective, the strong engagement of public-sector healthcare professionals may be particularly relevant, as digital transformation initiatives in healthcare are often implemented at the institutional or system level within publicly managed health services. At the same time, the participation of professionals from private institutions and other organisational contexts indicates that the training programme also reached a broader segment of the healthcare ecosystem.

It is important, however, to note that there are some limitations to the analysis of this variable. The distinction between “public” and “private” institutional contexts varies significantly across participating countries and healthcare systems, limiting the comparability of these categories at consortium level. In several contexts, healthcare professionals may simultaneously work

within both sectors, while in some professions the distinction itself is not straightforward. As participants represented highly heterogeneous institutional backgrounds, and the training was intentionally designed to be relevant across diverse healthcare settings, the interpretation of “public” and “private” categories at survey level remained context-dependent and therefore methodologically challenging in the international context.

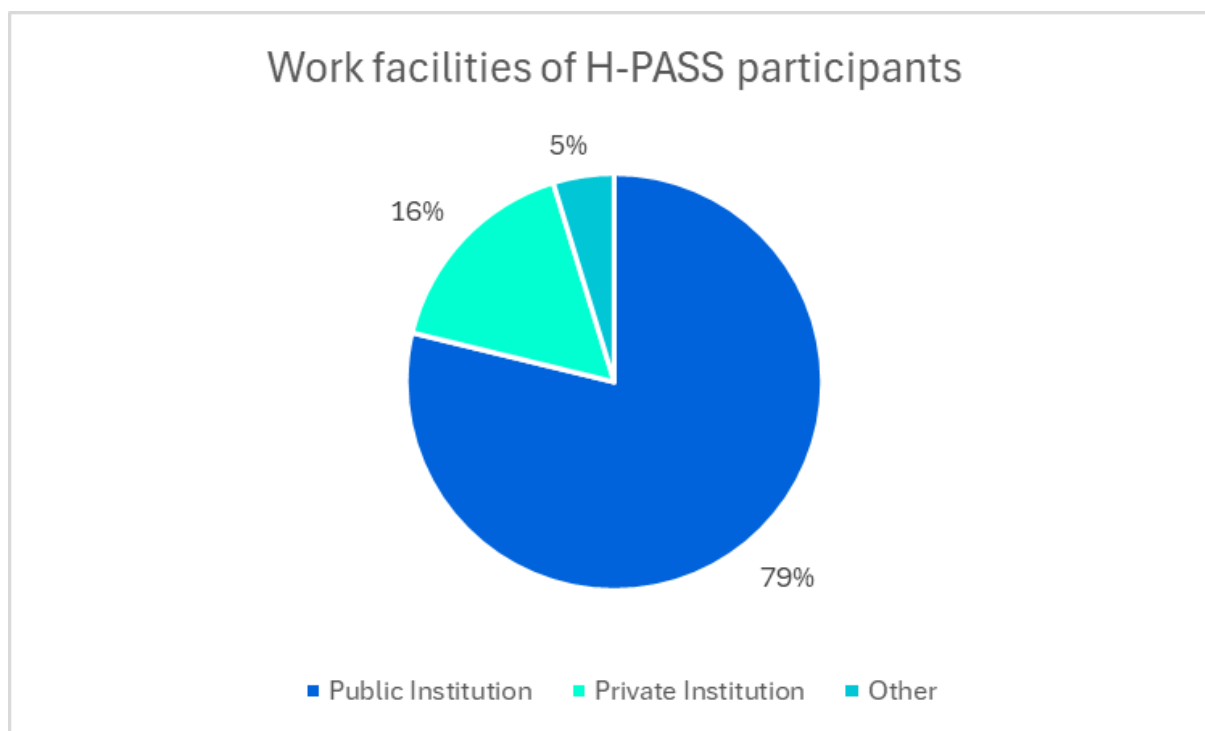


Figure 8. Work facilities of H-PASS participants (n = 632)

The employment status of participants in the H-PASS Project pilot trainings (Figure 9.) indicates that the programme predominantly reached healthcare professionals who are actively and stably employed within the health system. A very large majority of respondents, 89%, reported working full-time, highlighting that most participants were fully engaged in their professional roles at the time of the training; this of course influenced the retention of the courses too, and the validation of the training design. Smaller proportions of respondents indicated part-time employment (6%) or contract-based employment (2%), while only 1% reported being currently unemployed, and 2% selected other employment arrangements. This distribution suggests that the training primarily targeted professionals who are actively participating in daily healthcare service delivery. From an implementation perspective, this profile may support the practical application of newly acquired digital and transversal skills in workplace settings, as full-time staff are often more directly involved in organisational processes and care delivery. Overall, the findings suggest that the H-PASS pilot training courses successfully reached actively employed healthcare professionals who are well positioned to integrate and disseminate digital innovations within their respective institutions.

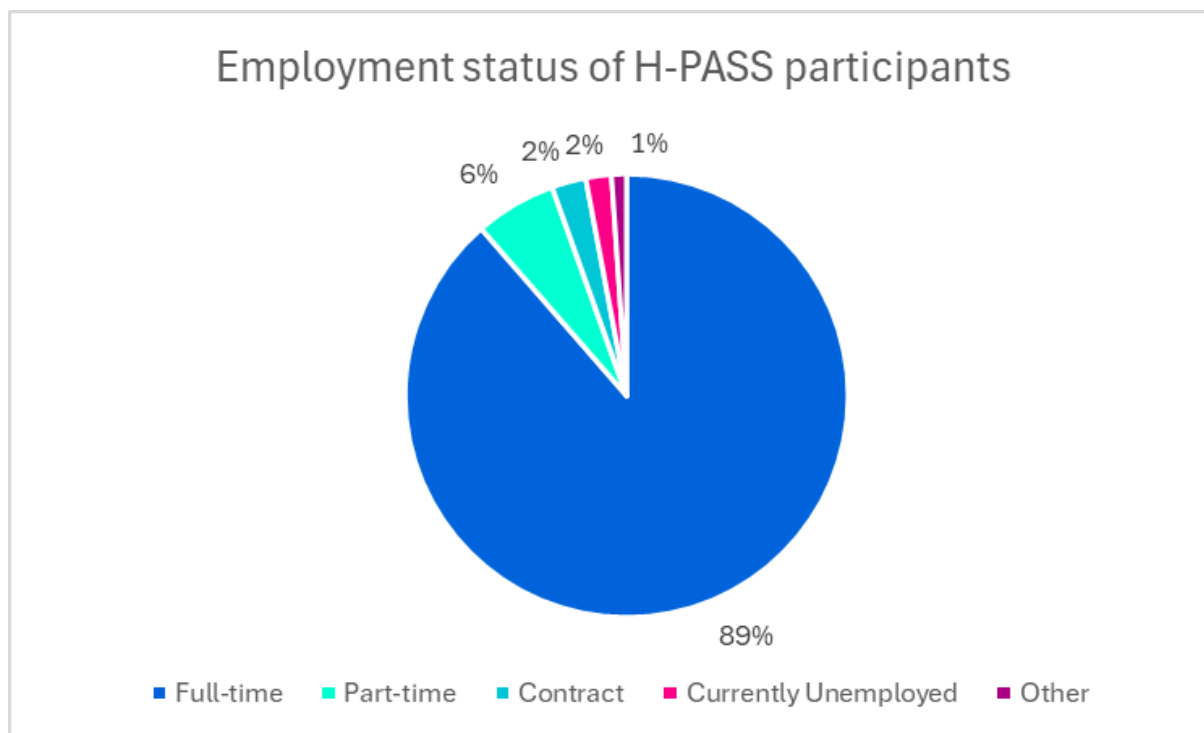


Figure 9. Employment status of H-PASS participants ($n = 640$)

The distribution of participants by work location (Figure 10.) indicates that the H-PASS pilot trainings primarily reached healthcare professionals working in urban environments. A large majority of respondents, 82%, reported working in urban areas (including capitals and larger cities), while 14% were employed in suburban settings and 4% in rural areas. This distribution suggests that the training programme was mainly accessed by professionals working in healthcare institutions located in larger cities or metropolitan regions. The predominance of participants residing in urban areas is consistent with the population distribution pattern across Europe, as well as with the earlier finding that most respondents were employed in public healthcare institutions, which are often concentrated in urban centres where major hospitals, specialised clinics, and administrative bodies are located. In addition, the smaller representation of suburban and rural professionals may reflect structural factors such as the geographic distribution of healthcare facilities, differences in access to training opportunities, or varying levels of institutional support for participation in professional development programmes. From a programme implementation perspective, these findings highlight the importance of considering geographical accessibility and outreach strategies in order to ensure broader participation from healthcare professionals working outside major urban centres.

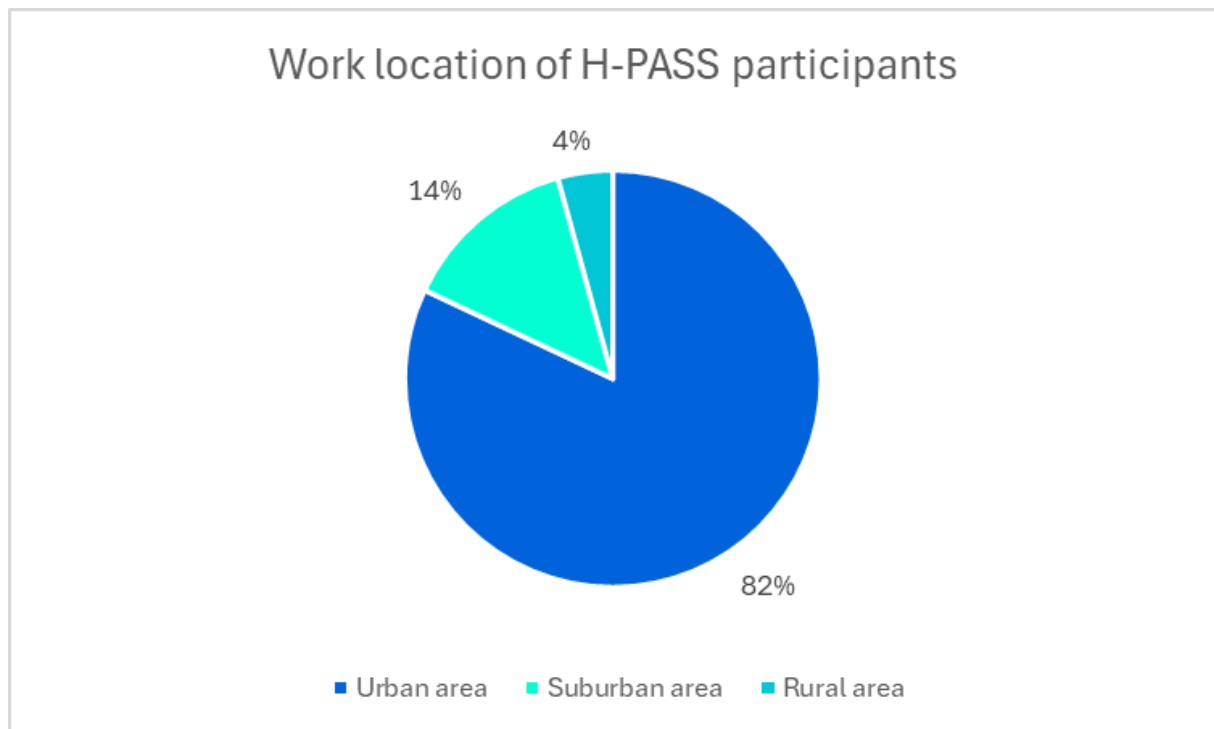


Figure 10. Work location of H-PASS participants ($n = 633$)

3.2. Satisfaction with the H-PASS training

Participants' overall satisfaction with the training (Figure 11.) delivered within the H-PASS Project pilot phase was assessed using a five-point Likert scale, where higher values represent higher levels of satisfaction. The results indicate a very positive evaluation of the training programme, with the majority of respondents expressing high levels of satisfaction. More than half of the participants (56%) selected the highest rating (5), while an additional 37% rated the training with 4, meaning that 93% of respondents evaluated the training positively. Only a small proportion of respondents reported moderate satisfaction (4% selected 3), and very few participants expressed dissatisfaction, with 2% selecting 2 and 1% selecting the lowest rating of 1. This distribution demonstrates a strongly skewed pattern towards the upper end of the scale, indicating that the training was widely perceived as valuable and relevant by participants. These findings are particularly notable when considered alongside the profile of participants described in the demographic section, which showed that the programme primarily reached experienced and highly qualified healthcare professionals. The high satisfaction levels therefore suggest that the training content, learning methods, and overall programme structure were well aligned with the expectations and professional needs of this target group.

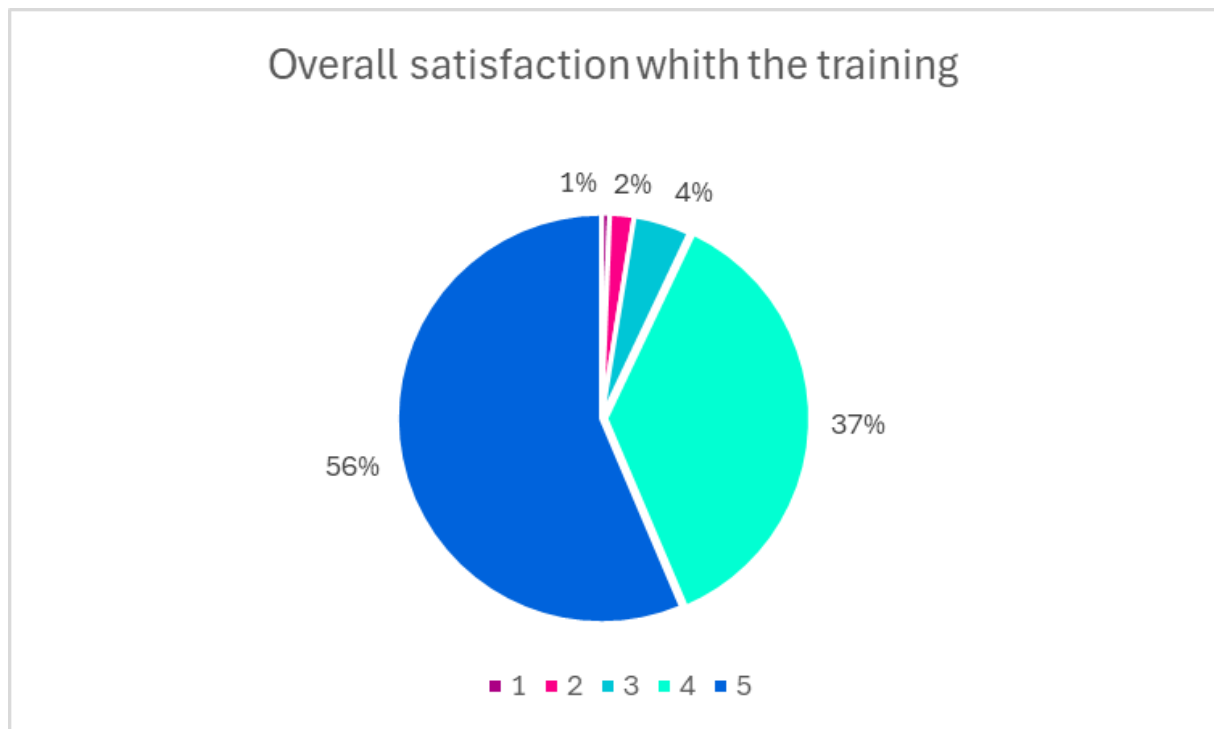


Figure 11. Overall satisfaction with the training (n = 468)

Participants were asked to evaluate how well the content covered in the training could be applied to their daily professional activities, using a five-point Likert scale, where higher values indicate greater perceived applicability. The results (Figure 12.) show a very positive assessment of the practical relevance of the training delivered within the H-PASS Project pilot phase. The largest proportion of respondents, 44%, selected the highest rating (5), while 42% rated the applicability as 4, indicating that 86% of participants considered the training highly applicable to their everyday work. A smaller proportion of respondents (10%) reported a moderate level of applicability (rating 3), while only 3% selected 2 and 1% indicated the lowest level (1). This distribution demonstrates that participants generally perceived the training content as directly relevant to their professional responsibilities and workplace contexts. These findings complement the high levels of overall satisfaction observed in the previous figure, suggesting that participants not only valued the training experience but also recognised its practical usefulness in real-world healthcare settings.

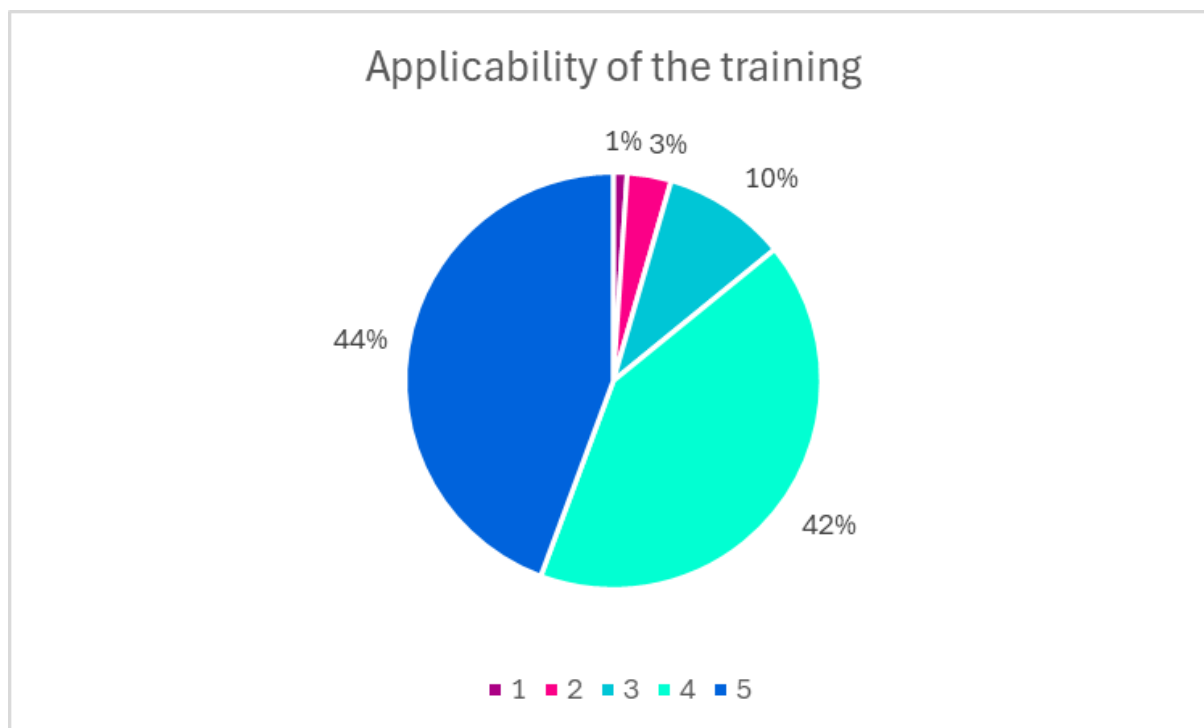


Figure 12. Applicability of the training to daily work (n = 467)

3.3. Digital and transversal skill development

Participants were asked to evaluate the extent to which their digital skills improved during the training, using a five-point Likert scale ranging from “not at all” to “a great deal.” The responses (Figure 13.) indicate a strong perceived improvement in digital competences among participants of the H-PASS Project training programme. Nearly half of respondents (45%) reported that their digital skills improved significantly (rating 4), while 25% indicated improvement “to a great deal” (rating 5). A further 22% reported moderate improvement (rating 3), suggesting that the large majority of participants perceived at least a meaningful enhancement of their digital competences. Only a small proportion reported limited improvement, with 7% selecting “slightly” (rating 2) and 1% indicating no improvement (rating 1). Overall, these results show that 92% of respondents experienced at least moderate improvement, highlighting the effectiveness of the training in strengthening participants’ digital capabilities.

Participants were also asked to identify specific digital competence areas in which they experienced improvement, based on the DigComp 2.2. (explanation of the framework was provided within the survey). The results (Figure 14.) show that improvements were reported across all five competence areas of the framework. The most frequently selected category was communication and collaboration, followed closely by safety and problem solving, indicating that participants particularly benefited from competencies related to digital interaction, responsible technology use, and practical digital problem-solving in professional contexts. Digital content creation was also widely reported as an area of improvement, while information and data literacy—although still substantial—was selected somewhat less

frequently compared with the other categories. Taken together, these findings suggest that the training programme contributed to strengthening a broad spectrum of digital competences, rather than focusing narrowly on a single skill area.

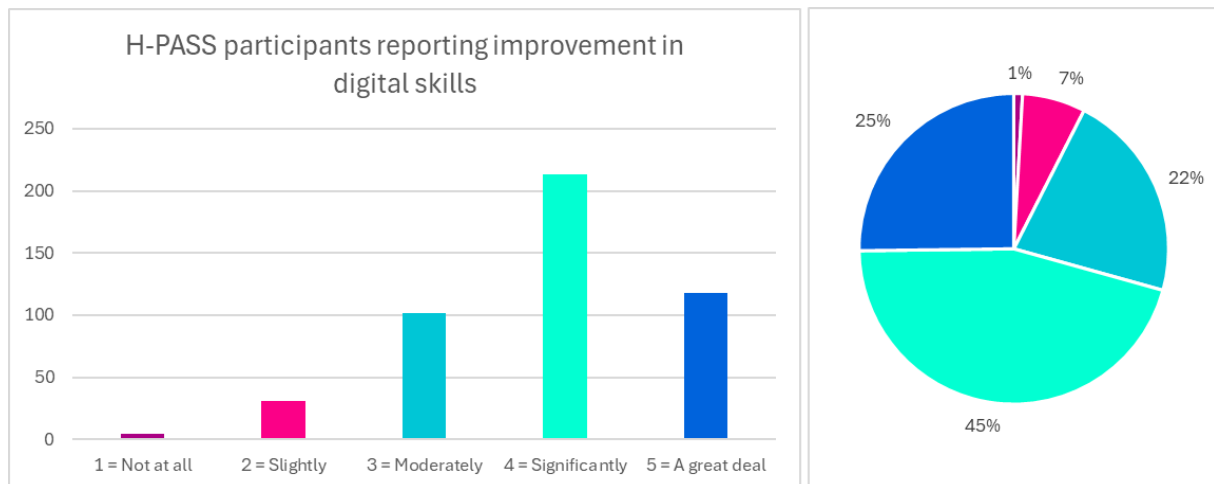


Figure 13. Self-reported improvement in digital skills (n = 468)

The indicator “Improvement in digital skills among training participants (based on pre- and post-training surveys)” includes all respondents selecting 2–5 on the Likert scale, indicating at least slight improvement in their digital skills. Based on this criterion, the indicator value is 99.1%.

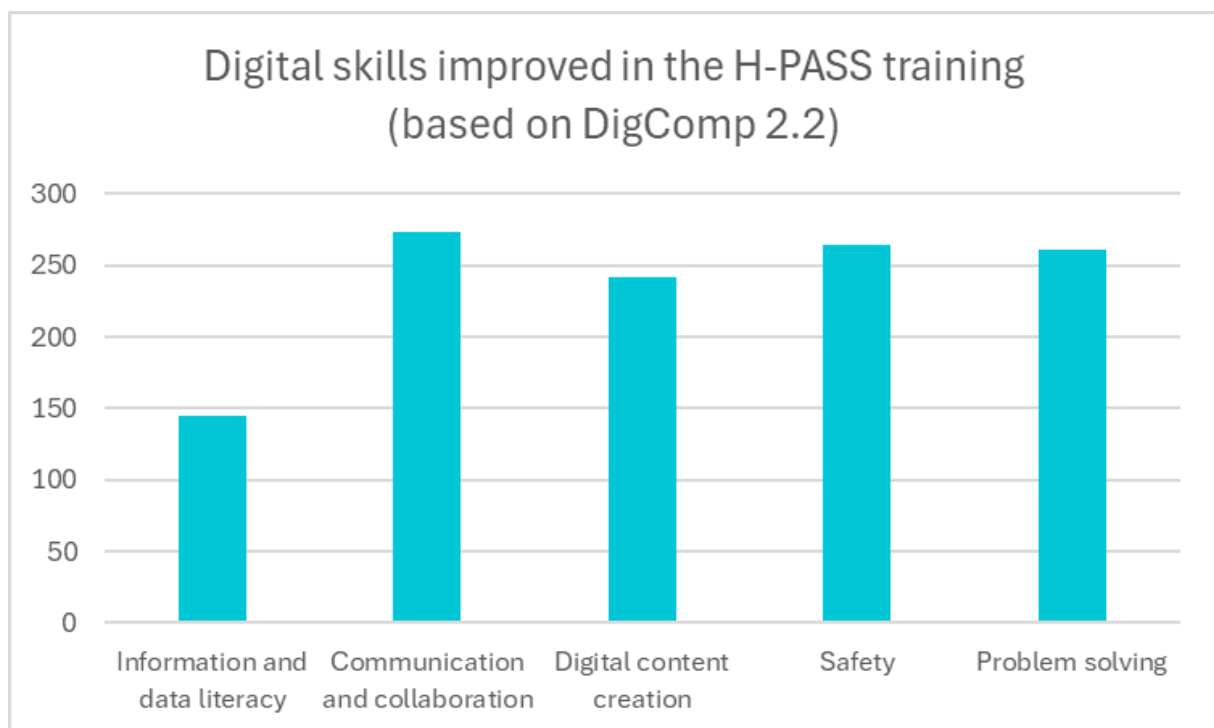


Figure 14. Specific digital competencies improved (n = 637)

Participants were asked to evaluate the extent to which their transversal skills improved during the training, using a five-point Likert scale ranging from “not at all” to “a great deal.” The responses (Figure 15.) indicate that the training delivered within the H-PASS Project pilot phase was perceived as highly effective in strengthening transversal competencies. The largest proportion of respondents (45%) reported significant improvement (rating 4) in their transversal skills, while 29% indicated improvement “to a great deal” (rating 5). An additional 20% reported moderate improvement (rating 3), meaning that the majority of participants perceived meaningful development in these competencies. Only 6% of respondents indicated slight improvement (rating 2), and no participants reported no improvement (rating 1). Overall, this distribution shows that 94% of respondents experienced at least moderate improvement in their transversal skills, demonstrating a strong perceived impact of the training in this area, even better than in digital skills training.

Participants were also asked to identify specific transversal competencies they felt had improved, based on the LifeComp framework (explanation of the framework was provided within the survey) (Figure 16.). Improvements were reported across all competence areas included in the framework, indicating a broad development of personal and social capabilities. The most frequently selected areas included critical thinking, communication, and collaboration, suggesting that the training effectively supported skills related to teamwork, reflective practice, and problem-solving in professional environments. Other frequently reported areas of improvement included growth mindset and managing learning, which are closely related to continuous professional development and adaptability—competencies that are particularly relevant in the context of digital transformation in healthcare. Improvements were also reported in self-regulation, flexibility, empathy, and wellbeing, highlighting the programme’s contribution to strengthening interpersonal and personal resilience skills among participants.

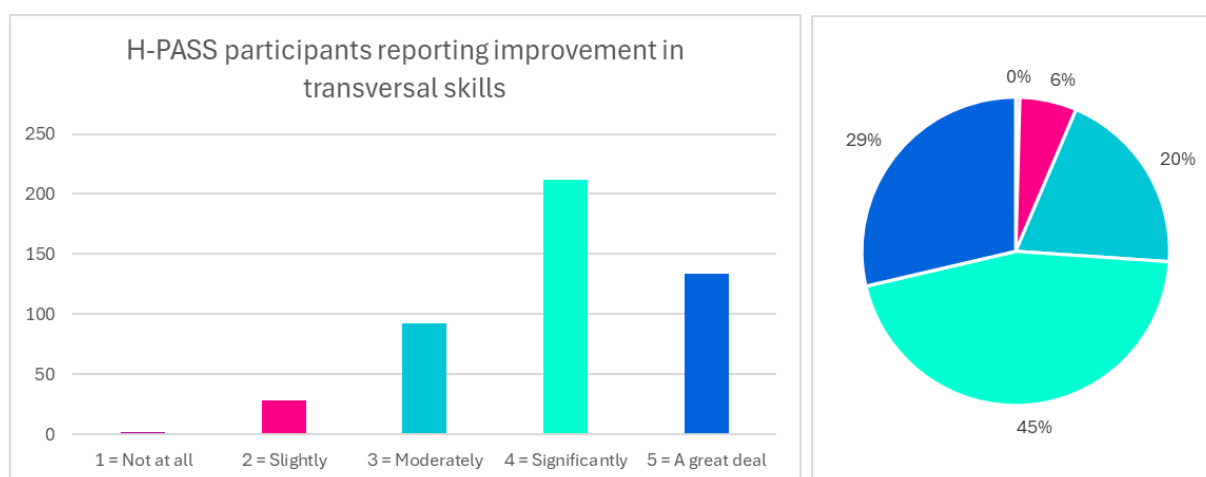


Figure 15. Self-reported improvement in transversal skills (n = 468)

The indicator “Improvement in transversal skills among training participants (based on pre- and post-training surveys)” includes all respondents selecting 2–5 on the Likert scale,

indicating at least slight improvement in their transversal skills. Based on this criterion, the indicator value is 99.6%.

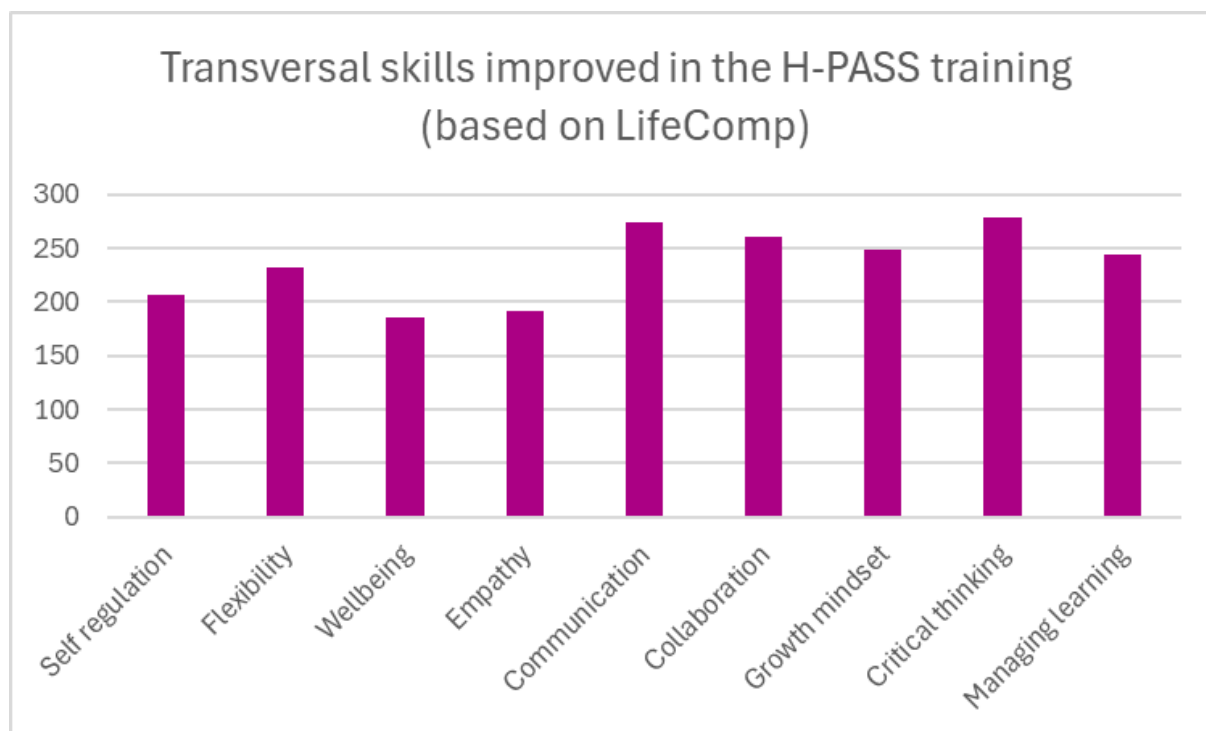


Figure 16. Specific transversal competencies improved (n = 637)

Participants were asked whether they felt more confident in their teamwork skills in digital settings after completing the training delivered within the H-PASS Project pilot phase. Responses were collected on a five-point Likert scale, where higher values indicate a greater perceived increase in confidence. The results (Figure 17.) demonstrate a strong positive effect of the training on participants' confidence in collaborating within digitally mediated environments. Half of the respondents (50%) reported a significant increase in confidence (rating 4), while 33% indicated a very strong increase (rating 5). In addition, 13% of participants reported moderate improvement (rating 3). Only a small proportion reported limited change, with 3% selecting rating 2, and 1% indicating no change (rating 1). Overall, this distribution shows that 96% of respondents experienced at least moderate improvement in their confidence to collaborate in digital settings.

These findings are consistent with the earlier results on digital competence development, particularly the strong improvements reported in the communication and collaboration domain of the DigComp framework. Together with the previously observed growth in transversal skills such as communication, collaboration, and critical thinking, the results suggest that the training programme effectively supported participants in developing the competencies required for teamwork in increasingly digitalised healthcare environments. Given that most participants were experienced healthcare professionals working full-time in institutional settings, the increased confidence in digital teamwork may contribute to more

effective collaboration across healthcare teams and support the integration of digital tools into everyday clinical and organisational practices.

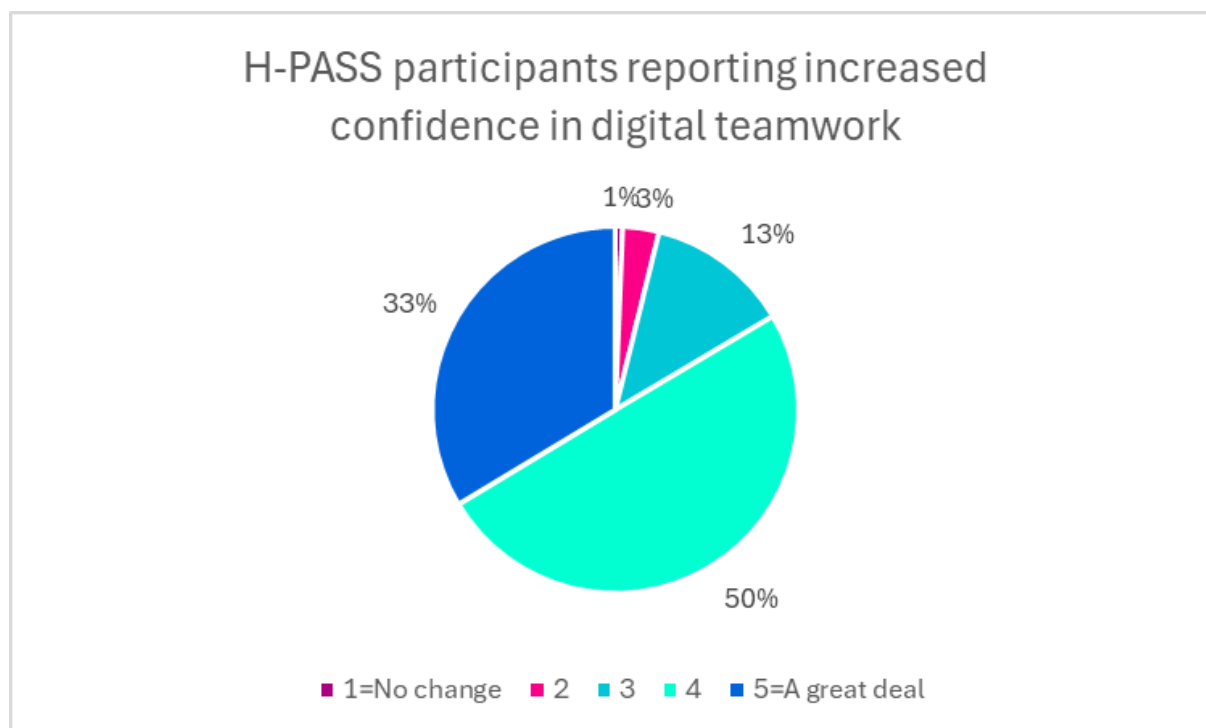


Figure 17. Increased confidence in digital teamwork after the training (n = 467)

The indicator “Improved capabilities for teamwork in digital settings (based on post-training surveys)” includes all respondents selecting 2–5 on the Likert scale, indicating at least slight improvement in their confidence to collaborate in digital environments. Based on this criterion, the indicator value is 99.3%.

3.4. Self-evaluation based on pre- and post-training assessment

The assessment is based on the self-evaluation statements on skills and attitudes that are targeted learning outcomes of the H-PASS training. Participants evaluated these 24 (12 skill and attitude) statements before and after the H-PASS training. In the analysis we connected these pre-post evaluations based on the self-generated identifiers that the participants provided at the beginning of the survey. Accordingly, we have surveys that could be matched and others that could not. For consistency reasons, we have only included those individual responses where the pre- and the post-training fill-out could be matched and compared.

In some cases not all the pre- or the post-training entry was missing, but only one module-specific set or only a couple of statements. We decided to include these data to gain a more complete picture and have these fill-outs statistically comparable. For all individual pre- and post-course evaluations, a score was calculated based on the Likert-scale evaluations, where normally the maximum score was $24 \times 5 = 120$. However, in the case of only three delivered modules the maximum score was only 90. Therefore, we did not take into account the absolute value of the score, but rather the ratio to the maximum score and compared these

ratios before and after the training, to assess how many percent the participants evaluated themselves better after the training.

The number of respondents was 641 for all pre-training evaluation and 475 for post-training evaluation. The number of matched survey responses from the six countries was 449, and 380 entries were discarded from the analysis (Table 1.). These 449 matched surveys include those where the final score percentage was statistically calculated.

	Number of surveys based on matchability	
	Matchable (included)	Non-matchable (not included)
Cyprus	24	4
Greece	31	44
Hungary	89	89
Italy	143	233
Lithuania	72	10
Romania	90	0

Table 1. Number of included and non-included survey entries per country

A total of 67,48% of respondents demonstrated an improvement, 5,35% remained at the same level in their scores, while 27.17% of entries showed a decrease in their final score. These “negative” results should be interpreted in context. In the Closing Survey, participants were asked to assess the extent to which they had improved their digital and transversal skills. Only 0.9% and 0.43% of respondents indicated that their digital and transversal skills, respectively, had not improved as a result of the training.

One possible explanation for this discrepancy is related to differences in self-assessment approaches. Prior to the training participants might have given themselves high baseline grades in the Welcome survey, maybe to complete it quickly, or even due to overestimating their competency levels. Following the training, participants may have developed a more nuanced understanding of the assessed competencies, enabling them to evaluate their skills more critically and realistically than prior to the training. This may result in lower self-assessment scores despite a perceived improvement in competence. These two dynamics inevitably, would render the degree of increase quite low or cause a decrease of the final survey score. While alternative interpretations cannot be excluded, this explanation is considered a plausible interpretation of the observed pattern, given the methodological differences between the measurement approaches.

Self-evaluations revealed an 8,16% increase in digital and transversal skills and attitudes targeted in the H-PASS training (including positive, negative and no change entries). Those evaluations that showed improvement (positive entries) the average increase in the targeted skills and attitudes was 15.8%.

The country-level analysis of matched pre–post self-evaluations (Figure 18.) shows a consistent pattern of improvement across all participating countries, with positive changes clearly outweighing negative ones in all cases.

Across countries, the average increase among participants who improved ranges from 10.0% in Romania to 19.0% in Italy, confirming a substantial positive shift in self-assessed digital and transversal skills and attitudes. Italy records the highest average increase (19.0%), followed closely by Cyprus (18.6%) and Lithuania (17.7%), while Hungary (13.5%) and Greece (11.1%) show more moderate but still clearly positive gains.

At the same time, a proportion of participants in each country reported a decrease in their post-training self-assessment, with average declines ranging from –4.5% in Lithuania to –13.0% in Italy. As noted in the methodological considerations, these decreases should not be interpreted as a lack of learning effect, but rather as a likely reflection of increased self-awareness and more critical self-assessment following the training.

The findings indicate that all countries demonstrate meaningful positive learning gains, supporting the effectiveness of the H-PASS training across diverse national contexts. Countries with the highest positive gains (Italy, Cyprus, Lithuania) also tend to show larger negative shifts, which may further support the interpretation of post-training recalibration in self-evaluation. Countries with more moderate increases (Greece, Romania) show relatively smaller negative shifts, suggesting a more stable self-assessment pattern.

In line with the overall results, this country-level analysis confirms that the H-PASS training contributed to a significant improvement in participants' perceived digital and transversal competencies, while also fostering a more reflective and critical approach to self-evaluation.

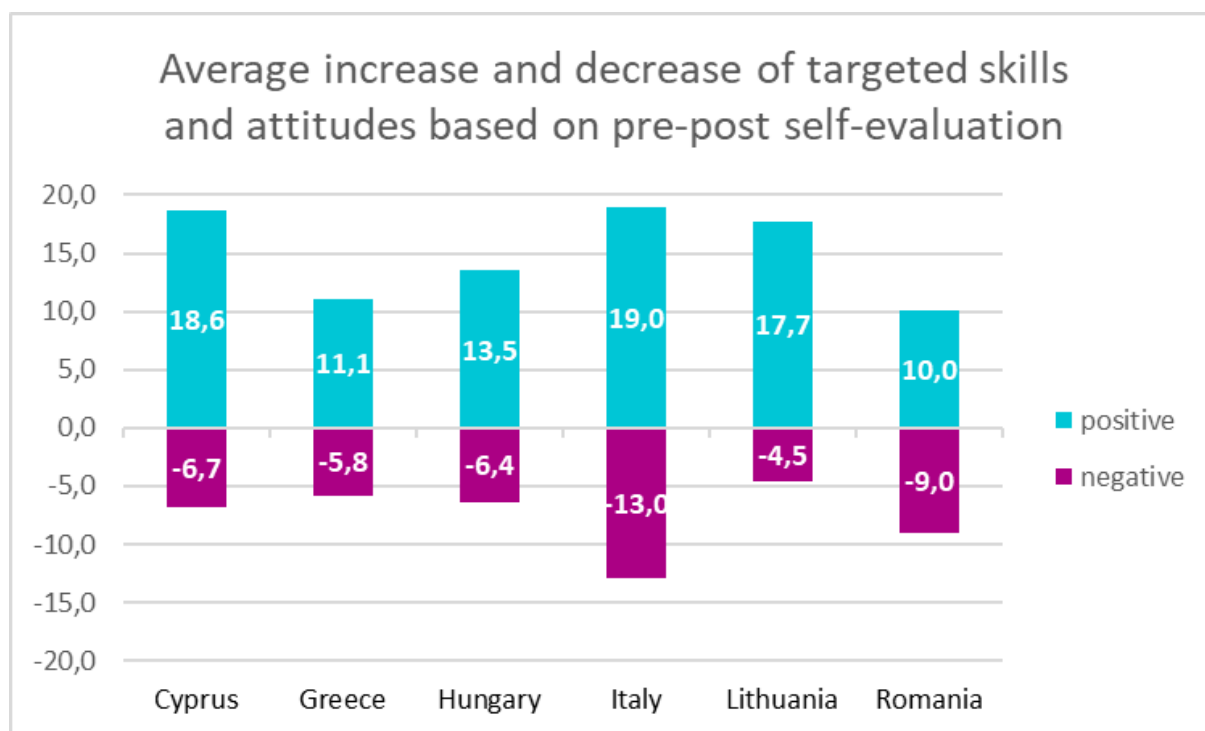


Figure 18. Average increase and decrease of targeted skills and attitudes based on pre–post self-evaluation by country (n=22 Cyprus; n=31 Greece; n=87 Hungary; n=136 Italy; n=72 Lithuania; n=77 Romania)

Complementing Figure 18., the distribution of improved, decreased, and unchanged (“same”) results (Figure 19.) provides a more nuanced understanding of the pre–post self-evaluation outcomes across countries.

Across all participating countries, the majority of responses fall into the “improved” category, confirming the overall positive trend identified in the average percentage changes. Greece, Cyprus and Lithuania have particularly high results if we compare the proportion of positive entries to other entries.

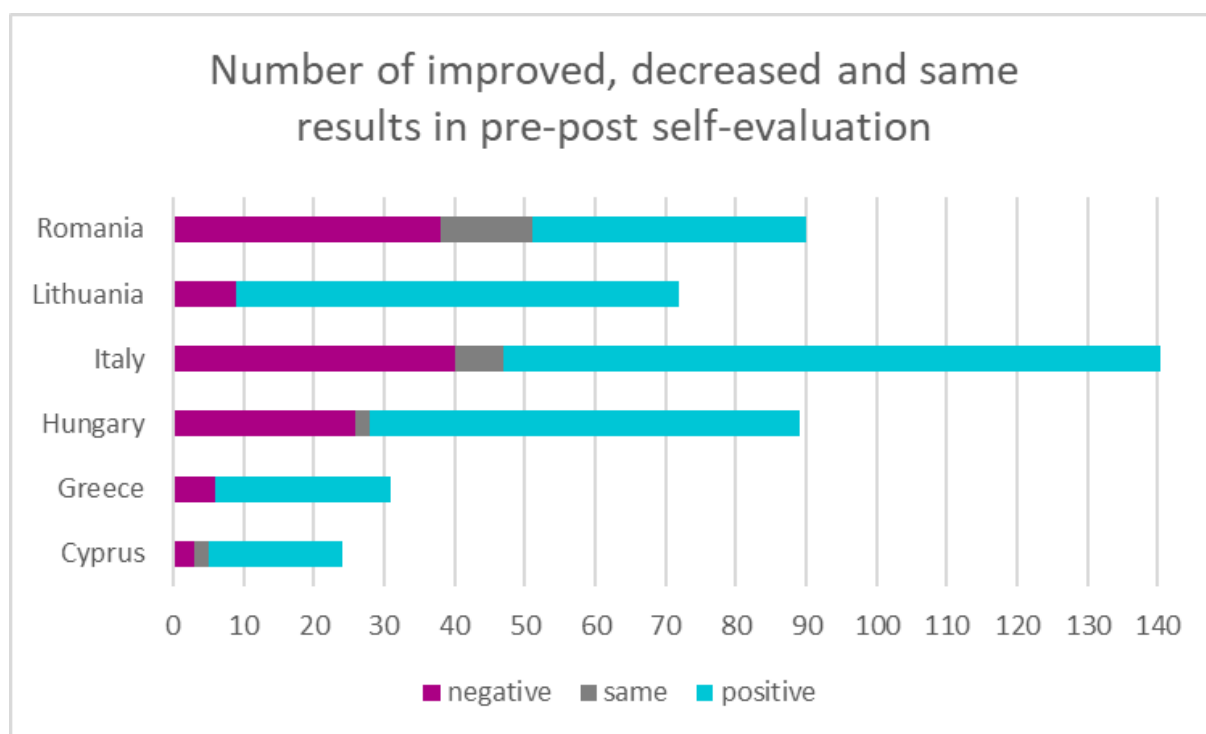


Figure 19. Distribution of improved, decreased and unchanged results in pre–post self-evaluation by country (n=24 Cyprus; n=31 Greece; n=89 Hungary; n=143 Italy; n=72 Lithuania; n=90 Romania)

When considering all matched pre–post responses—including positive, negative, and same-score entries—the results show (Figure 20.) an overall net increase in self-evaluated digital and transversal skills and attitudes across most countries, though with notable variation in magnitude.

The highest average increases are observed in Cyprus (16.8%), Lithuania (16.4%), and Italy (14.5%), indicating particularly strong overall gains in these contexts. Hungary (8.9%) and Greece (8.6%) show more moderate but still clearly positive improvements, aligning closely with the overall consortium average. In contrast, Romania (0.1%) shows a near-neutral net change, suggesting that positive and negative shifts in self-evaluation largely balanced each other out.

These findings should be interpreted in light of the observed distribution of improvements and decreases (see above in Figure 18.). Countries with high positive averages (e.g. Cyprus and

Lithuania) reflect not only strong improvements among participants but also a more favourable balance between positive and negative changes. Conversely, the very low net change in Romania likely reflects a greater offset between increases and decreases, rather than an absence of learning effects.

Importantly, as highlighted in the methodological considerations, decreases in self-evaluation scores may reflect more critical or informed self-assessment following the training, rather than an actual decline in competencies. Therefore, even in cases where net gains appear limited, the results may still indicate meaningful learning outcomes.

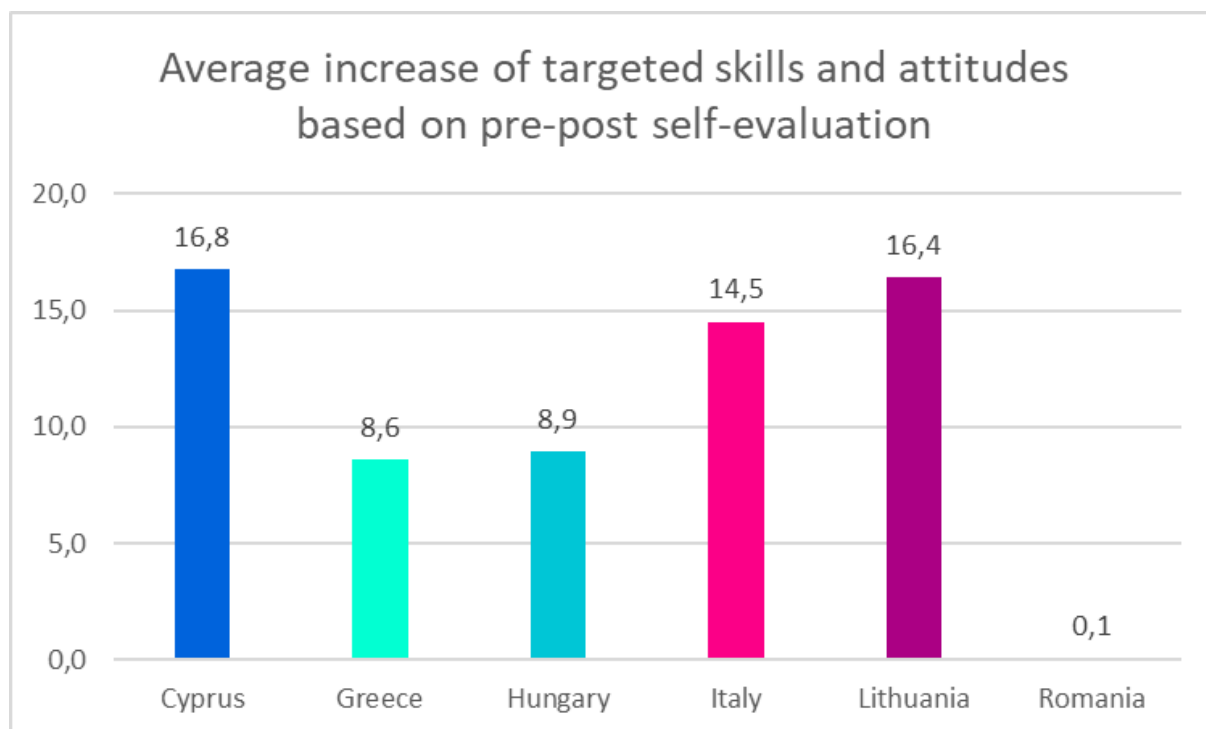


Figure 20. Average change in targeted skills and attitudes based on matched pre-post self-evaluation across countries (n=24 Cyprus; n=31 Greece; n=89 Hungary; n=143 Italy; n=72 Lithuania; n=90 Romania)

3.5. Impact on digital tool usage

Participants were asked whether they had started to use digital tools more frequently in their professional tasks as a result of the training delivered within the H-PASS Project pilot phase. The responses indicate a notable behavioural impact of the training on participants' professional practices (Figure 21.). Nearly half of the respondents (47%) reported that they now use digital tools slightly more often, while 36% indicated that they use them significantly more in their professional work. Together, these results show that 83% of participants reported an increase in digital tool usage following the training. A smaller proportion of respondents (12%) indicated that they use digital tools the same amount or less, suggesting that the training did not substantially change their usage patterns. Additionally, 5% of respondents selected "not relevant," indicating that the question did not apply to their professional responsibilities or that digital tools are not directly used in their specific tasks.

These findings suggest that the training programme contributed not only to perceived improvements in digital competences, but also to changes in actual professional behaviour, particularly in the use of digital technologies within work processes. This behavioural shift is consistent with the earlier results showing high levels of perceived improvement in digital skills and confidence in digital teamwork, as well as the strong applicability of the training to daily work.

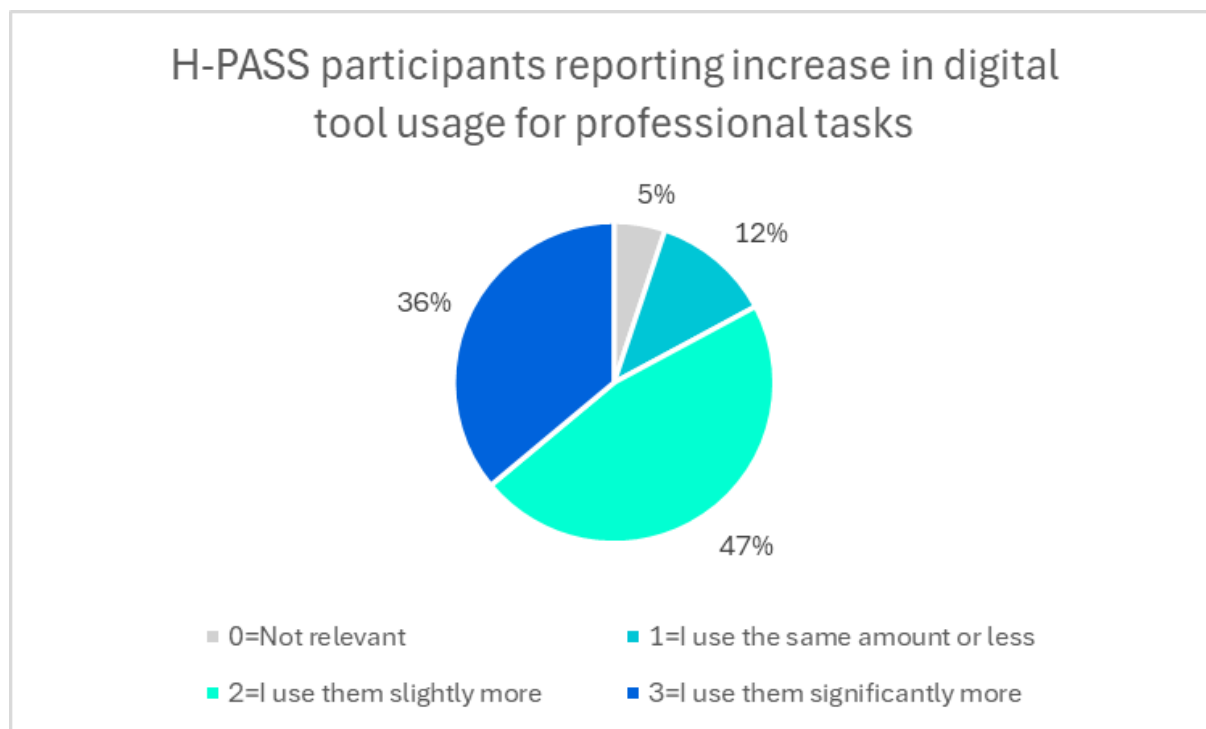


Figure 21. Increased use of digital tools for professional tasks after the training (n = 466)

The indicator “Increased use of digital tools in clinical work (post-training survey)” includes respondents selecting 2 – “I use them slightly more” or 3 – “I use them significantly more.” Based on this criterion, the indicator value is 82.9%.

Participants were also asked whether they had begun using digital tools more frequently in administrative tasks as a result of the training delivered within the H-PASS Project pilot phase. The responses indicate a clear increase in the use of digital tools in administrative work processes (Figure 22.). Nearly half of respondents (47%) reported that they now use digital tools slightly more often, while 32% indicated that they use them significantly more for administrative tasks. Together, these responses show that 79% of participants experienced an increase in digital tool usage in administrative activities following the training. A smaller proportion of respondents (15%) reported that they use digital tools the same amount or less than before the training, suggesting that for some participants the training did not substantially alter their administrative practices. Additionally, 6% selected “not relevant,” indicating that administrative digital tool use was not applicable to their professional responsibilities. The somewhat lower proportion of increased usage compared with professional tasks may reflect the fact that administrative responsibilities vary across

professional roles within healthcare teams, or maybe also because administrative tasks are mostly standardized and fixed (per each organization's standard operating procedures) and less modifiable to on-demand changes.

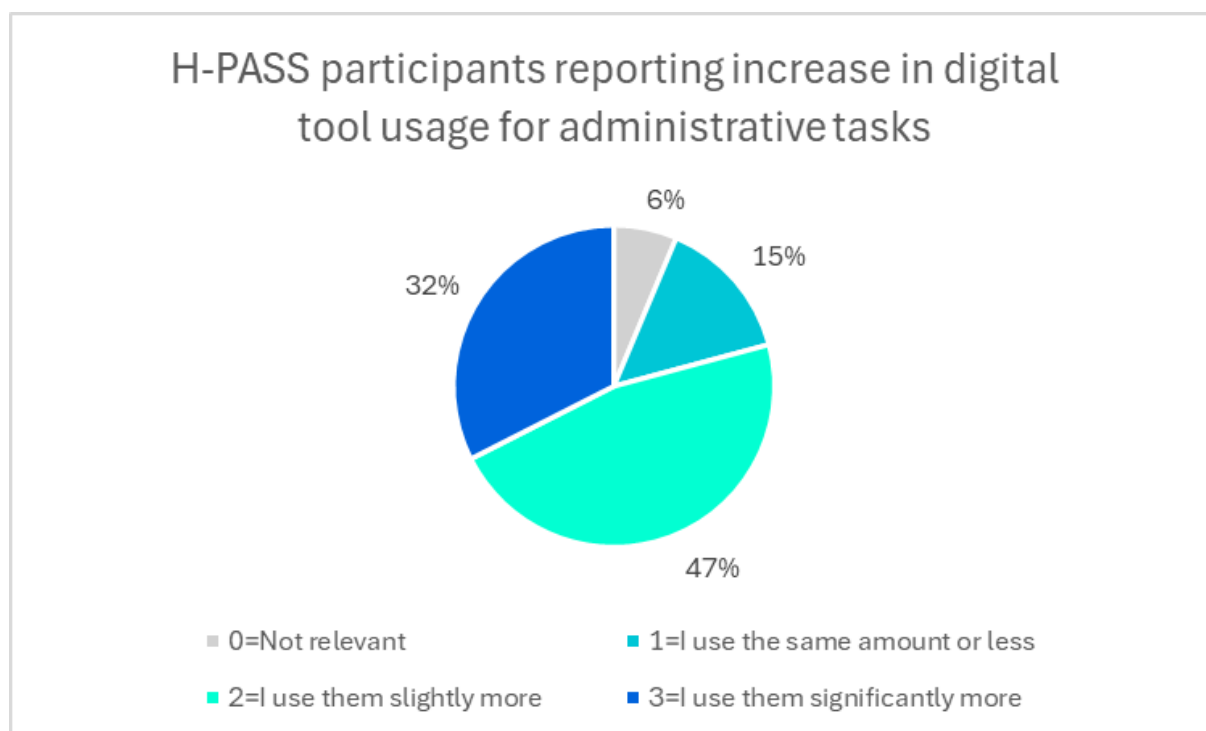


Figure 22. Increased use of digital tools for administrative tasks after the training (n = 456)

The indicator “Increased use of digital tools in administrative work (post-training survey)” includes respondents selecting 2 – “I use them slightly more” or 3 – “I use them significantly more.” Based on this criterion, the indicator value is 79.2%.

3.6. Training follow-up results

As part of the follow-up survey conducted among H-PASS alumni, participants were asked whether they could observe changes in their workplace as a result of their participation in the H-PASS Project training programme. The options to mark were teamwork patterns, workflow and processes, workload among health professionals, task-shifting practices or participants could mark that they couldn’t observe any changes in above fields, allowing a multiple-choice fill-out. The survey was filled out by 207 H-PASS alumni.

The results indicate that a substantial majority of respondents perceived positive organisational changes after completing the training. Specifically, 81% of respondents reported observing improvements in their organisation, while 19% indicated that they did not perceive any changes in the examined areas.

Participants were asked to indicate in which areas they observed organisational changes as a result of their participation in the H-PASS Project training. The results show (Figure 24.) that

the most frequently reported change concerned teamwork patterns, which were identified by 50.24% of respondents (104 participants). This suggests that the training may have contributed to improvements in team collaboration and coordination, potentially linked to the previously reported gains in digital teamwork confidence and communication-related competencies.

The second most frequently reported change related to workflow and organisational processes, reported by 39.61% of respondents (82 participants). This indicates that participants perceived improvements in the way tasks and processes are organised within their teams or departments. Additionally, 32.37% of respondents (67 participants) reported improvements in task-shifting practices, suggesting that the training may have supported more flexible distribution of responsibilities among healthcare professionals. Changes related to workload distribution among health professionals were reported by 26.57% of respondents (55 participants), indicating that a smaller but still notable share of participants observed improvements in how work responsibilities are balanced within teams.

Importantly, participants frequently reported changes across multiple organisational domains, with respondents selecting an average of 1.84 areas of improvement among those who reported any change. This suggests that the perceived organisational impact of the training was not limited to a single aspect of workplace practice but rather extended across several dimensions of team functioning and work organisation.

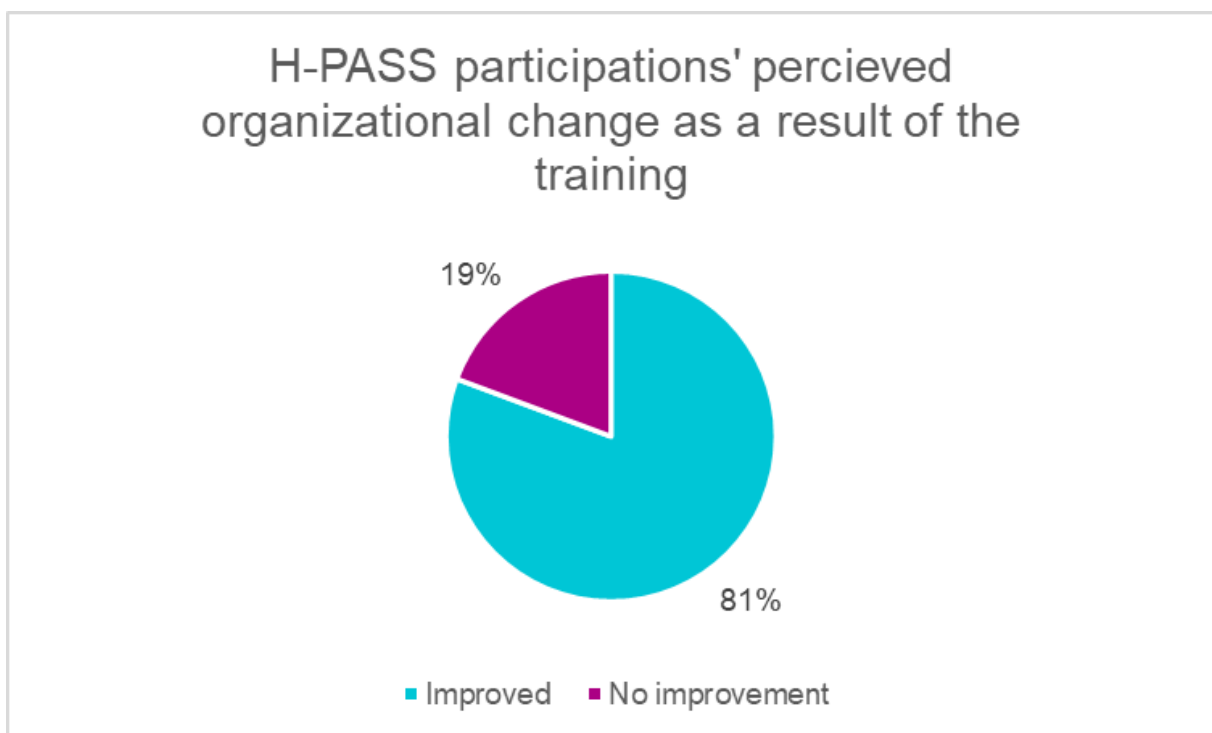


Figure 23. Perceived organizational change as a result of the H-PASS training (n = 207)

The indicator “Utilisation of acquired digital and transversal skills in practice (follow-up survey)” includes respondents who reported observing at least one organisational change in teamwork patterns, workflow and processes, workload distribution, or task-shifting practices. Based on this criterion, the indicator value is 80.68%.

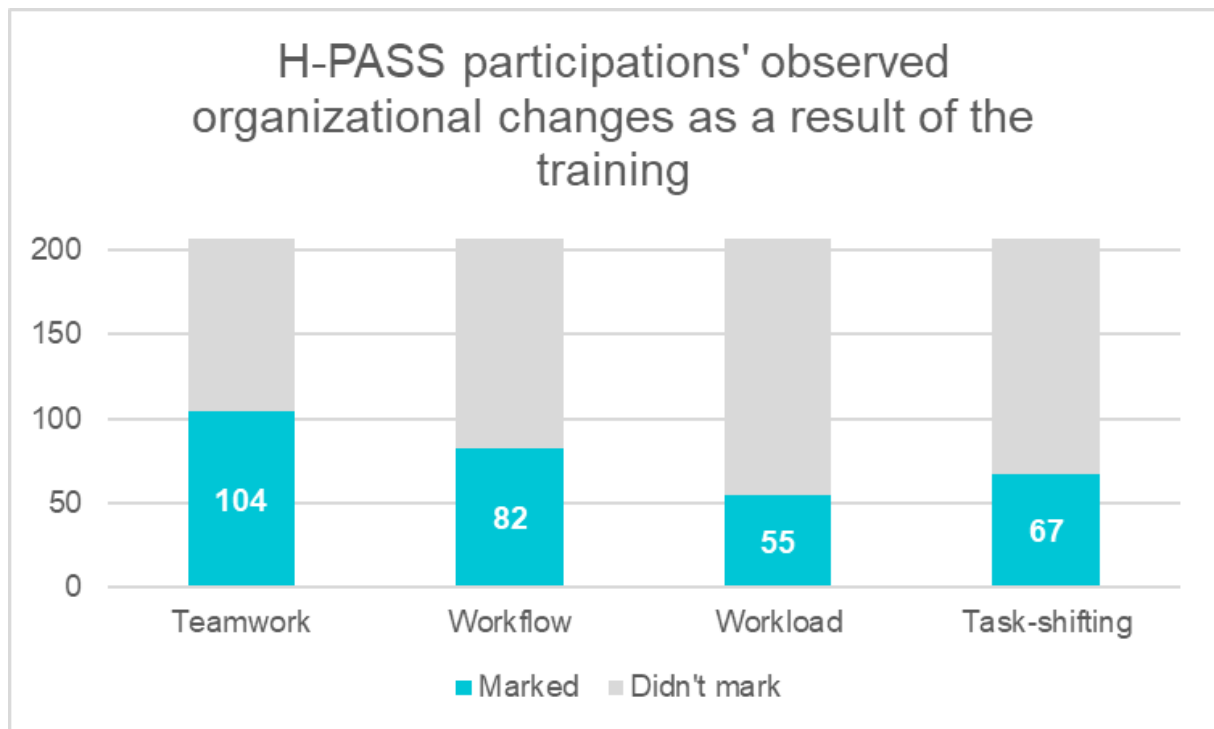


Figure 24. Types of organisational changes observed following participation in the H-PASS training (n = 207)

3.7. Module evaluation overview

Participants evaluated each training module across five dimensions reflecting different aspects of the learning experience: overall organisation (ME1), technical aspects of delivery (ME2), relevance and usefulness of the content (ME3), alignment with personal development needs (ME4), and overall learning experience (ME5). Responses were measured on five-point scales ranging from negative to positive evaluations depending on the dimension (e.g., very dissatisfied–very satisfied, not at all–completely, poor–excellent). Across all modules and evaluation aspects, the results (Figure 25.) show consistently high average ratings, generally averages ranging between approximately 4.07 and 4.58, indicating strong overall satisfaction with the module design, content, and delivery.

Among the evaluated aspects, relevance and usefulness of the module content (ME3) consistently received some of the highest ratings across modules, suggesting that participants perceived the training material as directly applicable to their professional practice. Similarly, the overall organisation of the modules (ME1) and the overall learning experience (ME5) were highly rated, indicating that participants appreciated both the structure of the training and the quality of the learning process. The technical aspects of the training (ME2), including the functioning of online tools and technical support, were also positively evaluated, reflecting

the effectiveness of the digital learning environment used for the programme. Ratings for alignment with personal development needs (ME4) were slightly lower in some modules compared with other aspects, though still strongly positive overall, suggesting that while the training broadly met participants' expectations, individual professional needs may vary across the diverse target group.

When comparing modules (Figure 26.), Module 4 generally received the highest ratings across several evaluation aspects, followed closely by Module 3, indicating particularly strong participant appreciation for the later stages of the training programme. Modules 1 and 2 also received positive evaluations, though with slightly lower average scores in some dimensions.

It should also be noted that country-level implementation differences may influence the aggregated results. For example, Module 4 was not delivered in the Italian pilot, Module 3 was not implemented in the Romanian pilot, while in Lithuania modules were evaluated through a combined module evaluation survey, thus excluded from the module-level evaluation data. Furthermore, evaluation surveys on Modules 1 and 2 were completed by those participants as well, who later dropped out of the courses due to lower satisfaction with the training by the time later modules started, resulting in better evaluations for these modules within the course. These may affect the overall distribution of responses across modules. Despite these methodological and operative differences, the consistently high ratings across all evaluation aspects suggest that the H-PASS modules were well designed, technically sound, and perceived as relevant to participants' professional development.

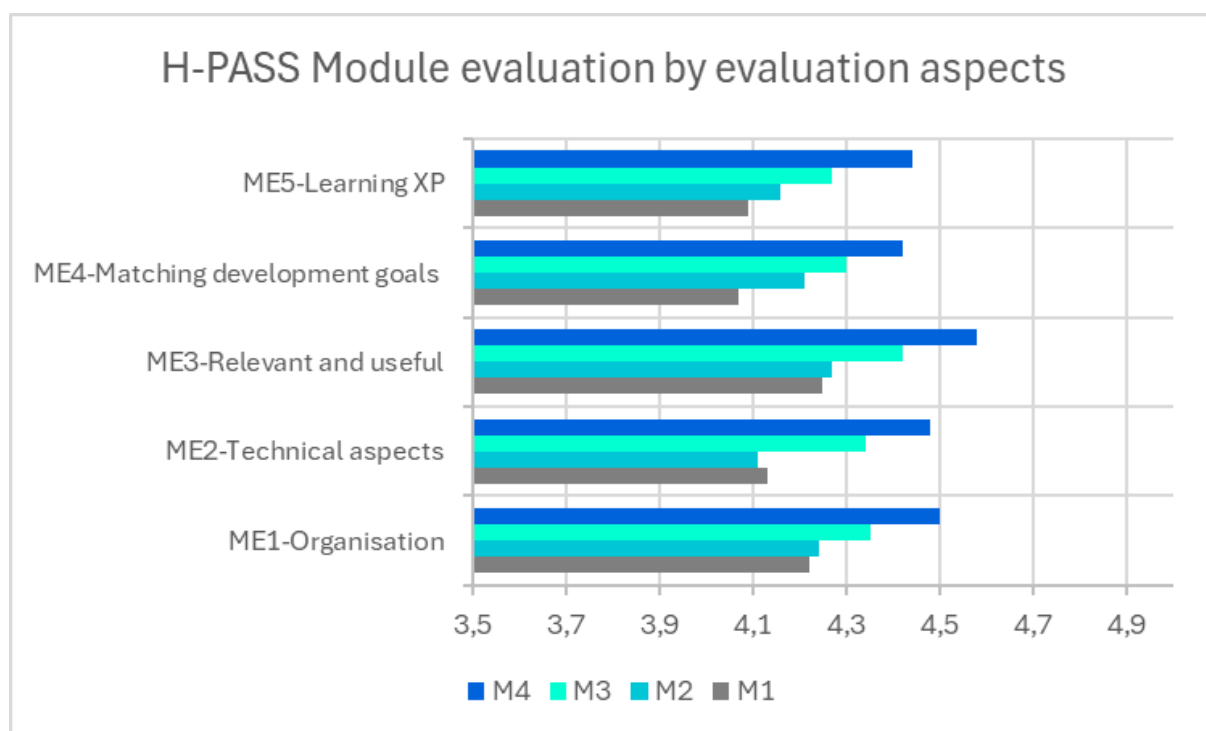


Figure 25. Module evaluation results by evaluation aspects ($n = 248-443$)

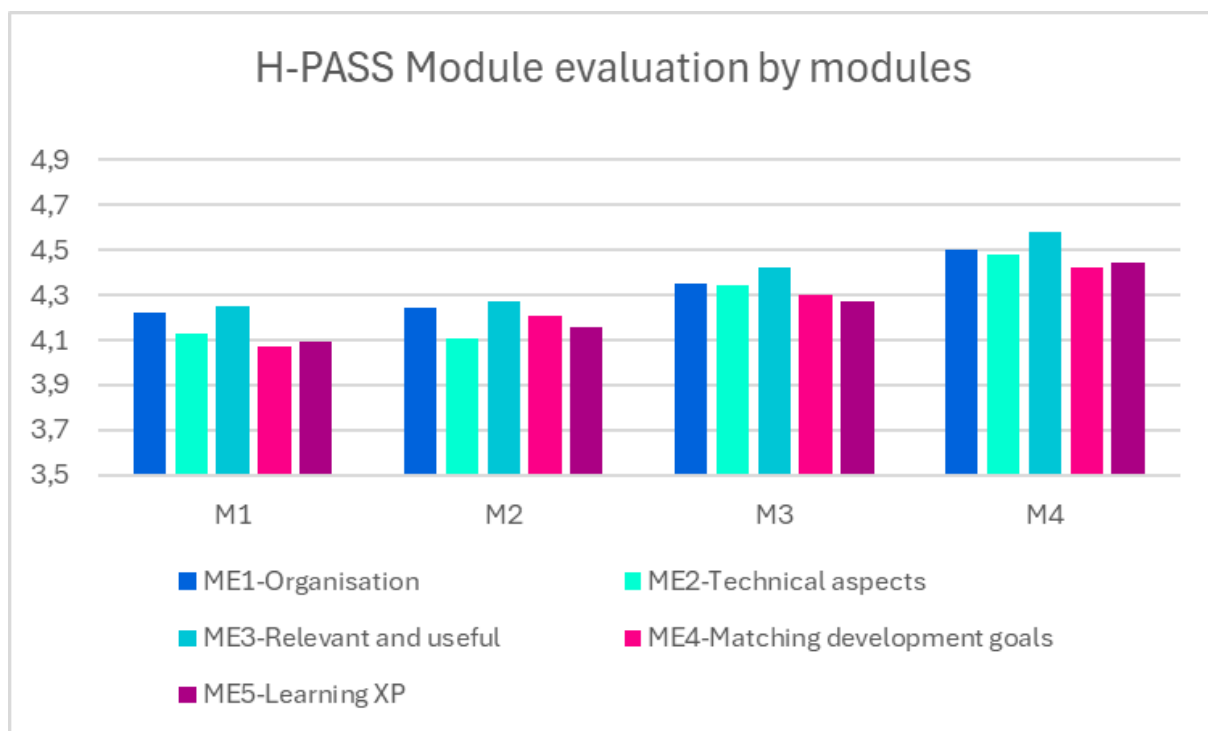


Figure 26. Module evaluation results by modules ($n = 248-443$)

Based on the list of the highest- and lowest-performing training items presented in Table 2., Module 4 again appears as the most highly rated module, confirming the previously presented module-level results. The three highest-rated exercises all originated from Module 4: “Digital health and smart device-based patient follow-up: A case study” (4.60), “Cyber security and digital wellbeing” (4.56), and “Data Biases” (4.54). This further reinforces the finding that the later module of the programme was particularly well received by participants.

At the lower end of the ranking, the exercises “Let’s develop healthcare solutions!” (4.16) and “Forum debate” (4.15) from Module 3 received the lowest scores among the internally developed activities, although their evaluations remain relatively high on the five-point scale. The lowest-rated exercise overall was “AR-in-a-Box” (3.47) from Module 4. This exercise was not originally developed within the H-PASS project but was adapted from external material. Despite its lower rating, the exercise is considered pedagogically valuable; however, the results suggest that language barriers or differences in style and structure compared with the otherwise highly consistent training materials may have influenced participants’ evaluations.

TOP1	M4B7	Digital health and smart device-based patient follow up: A case study	4,6
TOP2	M4B2	Cyber security and digital wellbeing	4,56
TOP3	M4B9	Data Biases	4,54
BOTTOM3	M3B5	Let's develop healthcare solutions!	4,16
BOTTOM2	M3B2	Forum debate	4,15
BOTTOM1	M4B4	AR-in-a-Box	3,47

Table 2. Highest and lowest performing training items (n = 85–523)

3.8. Evaluation results of the DCA training

Participants of the Digital Change Agent (DCA) training were asked to evaluate their overall satisfaction with the programme using a five-point scale. The results show (Figure 27.) a very high level of satisfaction among participants, indicating that the training was well received by those participating in the advanced component of the H-PASS Project. The majority of respondents (57%) selected the highest rating (5), while 31% rated their satisfaction as 4, meaning that 88% of participants expressed a high level of satisfaction with the training. An additional 11% reported moderate satisfaction (rating 3), while only 1% selected rating 2, and no respondents reported the lowest level of satisfaction.

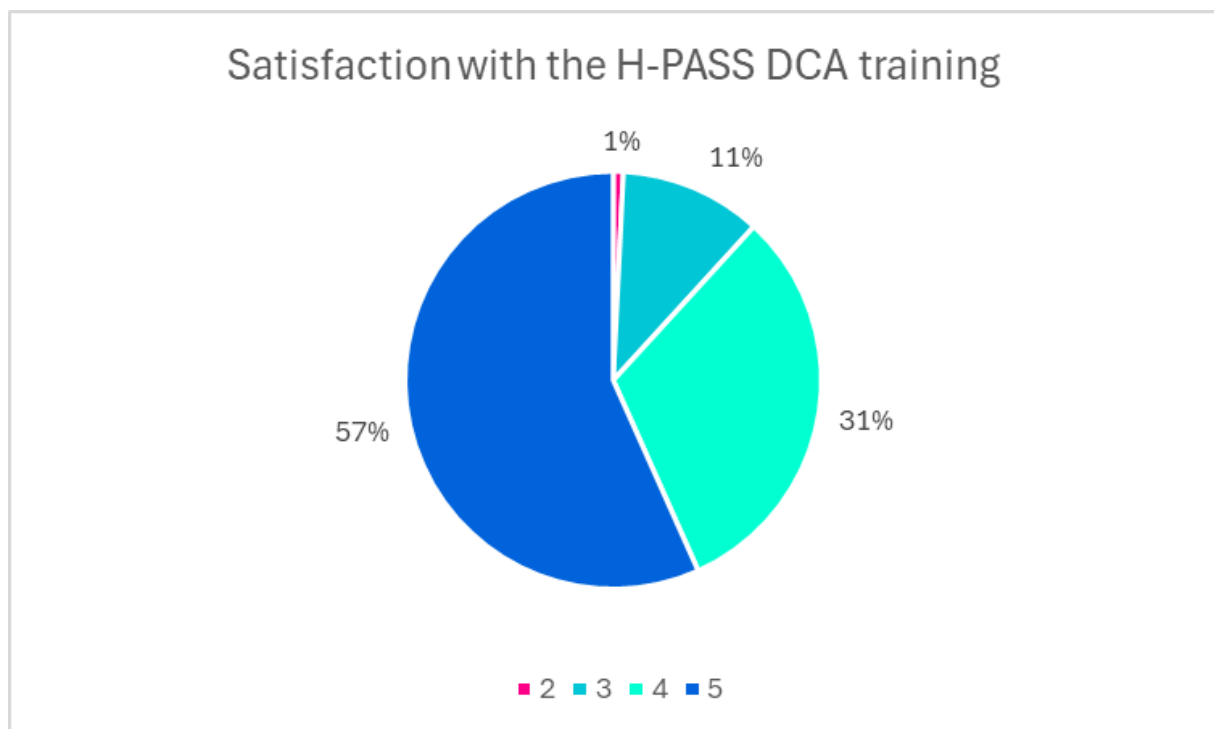


Figure 27. Satisfaction with the H-PASS Digital Change Agent (DCA) training (n = 127)

Participants of the DCA training were asked to assess the extent to which they felt prepared to foster collaboration in building an H-PASS network of healthcare professionals. Responses were measured on a five-point Likert scale ranging from “don’t agree” (1) to “completely agree” (5). The results indicate (Figure 28.) a generally strong level of perceived readiness among participants to contribute to collaborative network activities following completion of the training. The largest share of respondents (36%) selected the highest rating (5), indicating a very high level of agreement with the statement. An additional 29% rated their readiness as 4, meaning that 65% of participants expressed a high level of preparedness to actively support collaboration within the H-PASS network.

A further 21% of respondents selected rating 3, suggesting a moderate level of agreement and indicating that these participants may still be developing confidence in their ability to foster collaborative initiatives. A smaller proportion (14%) selected rating 2, indicating lower levels of perceived readiness. Notably, no respondents selected the lowest rating, suggesting that at least some level of readiness to support collaboration was reported across the participant group.

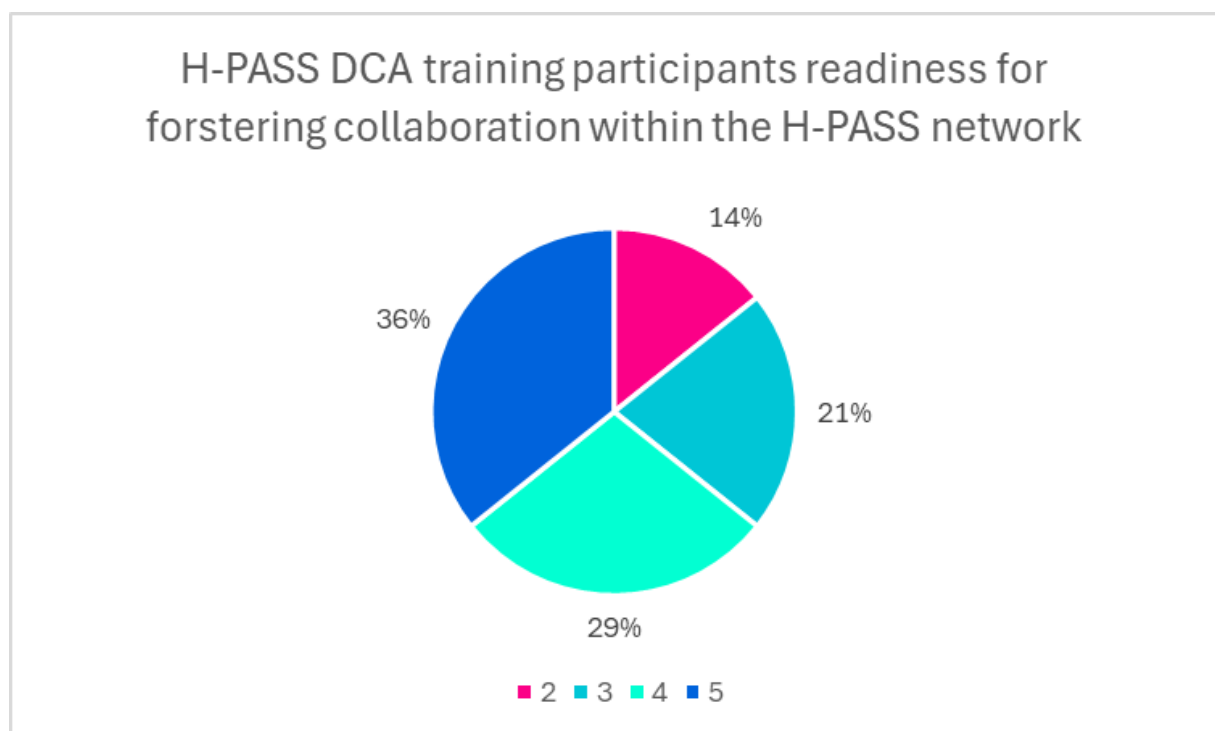


Figure 28. Readiness of DCA training participants to foster collaboration within the H-PASS network (n = 128)

To assess the impact of the DCA training, participants completed pre- and post-training self-evaluation surveys measuring several competencies related to the DCA role. The graph in Figure XX. presents the proportion of participants whose post-training score on a five-point Likert scale was higher than or at least equal to their pre-training score, indicating either improvement or maintained confidence in the assessed competencies.

The results show (Figure 29.) that a large majority of participants reported stable or increased self-evaluations across all measured areas. Understanding of the Digital Change Agent role improved or remained stable for 86% of respondents, indicating that most participants strengthened or maintained their clarity regarding the responsibilities and functions associated with this role in healthcare environments. Even higher proportions were observed for change management competence and knowledge of educational and communication methods, with 88% of participants reporting improved or unchanged scores in both areas. These findings suggest that the training effectively supported participants in developing or reinforcing skills required to facilitate organisational change and engage colleagues in digital transformation processes.

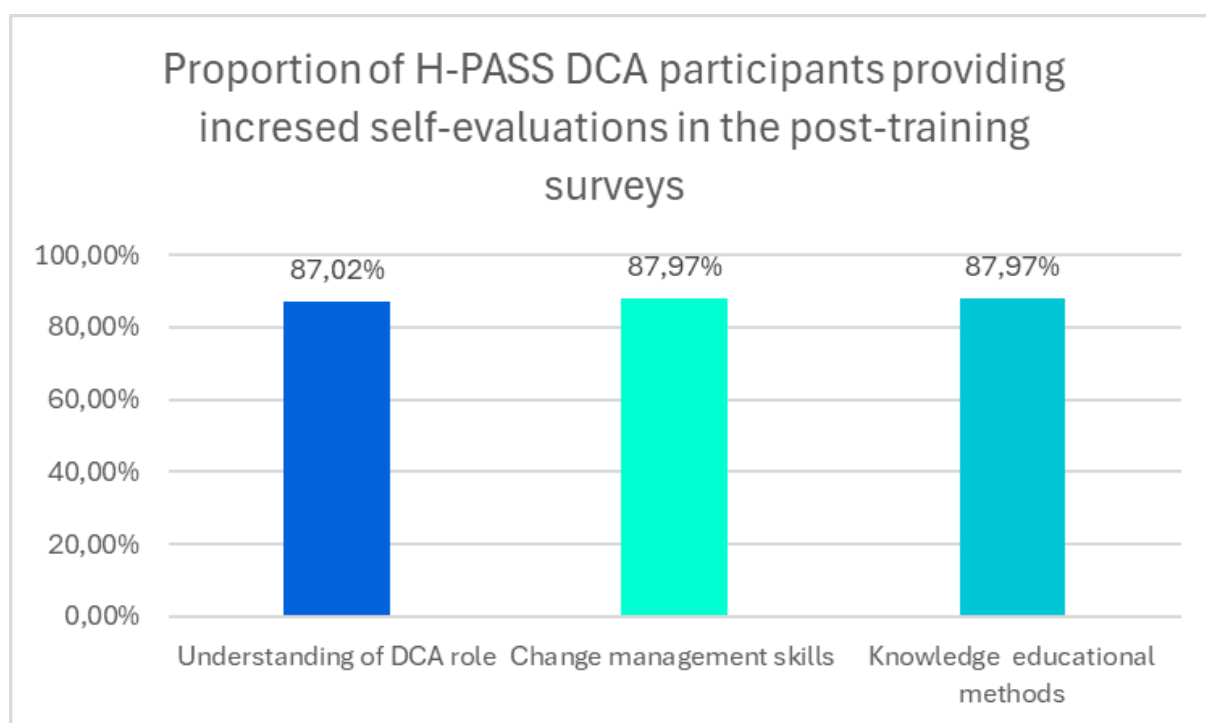


Figure 29. Proportion of DCA participants reporting improved or maintained self-evaluations after the training (n = 131–133)

The indicator “Improved change management skills among participants of the train-the-trainer training (based on pre- and post-training surveys)” was calculated as the proportion of participants whose score on the post-course self-evaluation (Likert scale 1–5) was higher than or equal to their score in the pre-course survey. Based on this definition, the indicator value is 87.97%.

The indicator “Increase in knowledge of educational methods among participants of the train-the-trainer training (based on pre- and post-training surveys)” was calculated as the proportion of participants whose score on the post-course self-evaluation (Likert scale 1–5) was higher than or equal to their score in the pre-course survey. Based on this definition, the indicator value is 87.97%.

Taken together, the results indicate that the DCA training successfully contributed to strengthening participants' leadership and facilitation capacities related to digital transformation, while also maintaining high levels of confidence among those who may have already possessed strong competencies in these areas before the training. This pattern is consistent with earlier evaluation results showing high satisfaction with the DCA training and strong readiness among participants to foster collaboration within the H-PASS network.

The follow-up survey of the DCA training measured the indicator "Utilisation of acquired digital and transversal skills in practice (based on the post-training survey)" and asked participants about specific actions taken as a result of their DCA training participation. The survey was completed by 63 DCA alumni.

Participants were asked whether they had taken actions in their professional or work environment to enable digital innovation or to improve teamwork and collaboration following the training. According to the responses, 58.73% of participants reported that they had taken such actions, indicating that more than half of the respondents had already begun applying the knowledge and skills acquired during the DCA training in their professional practice.

In addition, participants were asked whether they believed that the DCA training had strengthened their leadership skills in facilitating digital transformation within their professional or work environment. The results show (Figure 30.) that 92% of respondents agreed with this statement.

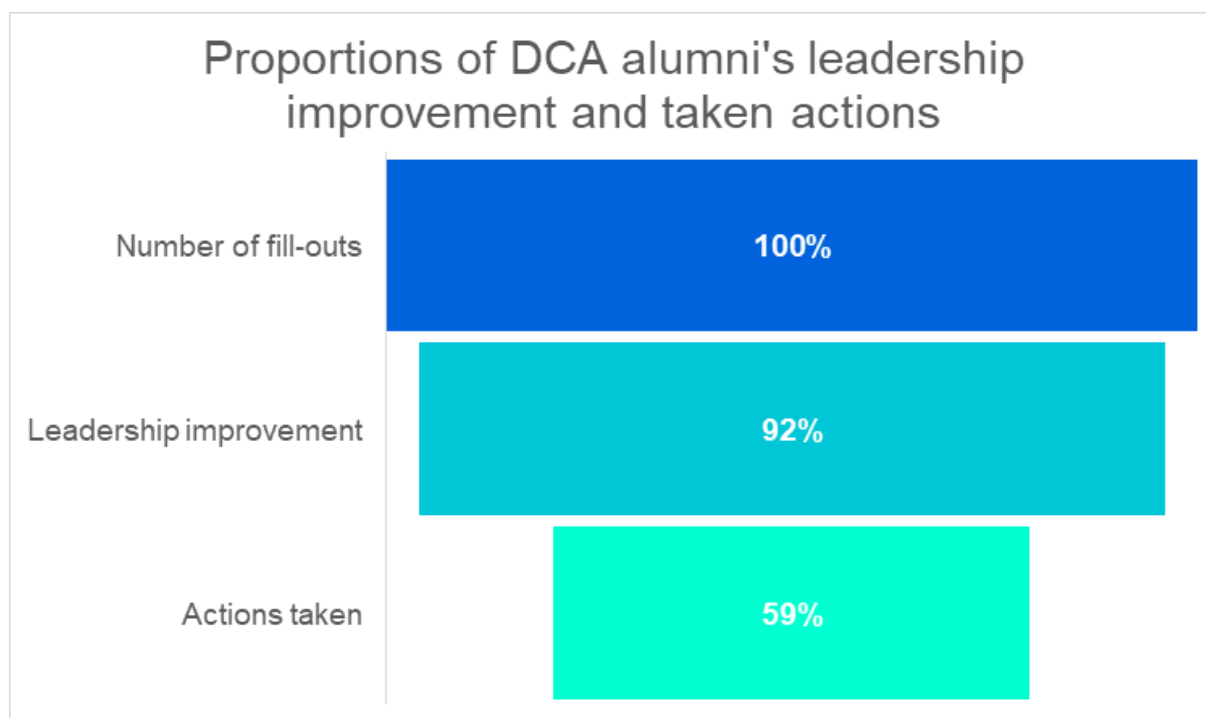


Figure 30. Proportion of Digital Change Agent (DCA) alumni reporting leadership improvement and actions taken in their workplace following the training (n=63)

The indicator “Utilisation of acquired digital and transversal skills in practice (based on the post-training survey)”, measuring improved leadership capabilities in digital settings among participants of the train-the-trainer training, was calculated as the proportion of participants who agreed with the statement: “I believe that the Digital Change Agent training has strengthened my leadership skills in facilitating digital transformation within my professional or work environment.” Based on this definition, the indicator value is 92.06%.

3.9. Directions for improvement and future training

This report presents a synthesis of qualitative feedback collected from participants of the H-PASS programme. The scope of this summary is to identify pedagogical, technical, organisational, and operational areas where improvements may enhance the relevance and effectiveness of the training.

The analysis is based exclusively on participant feedback extracted from the Closing Survey and aims to support the continued evolution of this programme and future programmes.

Some factors should be considered, however, when interpreting the feedback results: Although the training incorporated flexibility, it was not intended to meet all learner preferences, such as fully asynchronous or highly specialised short courses, as the consortium considered interactive and reflective learning elements essential to the methodology. At the same time, in this segment, feedback from all participants are summarized, while some feedback comments were specific to individual national piloting contexts and may therefore not apply equally across all settings. Overall, the consortium believes that a variety of digital and transversal skills training opportunities is needed, allowing professionals to select learning pathways that best fit their needs. In this context, H-PASS can be regarded as a foundational or introductory training programme that supports participants in planning further professional development and future learning pathways.

Identified Areas for Programme Refinement

Participants’ written free-text feedback in the Closing Survey highlighted several recurring areas where adjustments to programme design and delivery could improve learning outcomes. The following sections summarise the main categories of issues reported. The piloting teams monitored these observations throughout the piloting phase and introduced adjustments where feasible.

In some cases, the identified issues may be addressed through local implementation measures, such as the development of profession-specific complementary content or pedagogical approaches that support more individualised learning pathways. However, several of the reported challenges are linked to structural aspects of the training design and could only be addressed through a different programme architecture. For example, fully profession-specific training formats were not compatible with the programme’s core objective of fostering interprofessional learning. Similarly, certain organisational factors—such as

scheduling and session duration—may require adjustments in future training cycles rather than within the current programme framework.

It should also be acknowledged that some challenges are difficult to eliminate entirely, including varying levels of participant engagement in online collaborative activities and occasional technical instability on either the platform or user side.

Despite these constraints, reviewing and documenting the reported issues provides valuable insights into the complexity of designing and delivering large-scale digital training programmes in healthcare settings, and offers important lessons for future programme development.

a) Organisational Aspects

Several operational factors related to programme organisation were identified as potential barriers to participant engagement.

Key issues include:

- Scheduling challenges
 - Friday sessions and programme launches in May–June coincided with previously scheduled vacation periods.
 - This created additional workload pressure for healthcare professionals.
- Session duration
 - Four-hour afternoon sessions were reported as difficult to sustain for participants working full-time in clinical settings.
- Delayed access to learning materials
 - Participants reported delays in uploading course materials.
 - In some cases, resources were not downloadable or printable.
- Administrative enrolment issues
 - Limited lead time between registration and programme start was reported in several cases.
 - Some participants indicated that organisational enrolment occurred without sufficient prior consultation.

b) Pedagogical Aspects

Participants identified several pedagogical challenges affecting the clarity and practical relevance of the training.

Main concerns included:

- Theory–practice imbalance

- Some participants perceived the content as overly theoretical and insufficiently linked to real clinical challenges.
- Linguistic complexity
 - Dense wording and complex terminology increased cognitive load and required repeated reading of materials.
- Programme branding confusion
 - Participants reported uncertainty regarding the relationship between the programme title (“Digitalisation in Healthcare”) and the strong focus on process-management tools such as Gantt charts and workflow diagrams.
- Role-specific relevance
 - Certain modules were perceived as less relevant for non-clinical professionals or specific departments.

c) Technical Aspects

Technical issues affecting the digital learning environment were also reported.

These included:

- VR performance limitations
 - Participants reported long loading times and performance issues when accessing VR modules from personal computers.
- Audio delivery challenges
 - AI-generated text-to-speech narration was sometimes perceived as mechanical or distracting.
- Platform usability issues
 - The learning platform interface was frequently described as unintuitive and difficult to navigate.
- System instability
 - Technical disruptions occurred during some synchronous sessions, affecting continuity of learning.

d) Interactive and Collaborative Aspects

Participants also highlighted challenges related to interaction and collaboration within the training environment.

Reported issues include:

- Limited participation in group work
 - Online teamwork was occasionally affected by passive participation, including limited use of cameras or microphones.
- Insufficient guidance in asynchronous modules

- Participants reported feeling insufficiently supported during self-directed learning segments.
- Breakout group management limitations
 - Technical limitations sometimes prevented colleagues from the same institution from being placed in the same digital working group.
- Limited opportunities for discussion
 - Participants requested more time for debate, Q&A sessions, and direct interaction with trainers.

Participant Needs and Development Areas

The thematic analysis of participant feedback highlights several areas in which future training programmes could further support professional development and institutional digital transformation. A number of the suggestions identified—such as tiered digital literacy training, increased in-person learning formats, and more profession-specific training modules—had been considered during the design phase of the H-PASS training. However, given the operational and contextual constraints of the project, as well as professional decisions linked to the project’s objectives and jointly defined learning outcomes, the piloting partners opted to pursue alternative implementation approaches.

a) Need for Practical Application

Participants expressed a strong preference for training formats that closely reflect real clinical and organisational contexts. There is clear interest in expanding the programme’s practical components, including:

- Hands-on simulations demonstrating the application of digital technologies in clinical settings.
- Field visits or observational learning opportunities in healthcare institutions where digital tools such as IoT and AI solutions are already implemented.
- Case studies of real system implementations, including examples of Electronic Patient Record (EPR) deployment, which participants identified as a foundational element of digital transformation.

b) Development of Advanced Digital Competencies

Participants also indicated a demand for deeper engagement with advanced digital technologies, including:

- Artificial intelligence applications: Practical training on prompt engineering, identification of AI-generated inaccuracies (“hallucinations”), and comparative evaluation of tools such as ChatGPT and Microsoft Copilot.

- Specialised digital tools: Practical demonstrations of technologies relevant to healthcare workflows, including IoT-based systems, AI-supported documentation tools, and automated meeting summaries.
- Digital ethics and cultural competence: Exploration of the human-centred implications of digital environments, particularly in relation to maintaining patient-centred care in highly digitalised systems.

c) Personalised Learning Pathways

Feedback indicates that a single, uniform curriculum may not adequately address the diversity of professional roles represented among participants.

Participants highlighted the potential benefits of:

- Profession-specific learning modules addressing the needs of different professional groups, such as clinicians, healthcare managers, and public health specialists.
- Tiered digital literacy training, recognising the varying levels of digital competence among healthcare professionals.

d) Human-Centred Support Structures

Despite the digital focus of the programme, participants emphasised the importance of accessible human support mechanisms.

Suggested improvements include:

- Direct human technical support for troubleshooting platform issues.
- Coaching or mentoring opportunities to assist participants with applying newly acquired skills in their professional environments.
- More frequent opportunities for live interaction with trainers, including structured question-and-answer sessions.

4. Country reports

4.1. Cyprus

4.1.1. Indicator summary

Satisfaction rate (evaluated with 4 or 5): 92,9% (n=41)

Satisfaction rate (evaluated with 5): 61,9% (n=41)

Breakdown	Number of health professionals completing the H-PASS training
In total	75/48
Medical doctors	26
Nurses	5
Allied health professionals	16
Other	1
Pharmacists	0
CME credential attainment	33
TtT participants	21
TtT participants / Trainer pool	11
TtT participants / DCA training course	10

Table CY-1. H-PASS output indicators

Breakdown	Number of health professionals completing the H-PASS training
18–24	1
25–34	16
35–44	12
45–54	9
55–64	3
65 or older	4
No data on age	3
Female	32
Male	16

Table CY-2. H-PASS participants by age groups and by gender

Breakdown	Target/Result
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/100%
Improvement in transversal skills among training participants (based on pre- and post-training surveys)	75%/100%

Improved capabilities for teamwork for teamwork in digital settings (based on post-training surveys)	75%/100%
Increased use of digital tools in clinical work (based on post-training survey)	75%/92,31%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/87,18%
Utilization of acquired digital and transversal skills in practice (based on post-training survey)	50%/ 60%
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/100%
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/-
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/-
Utilisation of acquired digital and transversal skills in practice (based on post-training survey) <i>Improved capabilities for leadership in digital settings among participants of train-the-trainer courses</i>	50%/ 80%

Table CY-3. H-PASS outcome indicators

4.1.2. Demographics of the H-PASS training course

The Cypriot sample shows a diverse but mid-career–dominated participant group, with strong representation of highly educated healthcare professionals.

In terms of age distribution (Figure CY-1.), the largest group of participants falls within the 25–34 age range (32%), followed by 45–54 (28%) and 35–44 (21%). Older participants are also well represented, with 12% aged 55–64 and 5% aged 65+, while younger participants aged 18–24 account for only 2%. This indicates that the training primarily reached early- to mid-career professionals, with a notable inclusion of more experienced age groups.

Regarding gender (Figure CY-2.), the sample is predominantly female (65%), with 35% male participants, reflecting the gender distribution commonly observed in healthcare professions.

The educational background of participants is notably high (Figure CY-3.). A strong majority hold a Master’s degree (76%), followed by Bachelor’s degree holders (13%), Doctorate/PhD (8%), and a small proportion with VET qualifications (3%). This highlights a highly qualified participant group, suggesting strong baseline academic capacity.

Looking at professional roles (Figure CY-4.), the majority of participants are physicians (58%), followed by nurses (14%) and allied health professionals (2%), while administrative staff (3%) and a relatively large “other” category (23%) are also present. This distribution indicates that the training primarily engaged clinical professionals, particularly physicians.

In terms of work experience, the group is skewed towards more experienced professionals (Figure CY-5.). The largest share reports more than 20 years of experience (39%), followed by 1–5 years (30%) and 11–20 years (19%), with smaller proportions in 6–10 years (7%) and less than 1 year (5%). This suggests that the training attracted a substantial number of highly experienced practitioners, alongside a meaningful cohort of early-career professionals.

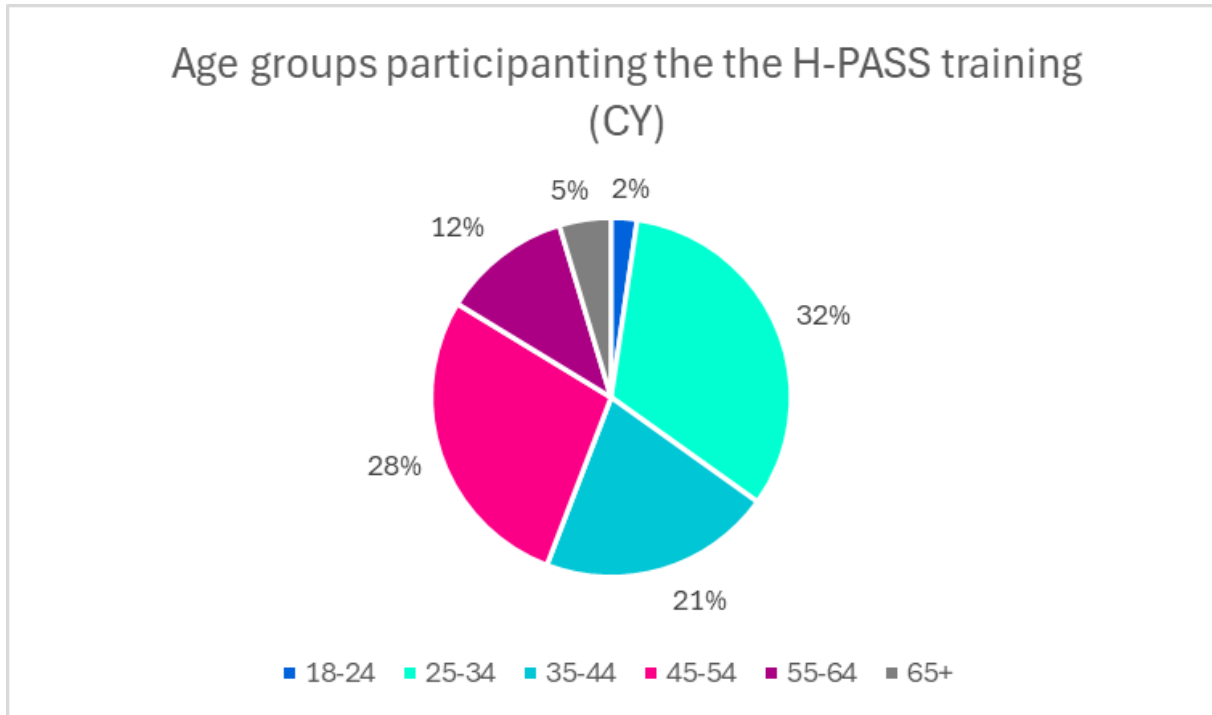


Figure CY-1. Age groups participating in the H-PASS training (n = 43)

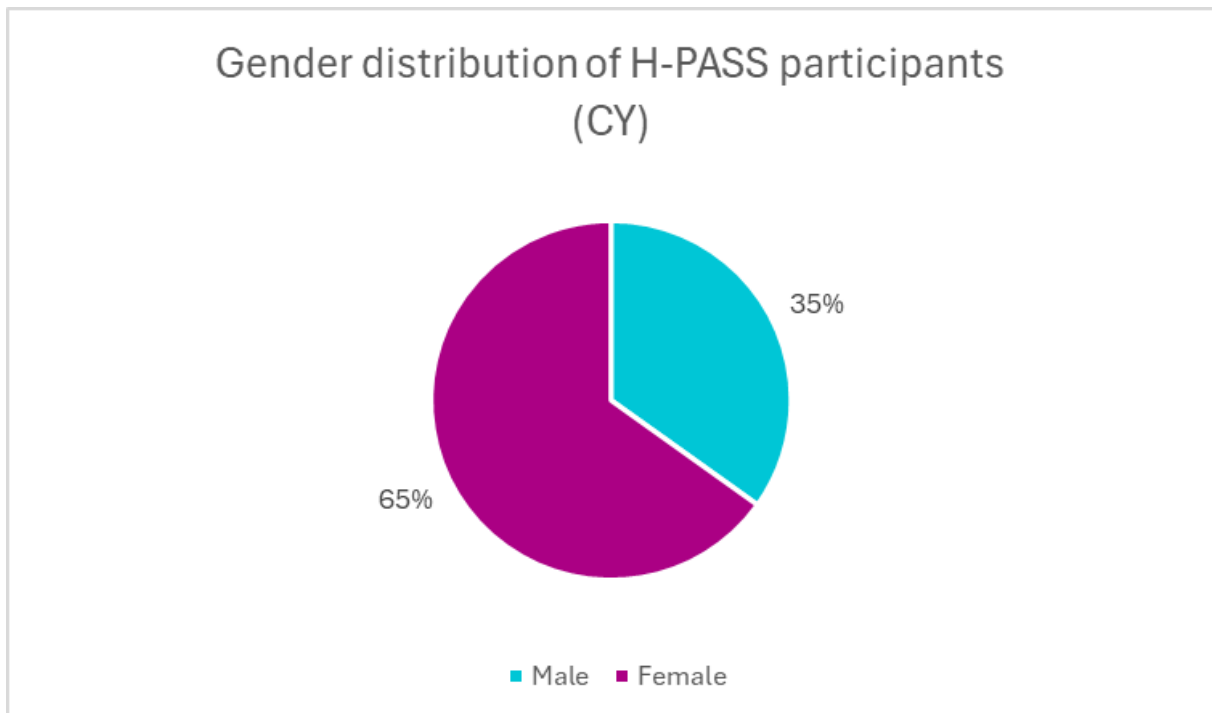


Figure CY-2. Gender distribution of H-PASS participants (n = 43)

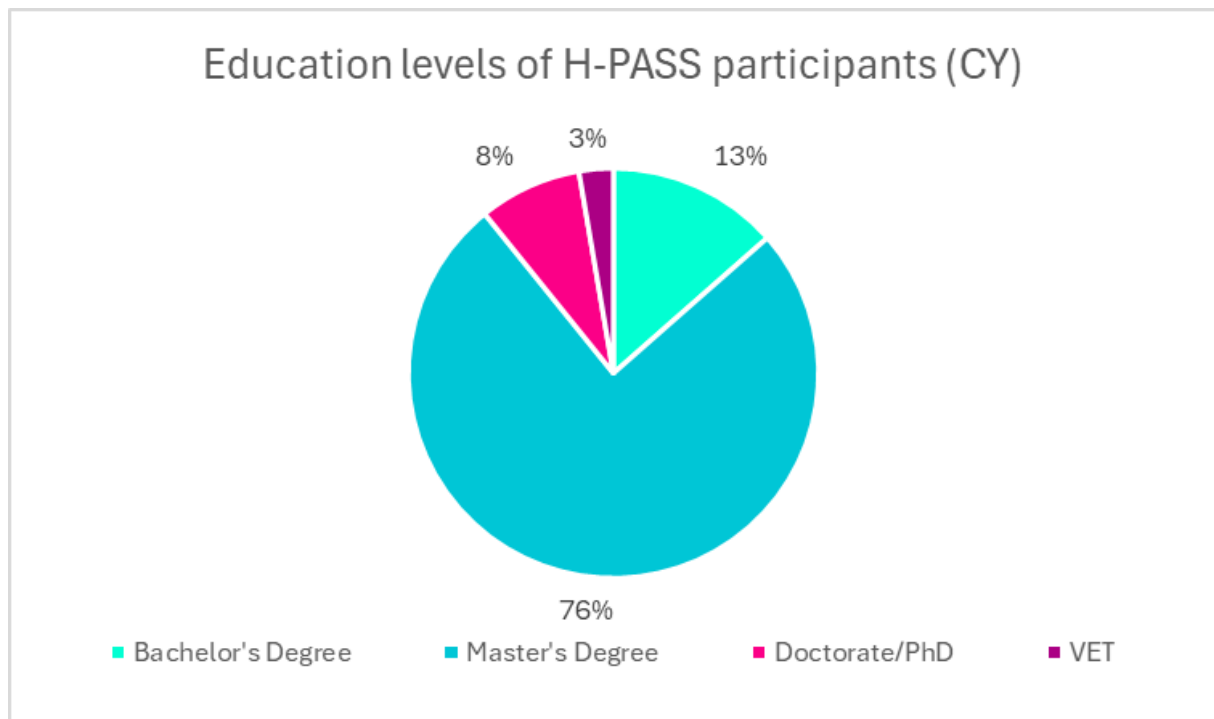


Figure CY-3. Education levels of H-PASS participants (n = 37)

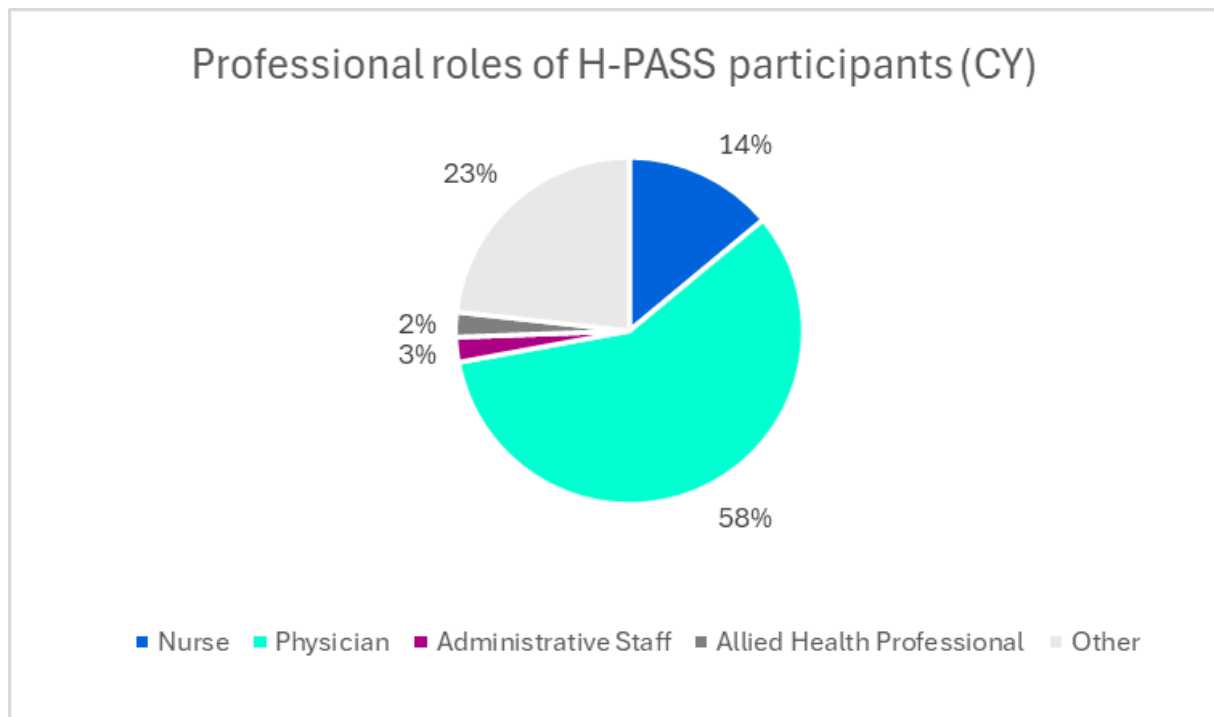


Figure CY-4. Professional roles of H-PASS participants (n = 43)

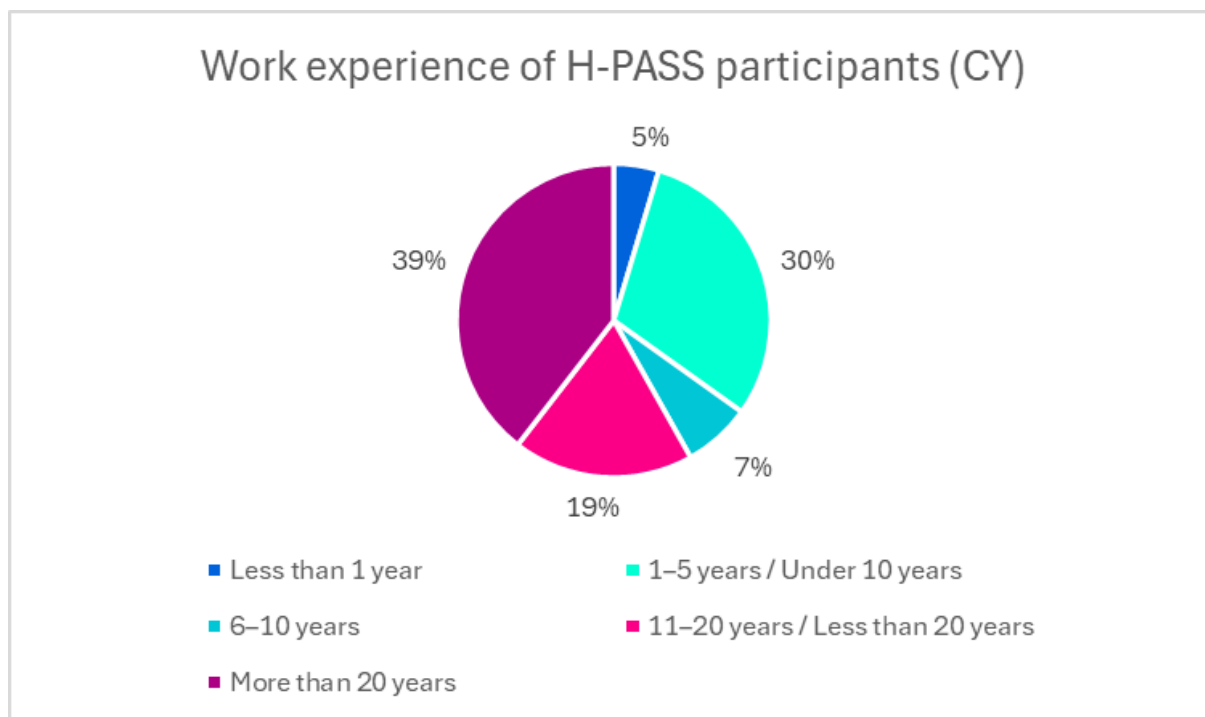


Figure CY-5. Work experience of H-PASS participants ($n = 43$)

The Cypriot sample is characterised by a strong concentration in the private sector, full-time employment, and urban settings.

Regarding work facilities (Figure CY-6.), the majority of participants are employed in private institutions (72%), followed by public institutions (21%). A small proportion report working in both public and private settings (2%) or in other types of organisations (5%). This distribution indicates that the training in Cyprus primarily engaged professionals from the private healthcare sector.

In terms of employment status (Figure CY-7.), most participants are full-time employees (85%), with smaller shares in part-time positions (10%) and contract-based roles (5%). This suggests a relatively stable workforce with strong institutional attachment.

The work location data shows a highly homogeneous pattern (Figure CY-8.), with 100% of participants working in urban areas. This reflects a clear urban concentration of the training participants and may point to limited reach into rural healthcare settings.

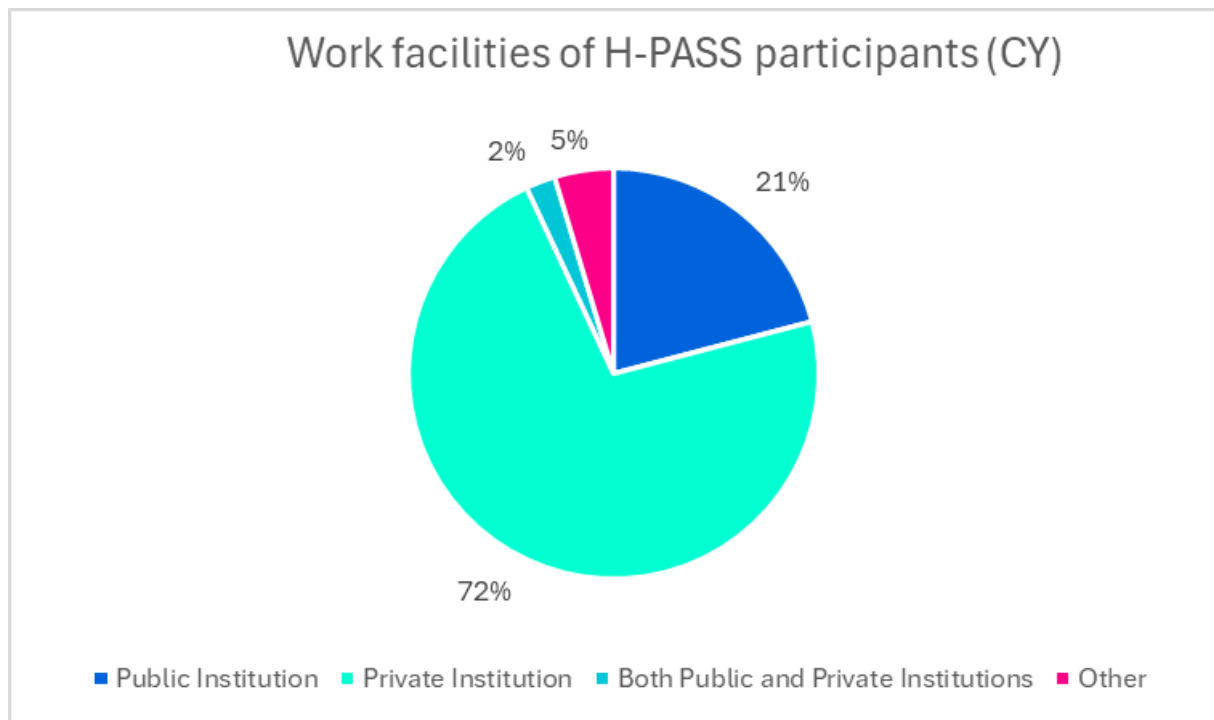


Figure CY-6. Work facilities of H-PASS participants ($n = 43$)

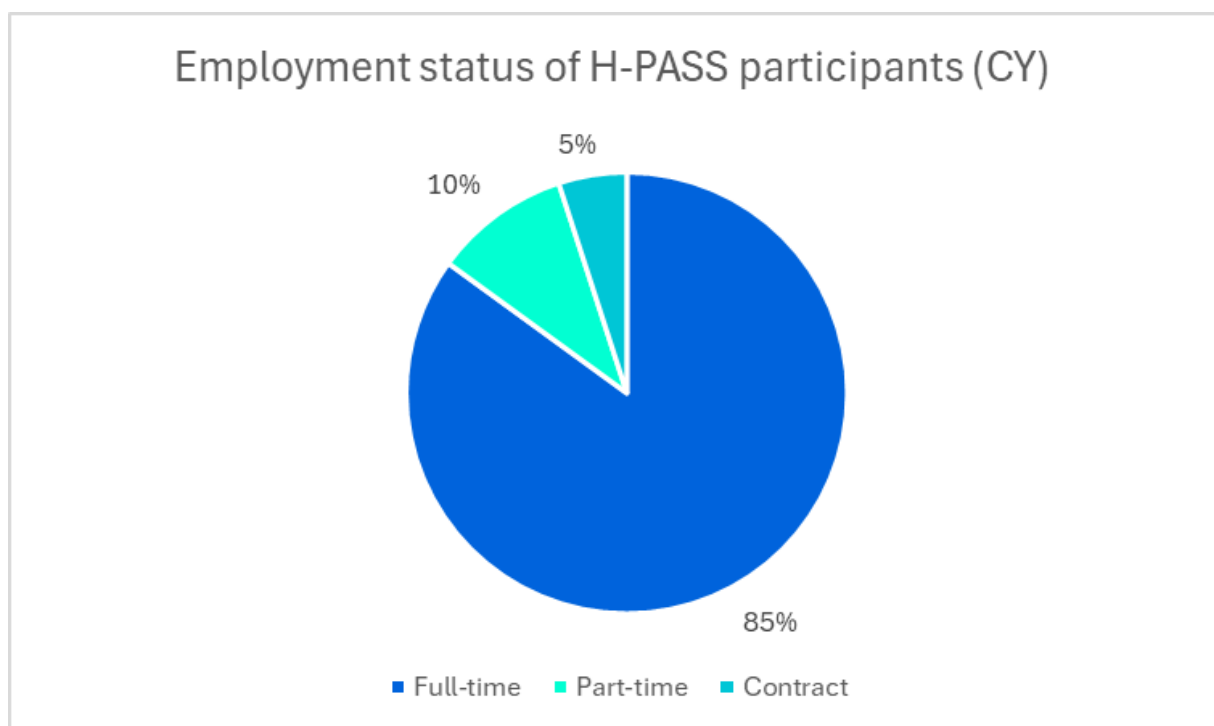


Figure CY-7. Employment status of H-PASS participants ($n = 40$)

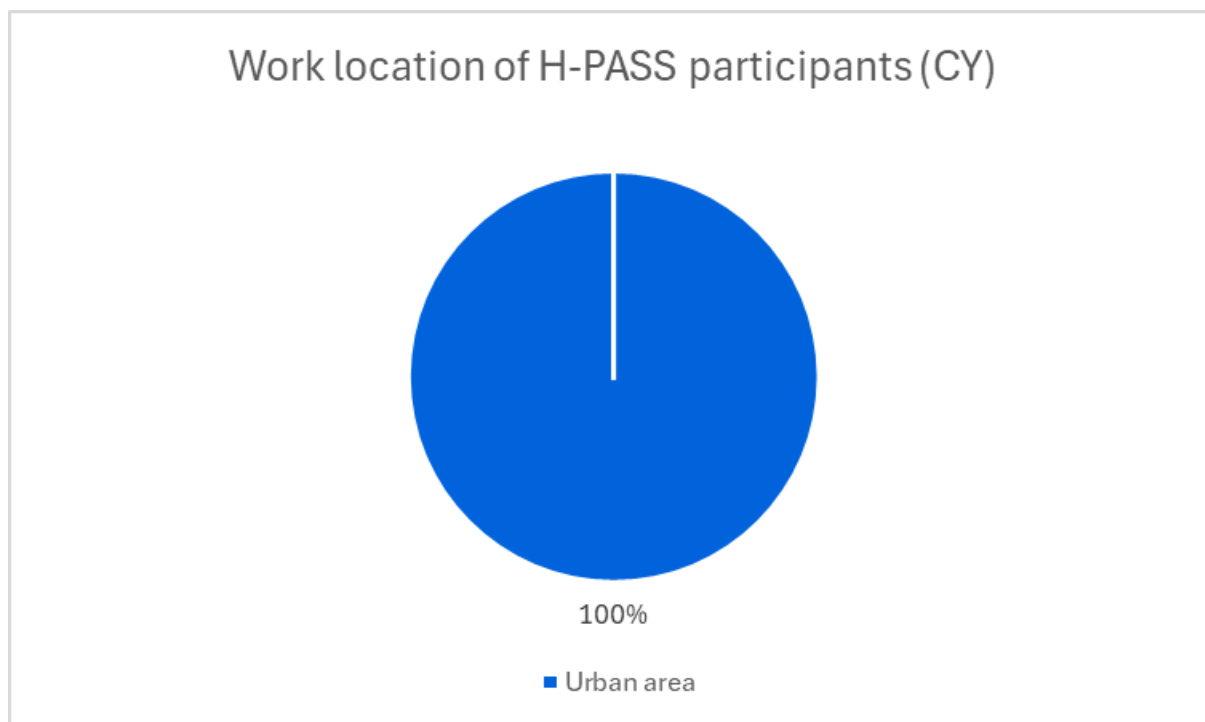


Figure CY-8. Work location of H-PASS participants ($n = 43$)

4.1.3. Satisfaction with the H-PASS training

In terms of overall satisfaction (Figure CY-9.), a clear majority of participants rated the training at the highest level, with 63% assigning a score of 5, and a further 32% rating it as 4. Only very small proportions selected lower scores (3% rating 2 and 2% rating 3, with no ratings at 1). This indicates an overwhelmingly positive reception, with 95% of participants expressing high or very high satisfaction (scores 4–5). Compared to consortium-level findings, Cyprus shows a similarly strong satisfaction pattern, though with a slightly higher concentration at the top score, suggesting particularly strong appreciation of the training.

Regarding the applicability of the training, responses are also highly positive (Figure CY-10.). Nearly half of participants (49%) rated applicability at the highest level (5), while 39% rated it as 4 and 12% as 3, with no lower ratings reported. This means that 88% of participants perceive the training as highly applicable (scores 4–5). Compared to consortium-level results, Cyprus again demonstrates a consistently strong applicability perception, with a slightly more balanced distribution across the top categories rather than a strong concentration in only the highest score.

The findings suggest that the H-PASS training in Cyprus was perceived as both highly satisfactory and practically relevant, with results closely mirroring the positive trends observed across the consortium, while indicating particularly strong endorsement among participants.

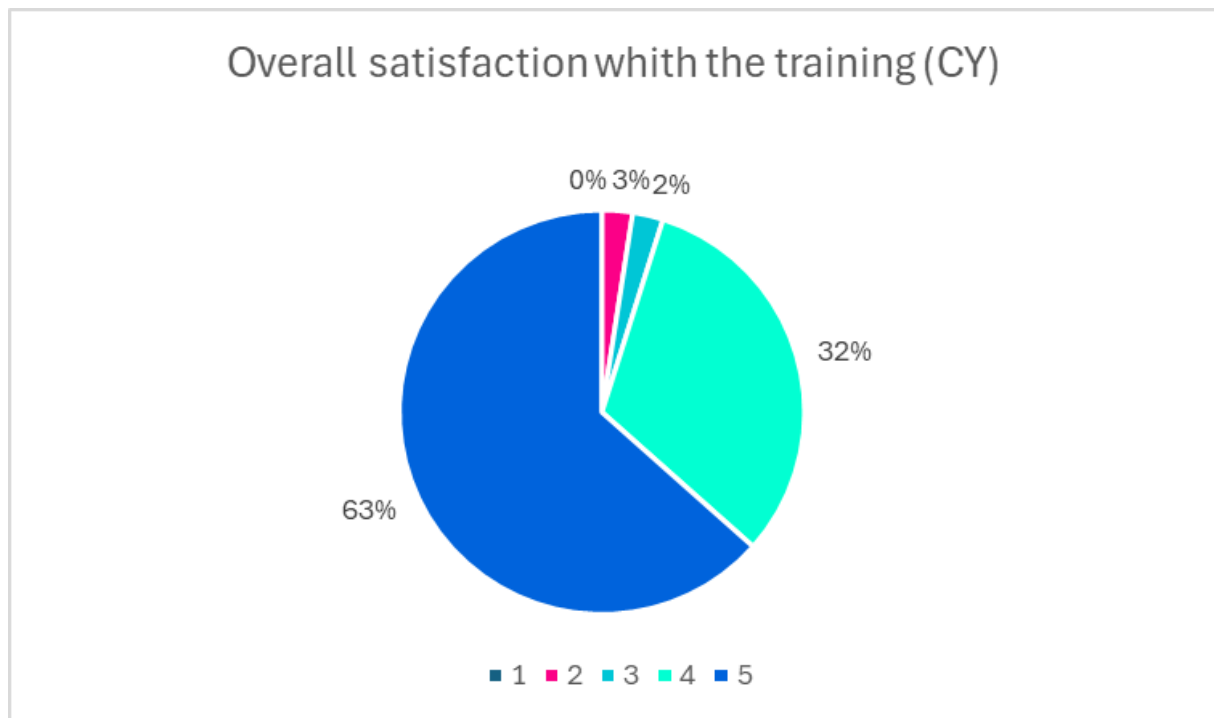


Figure CY-9. Overall satisfaction with the training (n = 41)

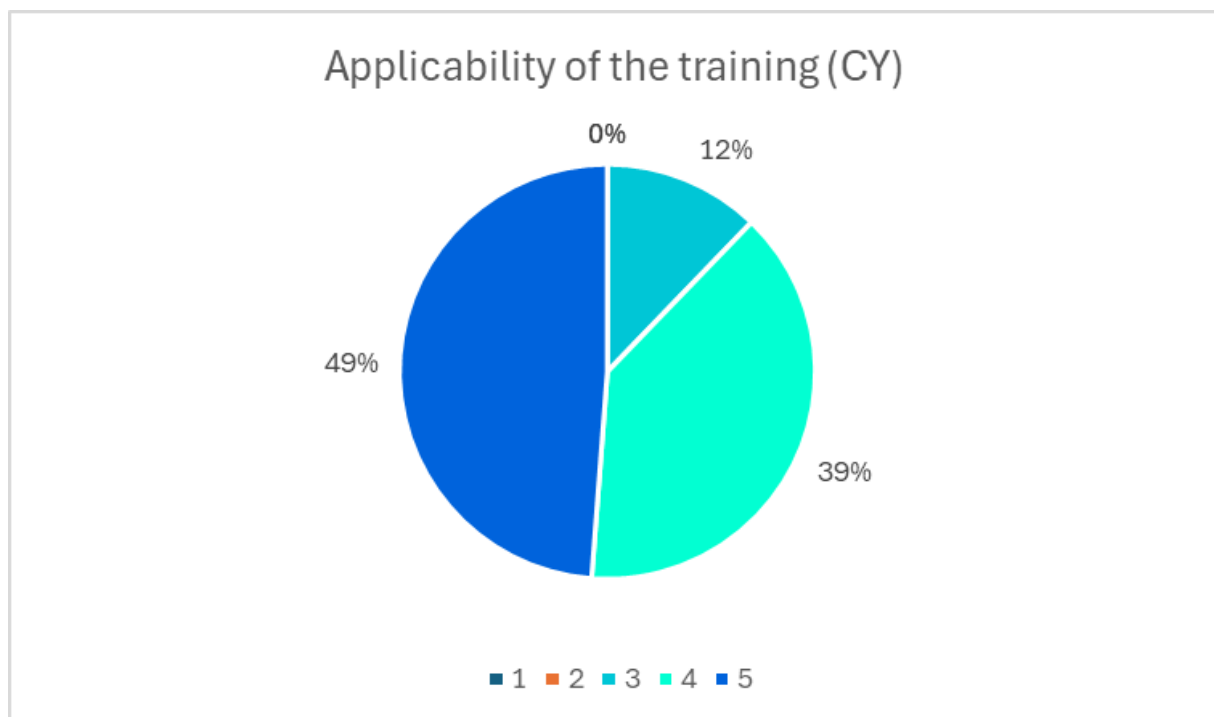


Figure CY-10. Applicability of the training (n = 41)

4.1.4. Digital and transversal skill development

In terms of overall perceived improvement (Figure CY-11.), the majority of Cypriot participants reported significant gains. Nearly half (49%) indicated that their digital skills improved “significantly” (level 4), while a further 32% reported improvement “to a great deal” (level 5). Additionally, 17% reported moderate improvement (level 3), and only 2% indicated slight improvement (level 2), with no participants selecting “not at all”. This means that 81% of participants experienced strong improvement (levels 4–5). Compared to consortium-level results, Cyprus shows a similarly positive pattern, with a slightly higher concentration in the “significant” category rather than the highest category, suggesting solid but more moderately distributed gains.

Looking at specific digital competences (DigComp 2.2), improvements are observed across all areas (Figure CY-12.). The highest levels of improvement are reported in safety (26) and communication and collaboration (25), followed closely by information and data literacy (23) and problem solving (21). Digital content creation (14) shows comparatively lower, though still substantial, improvement.

This distribution mirrors the consortium-level pattern, where safety and communication-related competences tend to show the strongest gains, while content creation remains comparatively less improved, likely reflecting its higher complexity and more specialised nature.

The findings indicate that the H-PASS training in Cyprus was effective in enhancing participants’ digital competences across all domains, with particularly strong outcomes in areas related to safe and collaborative use of digital technologies.

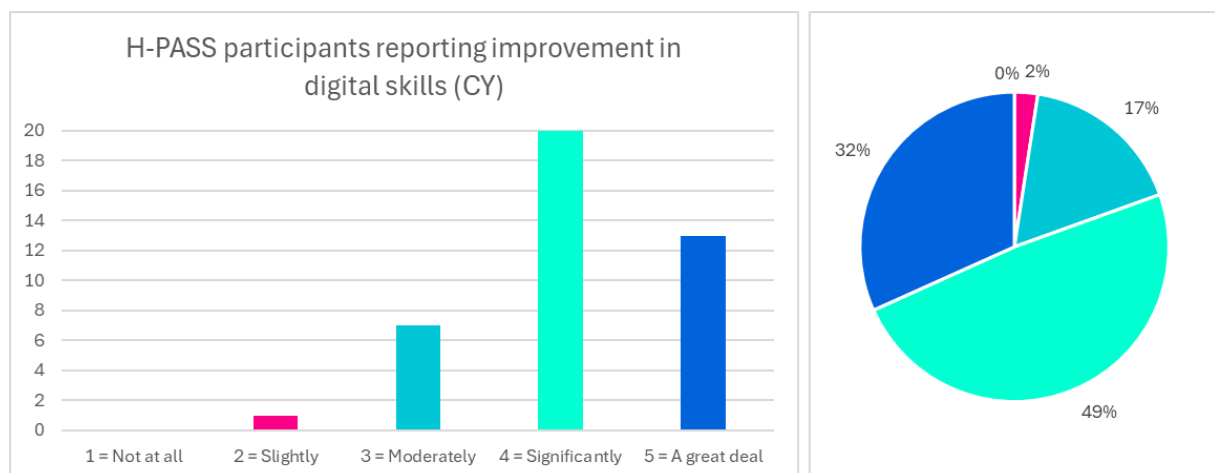


Figure CY-11. H-PASS participants reporting improvement in digital skills (n = 41)

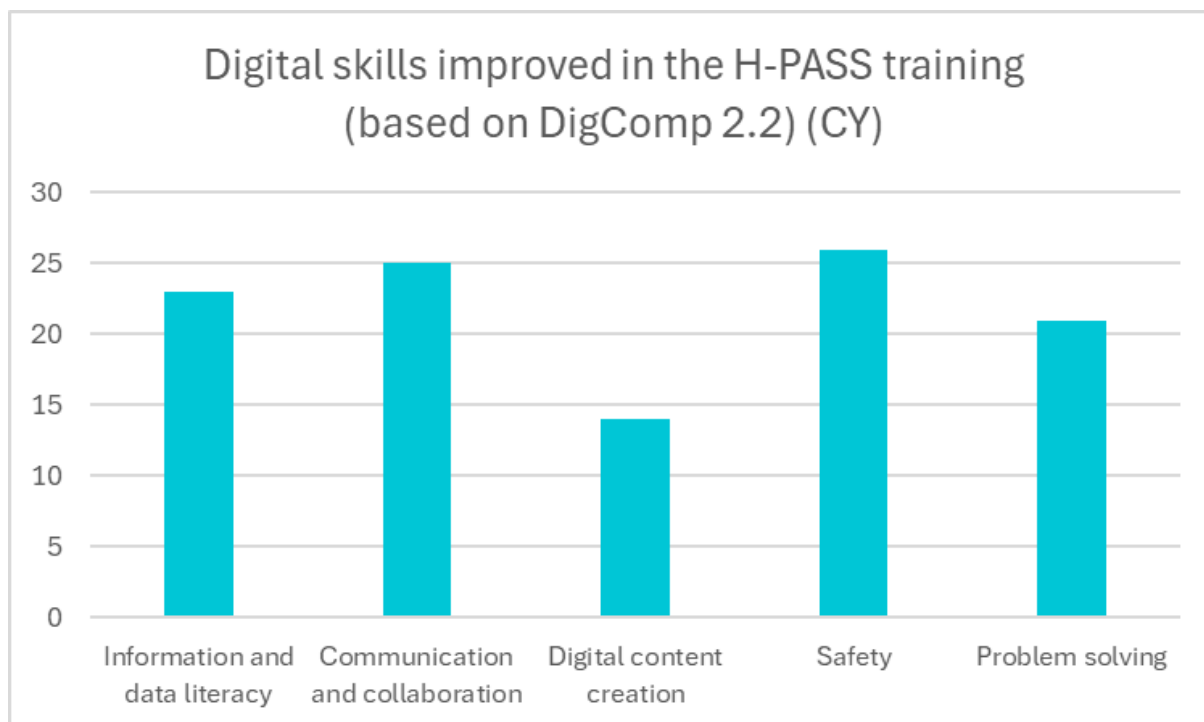


Figure CY-12. Digital skills improved in the H-PASS training based on DigComp 2.2 (n = 42)

Regarding overall perceived improvement of transversal skills in the Cypriot training (Figure CY-13.), 37% of participants reported significant improvement (level 4) and 34% improvement to a great extent (level 5), while 27% indicated moderate improvement (level 3). Only 2% reported slight improvement (level 2), and no participants selected “not at all”. This indicates that 71% of participants experienced strong improvement (levels 4–5). Compared to consortium-level findings, Cyprus shows a slightly more evenly distributed pattern across levels 3–5, suggesting that while improvements are widespread, they may be perceived with more nuance rather than concentrated at the highest level.

Looking at specific transversal competences (LifeComp) (Figure CY-14.), the highest levels of improvement are reported in communication (27), followed by collaboration (24) and growth mindset (23). Moderate improvements are observed in flexibility (17) and critical thinking and managing learning (15 each). Lower, though still notable, improvements are seen in wellbeing and empathy (12 each) and self-regulation (10).

These results show that the H-PASS training in Cyprus effectively supported the development of key transversal competences, particularly those related to communication, collaboration, and adaptive mindsets, which are essential for functioning in digitally enabled healthcare environments.

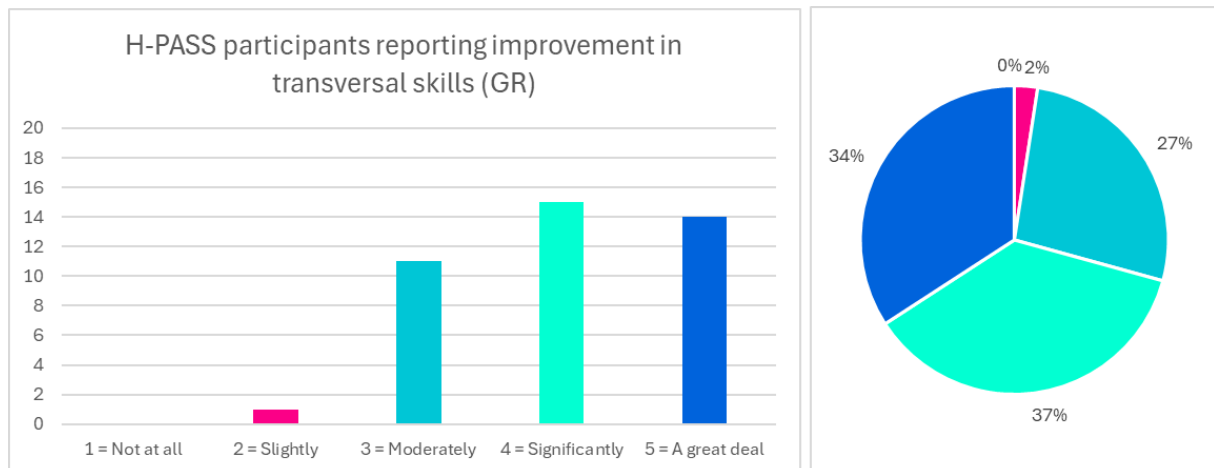


Figure CY-13. H-PASS participants reporting improvement in transversal skills (n = 41)

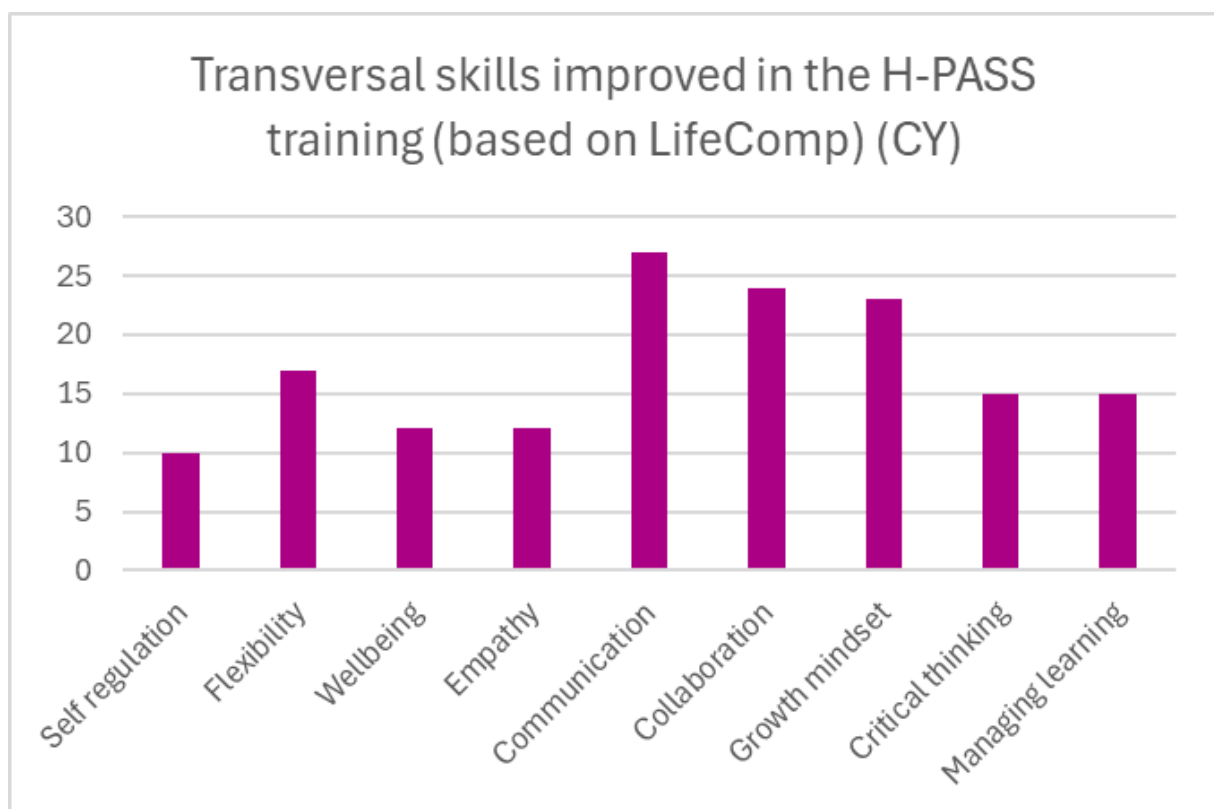


Figure CY-14. Transversal skills improved in the H-PASS training based on LifeComp (n = 42)

The majority of participants indicate moderate to high increases in confidence in digital teamwork (Figure CY-15.), with 40% reporting improvement to a great extent (level 5) and another 40% indicating significant improvement (level 4). A further 20% report moderate improvement (level 3), while no participants selected lower categories (levels 1–2). This means that 80% of participants experienced strong gains in confidence (levels 4–5).

Compared to consortium-level results, Cyprus demonstrates a particularly strong concentration in the highest improvement categories, with no reported negative or minimal changes. This suggests that the training was especially effective in enhancing participants' confidence in collaborative digital environments, which are critical for modern healthcare practice.

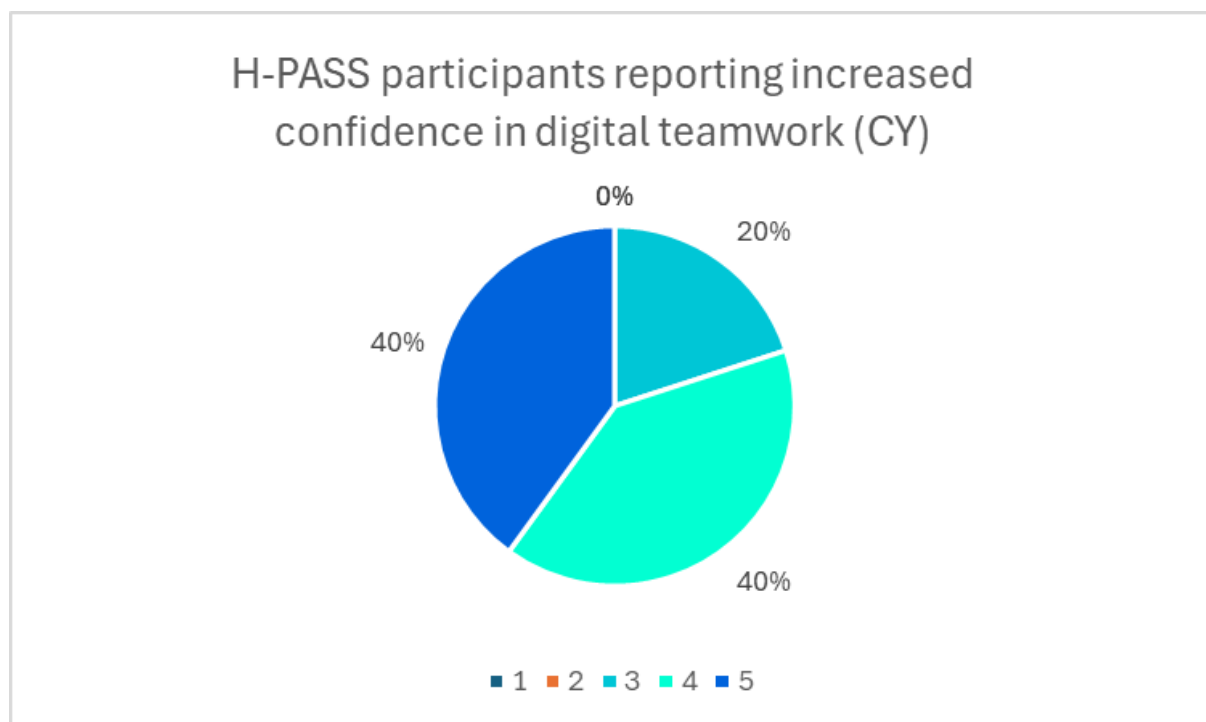


Figure CY-15. H-PASS participants reporting increased confidence in digital teamwork (n = 40)

4.1.5. Impact on digital tool usage

Cypriot participants report a clear increase in the use of digital tools, particularly for professional tasks (Figure CY-16.). The majority of participants (59%) report using digital tools significantly more, while 33% indicate slightly increased use. Only 8% report using digital tools the same amount or less, and no participants consider them not relevant. This indicates that 92% of participants increased their use of digital tools, with a strong emphasis on substantial change. Compared to consortium-level results, Cyprus demonstrates a more pronounced shift toward “significantly more” usage, suggesting that participants not only adopted digital tools but integrated them more deeply into their professional practice.

A similar pattern is observed for administrative tasks (Figure CY-17.), where again 59% of participants report significantly increased use, and 28% report slight increases. A smaller share (10%) indicates no increase or reduced use, and 3% consider digital tools not relevant for administrative purposes. This results in 87% of participants reporting increased use, with a dominant share experiencing substantial change.

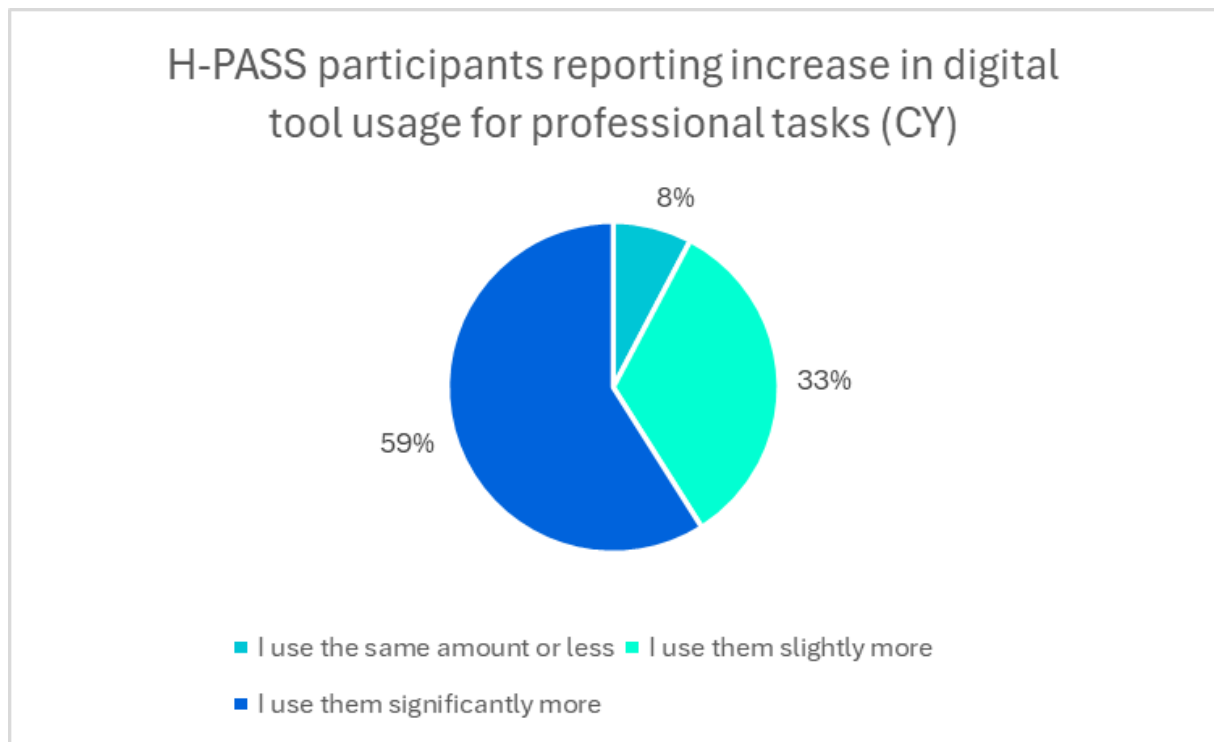


Figure CY-16. H-PASS participants reporting increase in digital tool usage for professional tasks (n = 39)

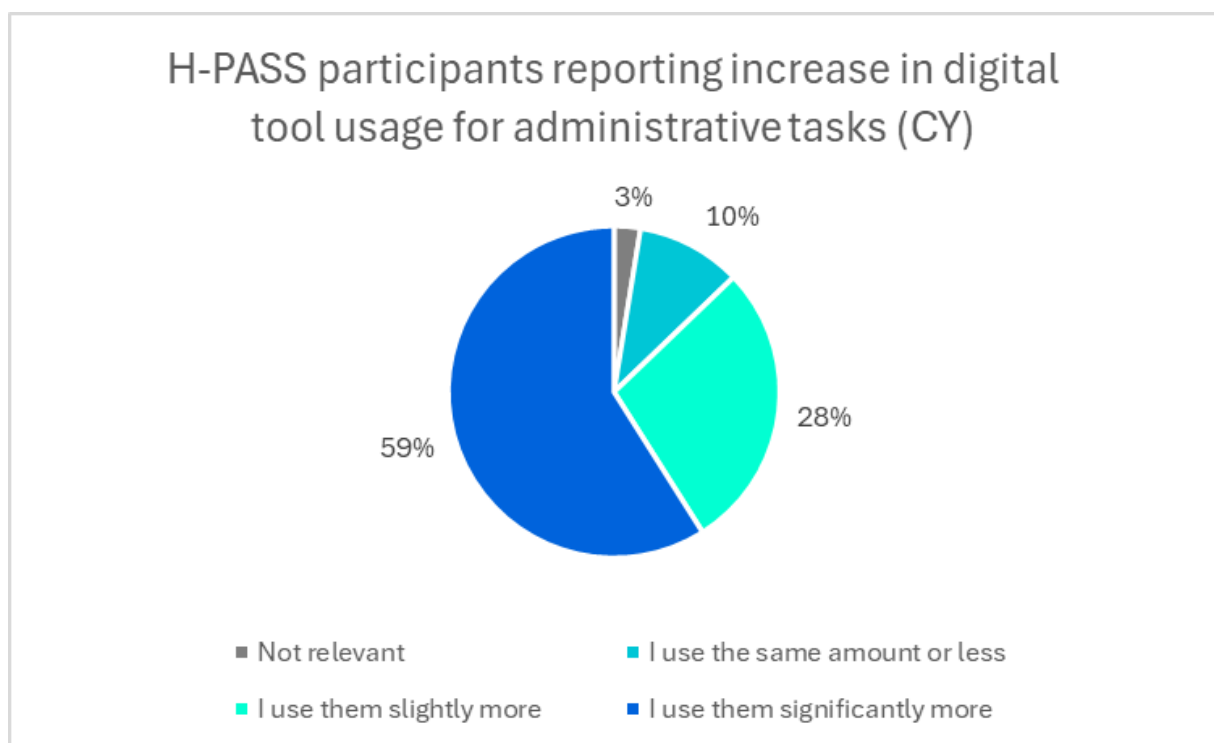


Figure CY-17. H-PASS participants reporting increase in digital tool usage for administrative tasks (n = 39)

4.1.6. Training follow-up results

The follow-up data for Cyprus provide indicative insights into perceived and observed organisational changes resulting from the H-PASS training, although the very small number of respondents requires cautious interpretation.

In terms of perceived organisational change (Figure CY-18.), 60% of participants report improvements, while 40% perceive no change. Compared to consortium-level findings (where perceived improvement was substantially higher), Cyprus shows a more moderate perception of organisational impact.

The observed organisational changes further nuance this picture (Figure CY-19.). Among respondents, improvements were most frequently reported in teamwork and workflow (2 mentions each), followed by task-shifting (2 mentions), while workload was less frequently identified (1 mention). At the same time, a considerable proportion of participants did not report observable changes across these domains, reinforcing the mixed perception seen in the previous figure. Participants marked 2,33 areas of improvement in the survey on average.

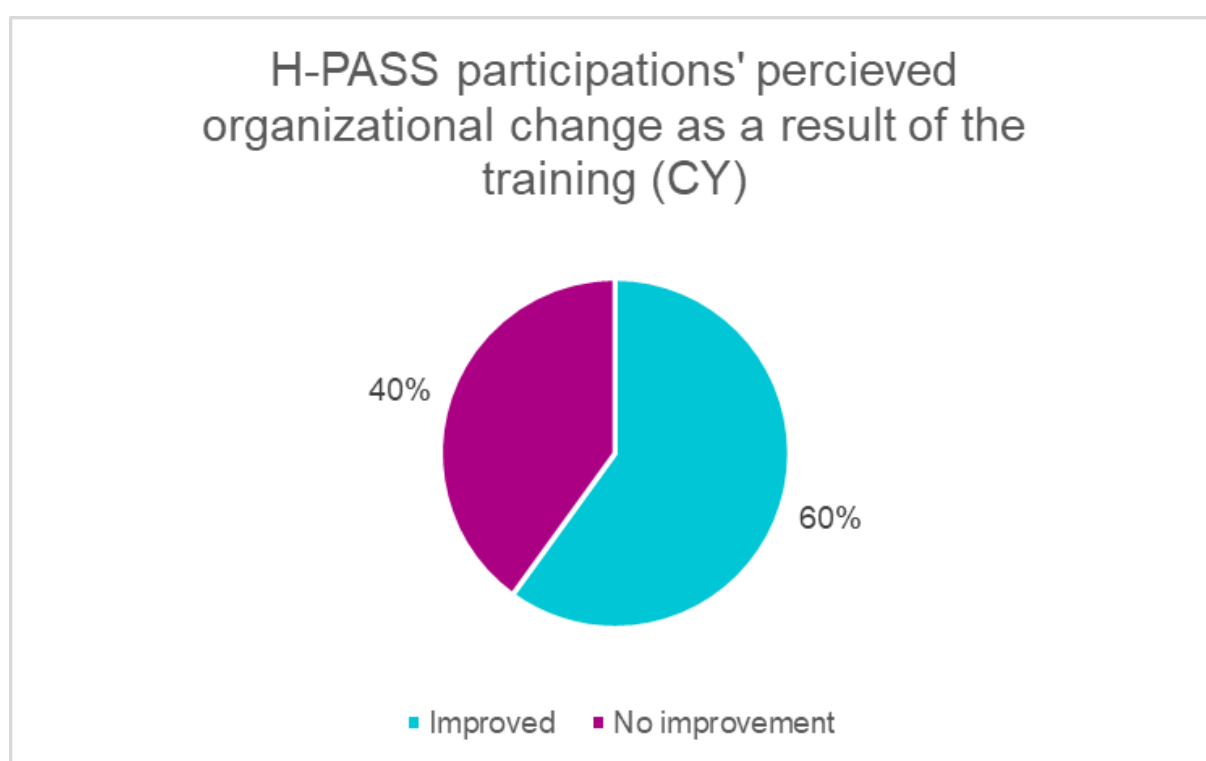


Figure CY-18. H-PASS participants' perceived organisational change as a result of the training (n = 5)

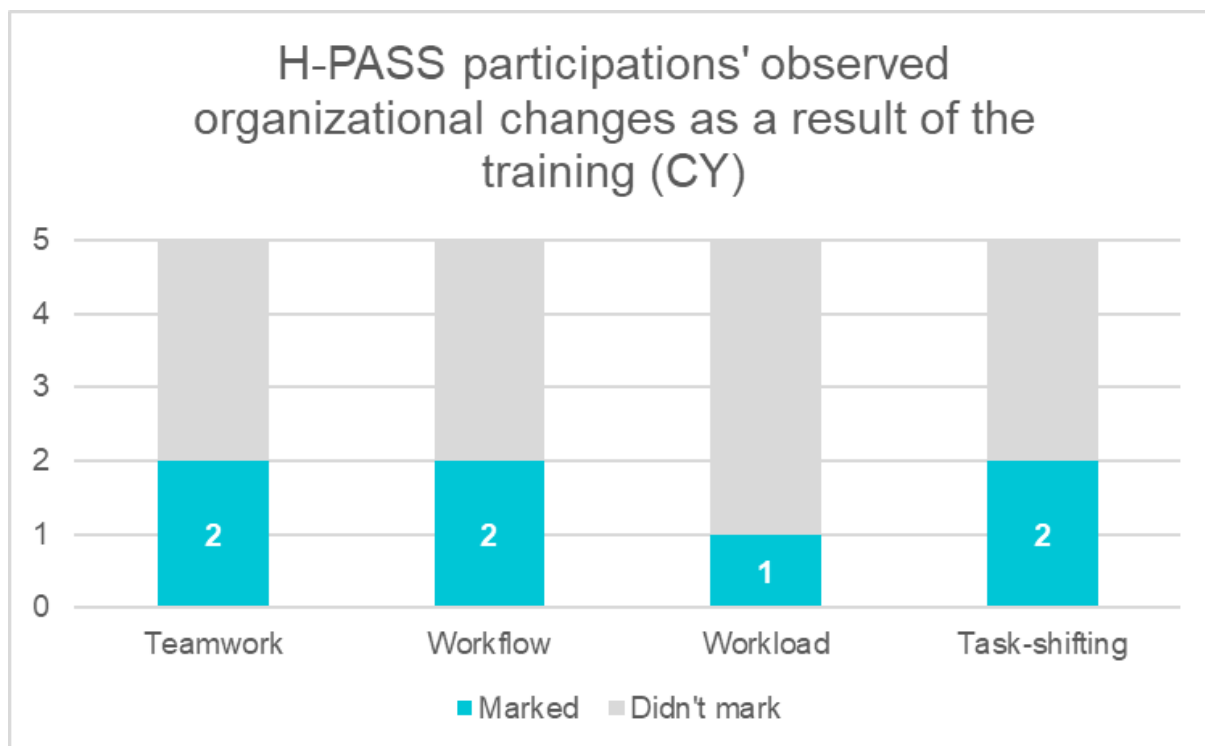


Figure CY-19. H-PASS participants' perceived organisational change as a result of the training (n = 5)

4.1.7. Module evaluation overview

The evaluation of H-PASS modules in Cyprus indicates consistently high satisfaction across all evaluation aspects, with scores generally ranging between 4.1 and 4.7, confirming a strong overall appreciation of the training content and delivery.

Across evaluation aspects (Figure CY-20.), ME1 – Organisation and ME5 – Learning experience receive particularly high scores, especially in Module 4 (M4), where both aspects reach approximately 4.7, representing the highest ratings across the Cypriot modules. This suggests that participants perceived the later stages of the training as especially well-structured and engaging. Similarly, ME3 – Relevant and useful and ME2 – Technical aspects also score highly across modules, typically above 4.4, indicating that both the content relevance and technical delivery met participants' expectations.

In contrast, ME4 – Matching development goals tends to receive slightly lower scores compared to other aspects, particularly in Modules 1 and 2 (around 4.11 and 4.16). While still positive, this may suggest that earlier modules were perceived as somewhat less aligned with participants' individual professional needs. However, this aspect shows improvement in later modules, particularly in M4, indicating a better alignment as the training progressed.

Looking at module-level performance (Figure CY-21.), Module 4 consistently achieves the highest ratings across all evaluation dimensions, followed by Module 2, while Module 1 tends to receive comparatively lower scores, especially regarding goal alignment and learning experience. This pattern mirrors consortium-level trends, where later modules are often

evaluated more positively, likely reflecting increasing familiarity with the training format and cumulative learning effects.

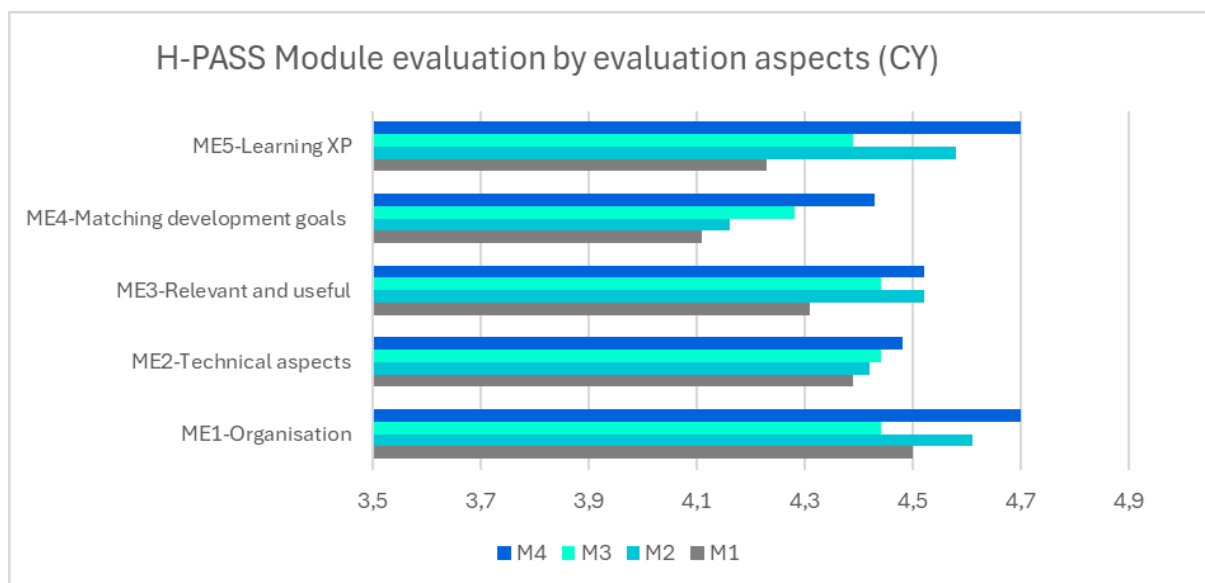


Figure CY-20. H-PASS Module evaluation by evaluation aspects ($n = 18-36$)

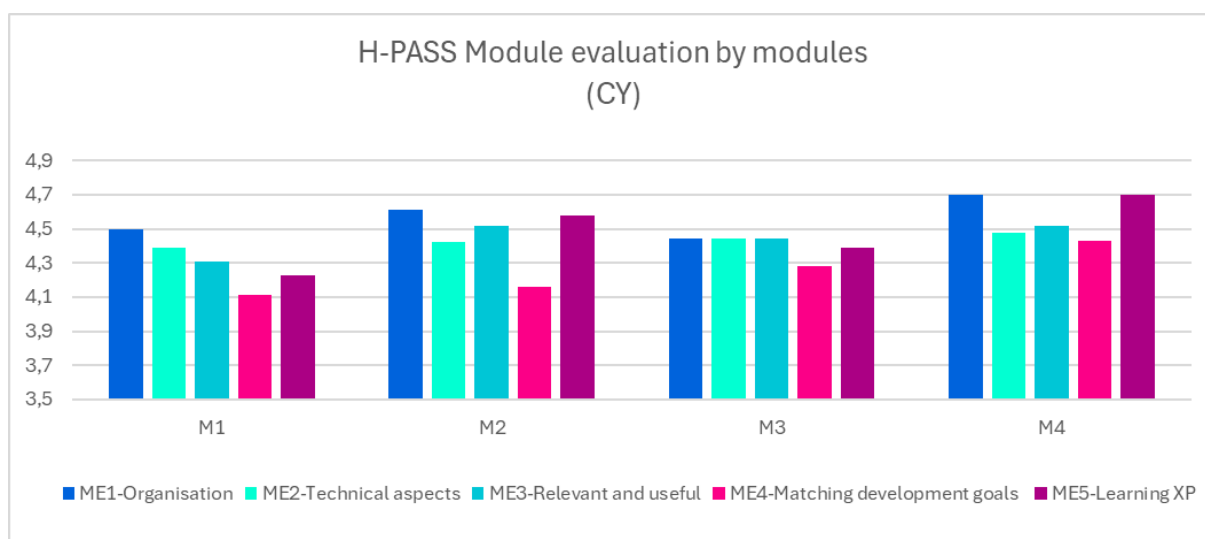


Figure CY-21. H-PASS Module evaluation by evaluation aspects ($n = 18-36$)

The evaluation of individual exercises within the H-PASS modules in Cyprus (Table CY-4.) shows a generally high level of satisfaction, with scores ranging from 3.86 to 5.00, indicating that participants perceived most learning activities as valuable and relevant.

The highest-rated exercises reflect a strong preference for practical, context-driven, and reflective learning approaches. Exercises focusing on healthcare system awareness and digital wellbeing achieved the highest possible ratings, suggesting that participants particularly

appreciated content that is directly applicable to their professional environment and personal practice. Similarly, case-based activities addressing organisational change were also rated very positively, highlighting the importance of real-life scenarios and experiential learning in supporting engagement and perceived usefulness.

At the lower end of the scale, exercises related to data handling, cybersecurity, and communication case discussions received comparatively lower, though still positive, evaluations. These findings may indicate that participants found these topics more complex or less immediately accessible, potentially requiring additional guidance or clearer contextualisation.

TOP1	M3B1	Healthcare system awareness	5
TOP2	M4B3	Digital wellbeing checklist	5
TOP3	M1B6	Case of an organisational change (New teleconsultation service 2.)	4,86
BOTTOM3	M4B2	Cyber security and digital wellbeing	3,94
BOTTOM2	M2B2a	Case discussions on communication in health care	3,87
BOTTOM1	M4B5	Working with Data	3,86

Table CY-4. Highest and lowest rated exercises within the H-PASS training (n = 14–43)

4.1.8. Evaluation results of the DCA training

Data from the Cypriot DCA pre- and post-training surveys are not available. The training was jointly delivered by the University of Crete (UOC) and European University Cyprus (EUC), with UOC acting as the lead institution.

Based on the available information, responses from participants associated with EUC were not captured in the survey dataset. This may be due to a combination of factors, such as variations in survey completion or communication processes. The absence of responses might be related simply to the relatively small number of participants too. As a result, DCA pre- and post-training evaluation data for Cyprus could not be included in the consortium-level analysis either.

The DCA follow-up results in Cyprus (Figure CY-22.), although based on a very small number of respondents (n = 5), provide initial insights into the translation of training outcomes into leadership development and practical action, despite the missing initial data.

Among the respondents, four out of five participants reported an improvement in their leadership competences, indicating a strong perceived impact of the DCA training on leadership-related skills. This suggests that the training was effective in supporting

participants in developing greater confidence and capability in leadership roles within their professional contexts. Two participants reported having taken concrete actions following the training. This gap between perceived improvement and actual implementation reflects a pattern also observed at consortium level, where skill development does not always immediately translate into organisational or behavioural change. Possible explanations may include structural constraints, limited opportunities to apply new competences, or the need for more time to operationalise newly acquired knowledge.

Given the limited sample size, these findings should be interpreted with caution. Nevertheless, they indicate that while the training appears to successfully foster leadership development, additional support mechanisms—such as follow-up activities, mentoring, or organisational enablers—may be beneficial to facilitate the translation of these improvements into concrete actions.

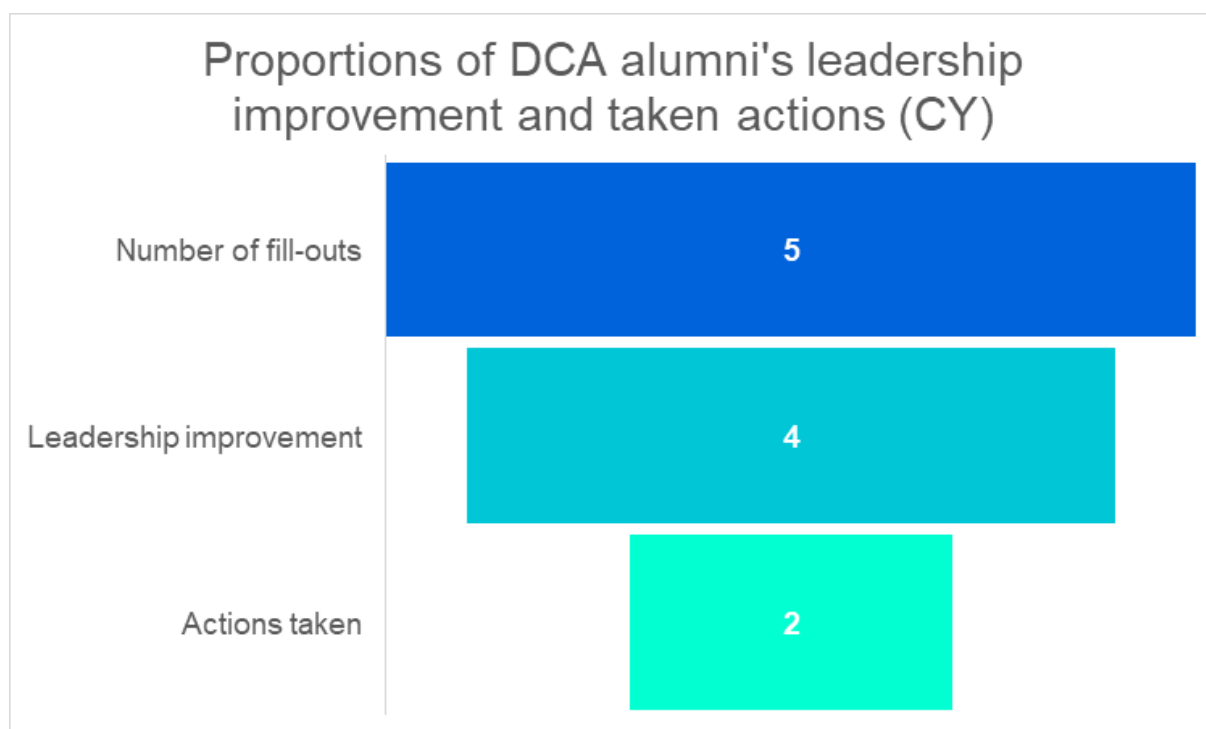


Figure CY-22. Proportions of DCA alumni reporting leadership improvement and actions taken ($n = 5$)

4.1.9. Participant testimonials

Responses from the Closing Survey:

“This training not only strengthened my knowledge but also increased my confidence in making evidence-based decisions in a clinical setting. At the same time, it highlighted the importance of a safety culture and continuous improvement in healthcare services.”

“The educational activity incorporates innovative elements, such as the use of digital self-assessment tools that enhance reflective learning and the active participation of learners. At the same time, it promotes the development of digital awareness and the responsible use of technology through practical exercises that connect theory with everyday experience. The interdisciplinary approach and the emphasis on digital well-being contribute to experiential learning, strengthening both the cognitive and metacognitive skills of the participants.”

The H-PASS training affected my work by strengthening the way I design and implement interventions in my professional setting. It helped me adopt a more structured approach to communication, engage colleagues more effectively, and use digital tools to enhance collaboration and decision-making. At the same time, it made me more receptive to innovation and more oriented toward continuous improvement of processes and outcomes.”

“The most applicable knowledge and skills I gained during the H-PASS training are effective communication with stakeholders, strategic action planning, collaboration in interdisciplinary teams, and leveraging digital tools to improve health services. In addition, I strengthened my ability in change management and in analysing and improving processes, with the aim of delivering higher-quality and more efficient care.”

Responses from the DCA Follow-up surveys:

As a response of specific actions taken as a result of the DCA Training:

“Creation of Viber groups for different initiatives (e.g., medical team, scientific committee) used to share news and brainstorm ideas.”

“I have tried to transfer knowledge and experience from the seminar to my work environment.”

4.2. Greece

4.2.1. Indicator summary

Satisfaction rate (evaluated with 4 or 5): 97,14% (n=70)

Satisfaction rate (evaluated with 5): 77,14% (n=70)

Breakdown	Number of health professionals completing the H-PASS training
In total	75/119
Medical doctors	22
Nurses	70
Allied health professionals	25
Other	0
Pharmacists	2
CME credential attainment	96
TtT participants	21
TtT participants / Trainer pool	4
TtT participants / DCA training course	17

Table GR-1. H-PASS output indicators

Breakdown	Number of health professionals completing the H-PASS training
18–24	0
25–34	26
35–44	28
45–54	50
55–64	10
65 or older	0
No data on age	0
Female	102
Male	17

Table GR-2. H-PASS participants by age groups and by gender

Breakdown	Target/Result
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/100%
Improvement in transversal skills among training participants (based on pre- and post-training surveys)	75%/100%
Improved capabilities for teamwork for teamwork in digital settings (based on post-training surveys)	75%/98,57%

Increased use of digital tools in clinical work (based on post-training survey)	75%/75,71%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/78,57%
Utilization of acquired digital and transversal skills in practice (based on post-training survey)	50%/87,88%
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/81,82%
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/90,91%
Utilization of acquired digital and transversal skills in practice (based on post-training survey) <i>Improved capabilities for leadership in digital settings among participants of train-the-trainer courses</i>	50%/100%

Table GR-3. H-PASS outcome indicators

4.2.2. Demographics of the H-PASS training course

The demographic profile of participants in the Greek H-PASS pilot training shows some differences compared with the consortium-level distribution, particularly in terms of age structure and professional composition.

The age distribution (Figure GR-1.) is concentrated in mid-career groups. The largest share of participants falls within the 45–54 age group (38%), followed by 35–44 (31%) and 25–34 (22%). Smaller proportions are observed among 55–64 (8%) and 18–24 (1%). Compared with the consortium-level pattern, the Greek cohort appears skewed toward mid-career professionals, with a strong concentration in the 35–54 age range.

The gender distribution (Figure GR-2.) shows a strong female majority, with 80% female and 20% male participants, closely reflecting the general consortium trend, where women represent the majority of healthcare professionals participating in the training.

In terms of educational background, participants are highly educated (Figure GR-3.). The majority (68%) hold a Master's degree, followed by 22% with a Bachelor's degree and 9% with a doctorate/PhD, while only 1% reported a high school or equivalent qualification. Compared with the consortium-level results, the Greek sample shows a particularly high proportion of Master's degree holders.

Regarding professional roles (Figure GR-4.), nurses constitute the largest group (63%), followed by allied health professionals (18%) and physicians (16%). Smaller proportions include administrative staff (2%) and pharmacists (1%). This distribution broadly aligns with the consortium-level pattern, where nurses represent the largest group, although Greece shows a particularly strong dominance of nursing professionals.

The distribution of work experience (Figure GR-5.) indicates a highly experienced cohort. The largest group (41%) reported more than 20 years of experience, followed by 34% with 11–20 years and 23% with 1–5 years (or under 10 years). Only 2% reported less than one year of experience, and no respondents fell into the 6–10 years category.

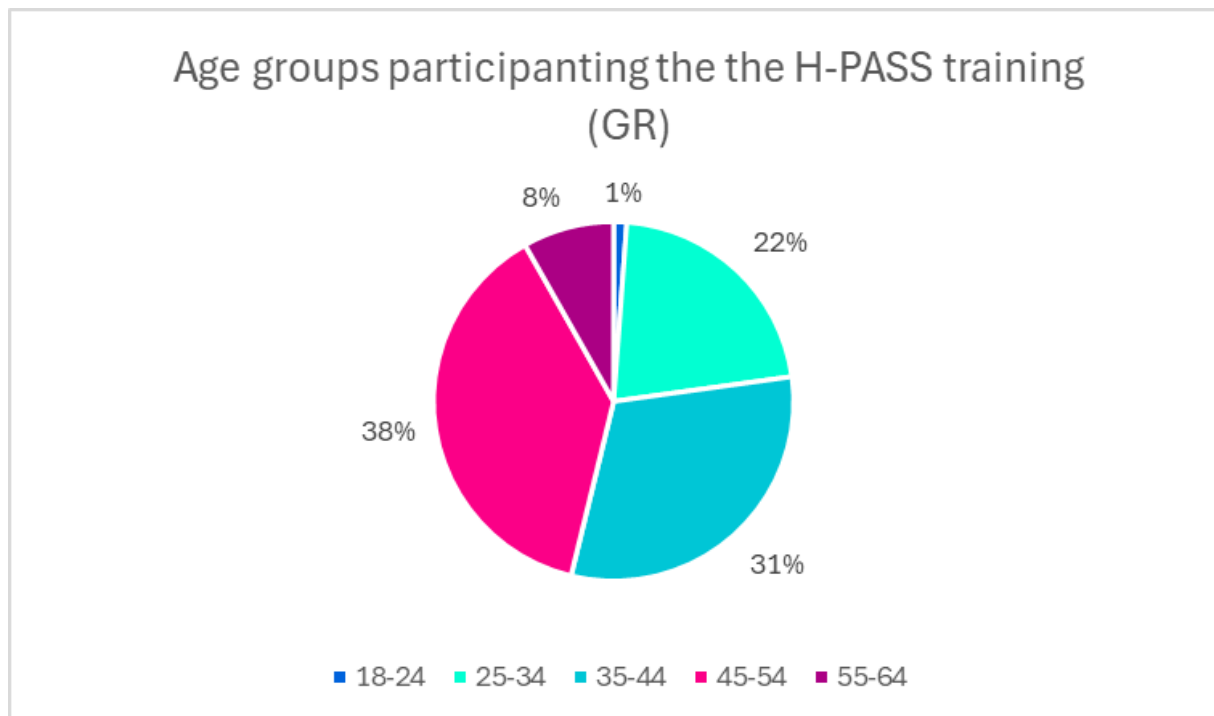


Figure GR-1. Age groups participating in the H-PASS training in Greece (n = 171)

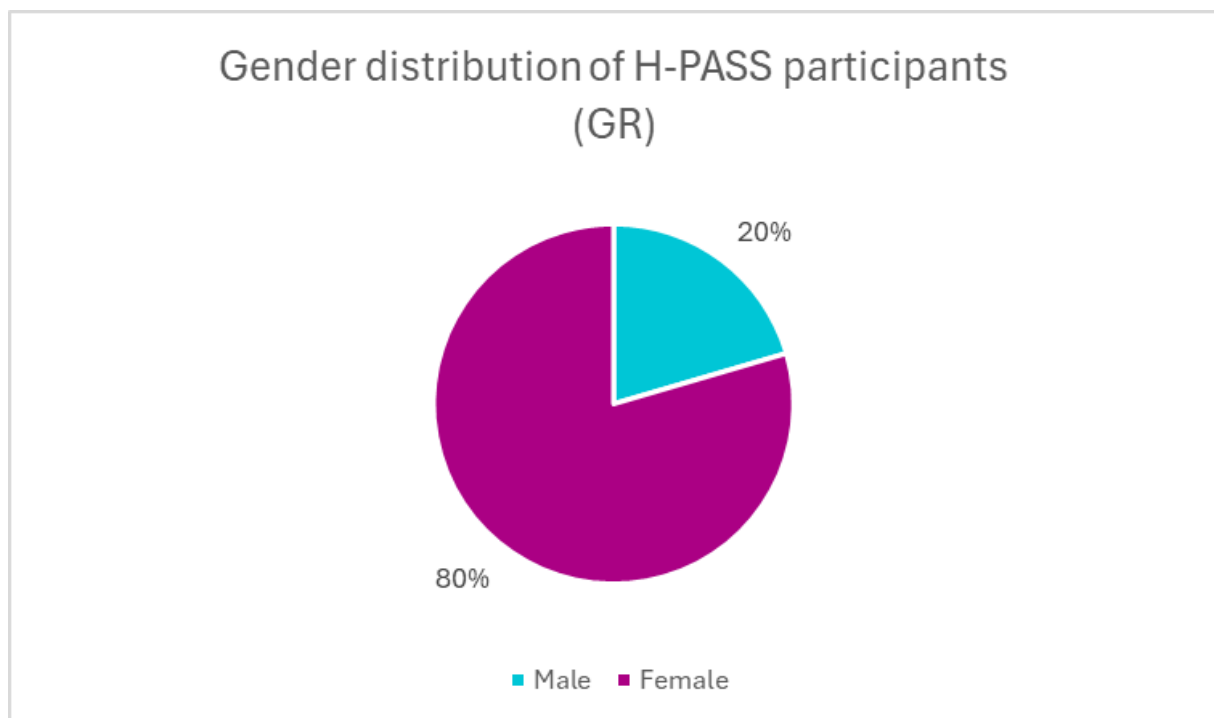


Figure GR-2. Gender distribution of H-PASS participants in Greece (n = 171)

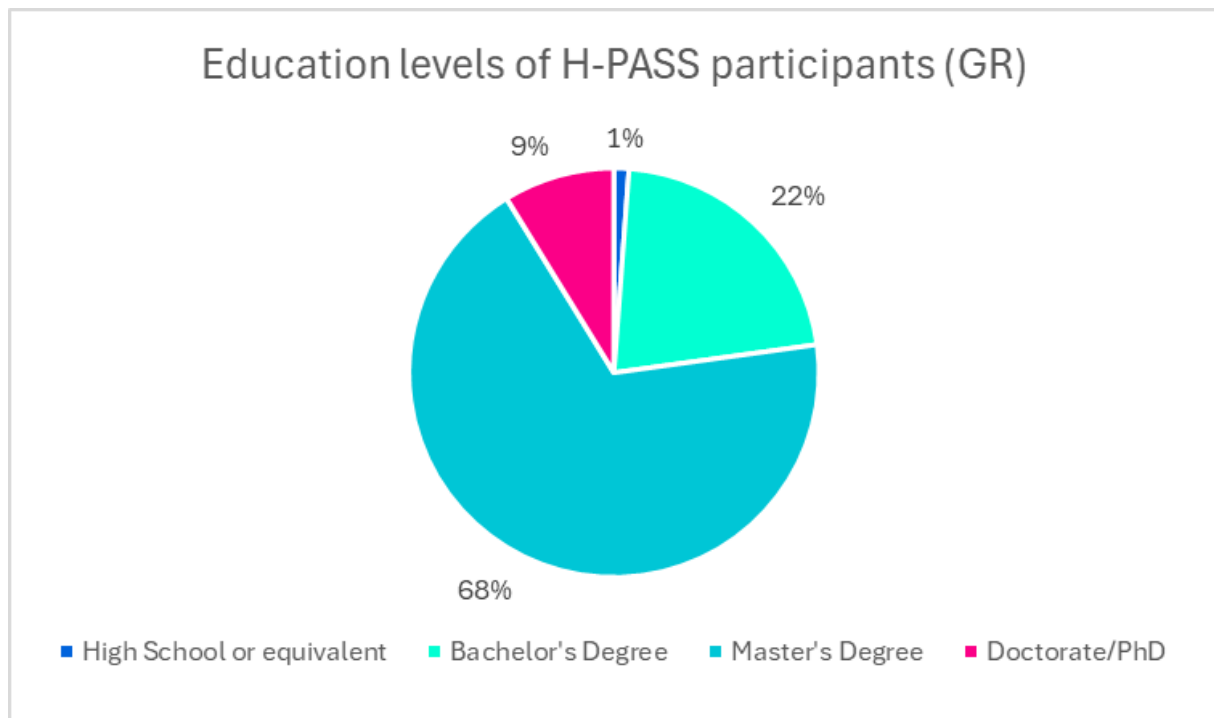


Figure GR-3. Education levels of H-PASS participants in Greece (n = 171)

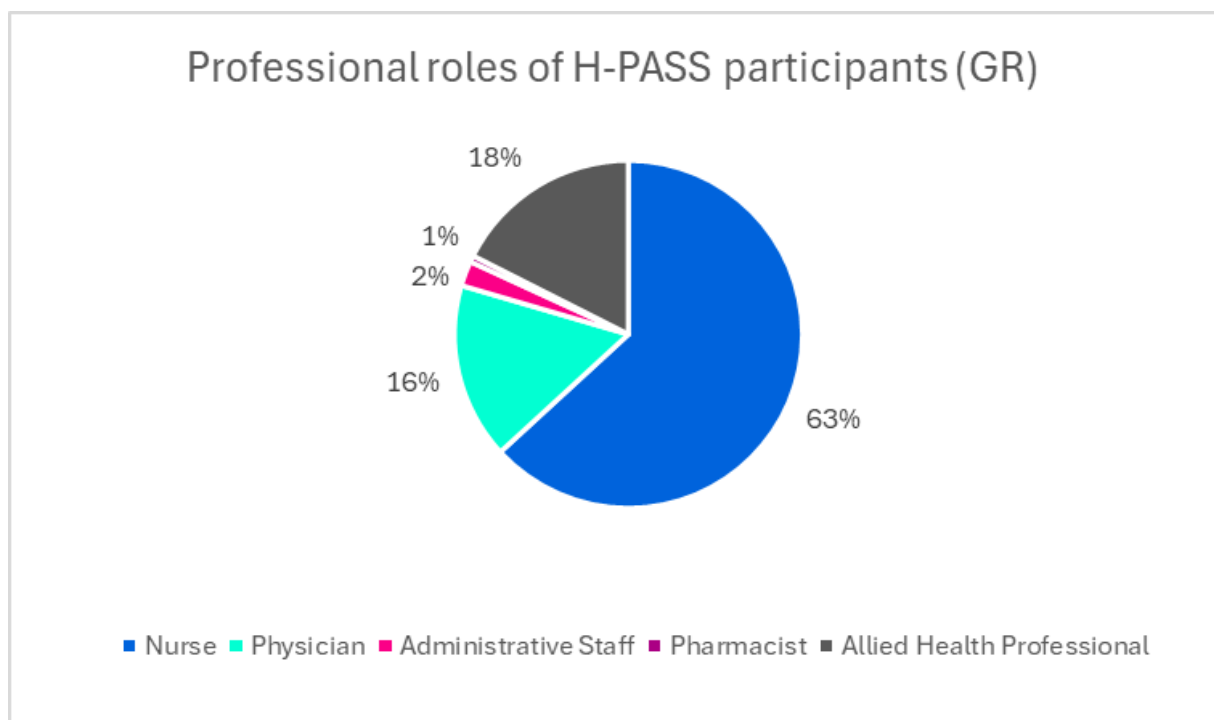


Figure GR-4. Professional roles of H-PASS participants in Greece (n = 171)

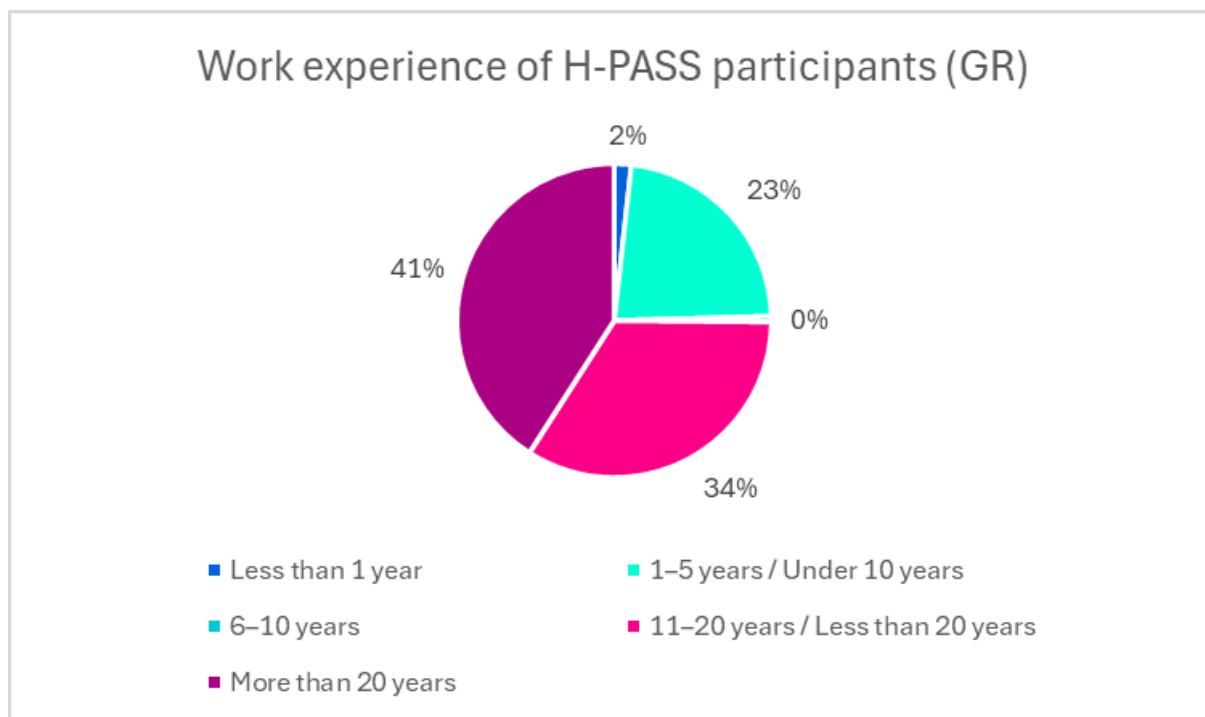


Figure GR-5. Work experience of H-PASS participants in Greece (n = 171)

The employment-related characteristics of participants in the Greek H-PASS pilot training further highlight a well-established and institutionally embedded workforce, with patterns broadly consistent with the consortium-level distribution.

In terms of work facilities (Figure GR-6.), the majority of participants (80%) are employed in public institutions, while 16% work in private institutions and a small share (4%) selected other types of organisations.

Regarding employment status (Figure GR-7.), the vast majority of participants (90%) are employed full-time, indicating a highly stable workforce. Smaller proportions include 8% working on contract, 1% part-time, and 1% currently unemployed. This distribution suggests that most participants are actively engaged in regular professional practice, which is important for the practical application of training outcomes.

The work location data (Figure GR-8.) shows a strong concentration in urban areas (85%), followed by suburban areas (10%) and rural areas (5%).

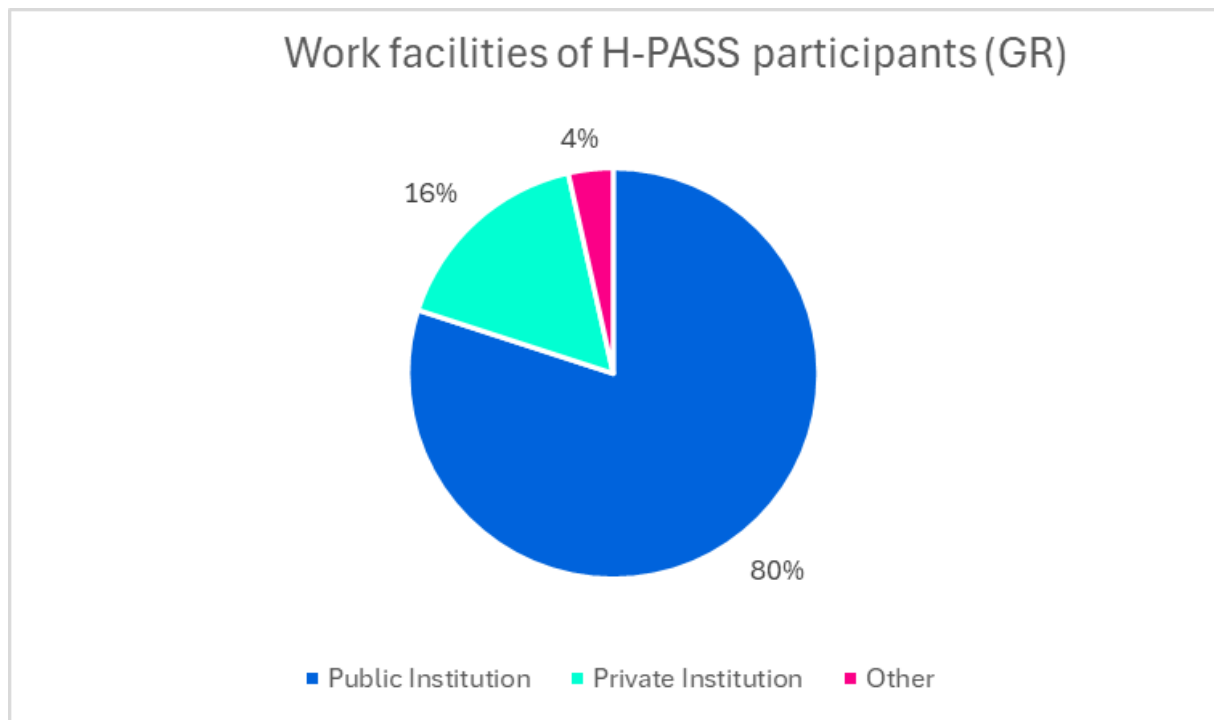


Figure GR-6. Work facilities of H-PASS participants in Greece (n = 170)

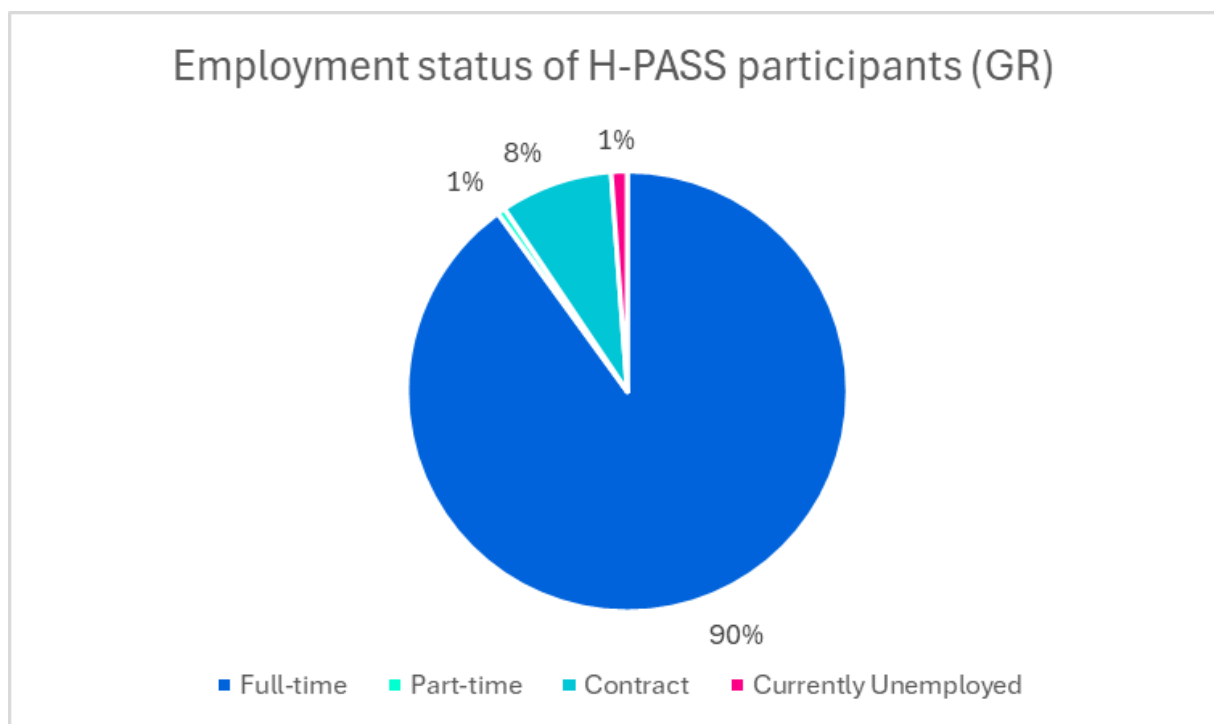


Figure GR-7. Employment status of H-PASS participants in Greece (n = 170)

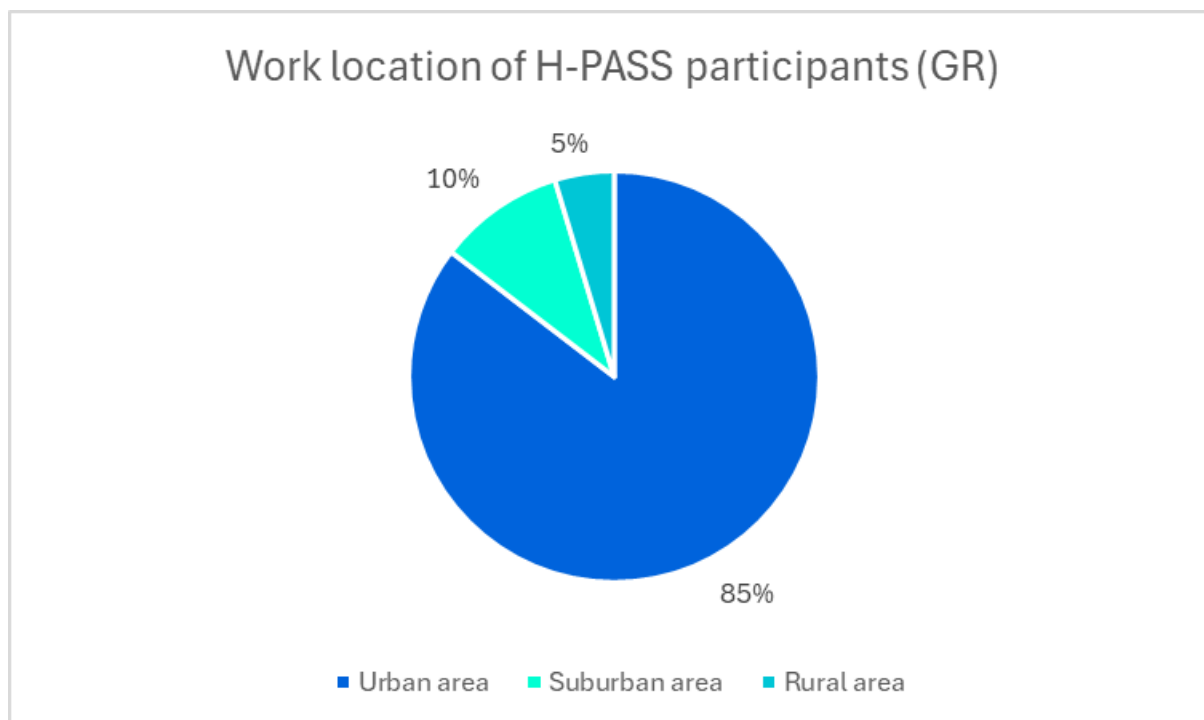


Figure GR-8. Work location of H-PASS participants in Greece (n = 171)

4.2.3. Satisfaction with the H-PASS training

Participants in the Greek H-PASS pilot training reported very high levels of satisfaction with the programme (Figure GR-9.). The majority of respondents (77%) rated their overall satisfaction with the highest score (5), while 20% selected score 4 and a small proportion (3%) rated it 3. No participants indicated dissatisfaction. These results demonstrate a very positive reception of the training among Greek participants, closely aligned with the overall consortium-level trend.

Participants also evaluated the applicability of the training to their professional practice (Figure GR-10.). Over half of respondents (51%) selected the highest score (5), while 33% rated it 4, 10% selected 3, and 6% rated it 2. No respondents chose the lowest category. This indicates that the majority of participants found the training highly relevant and applicable, although a slightly wider distribution of responses compared to satisfaction suggests some variation in how easily the content could be transferred into practice.

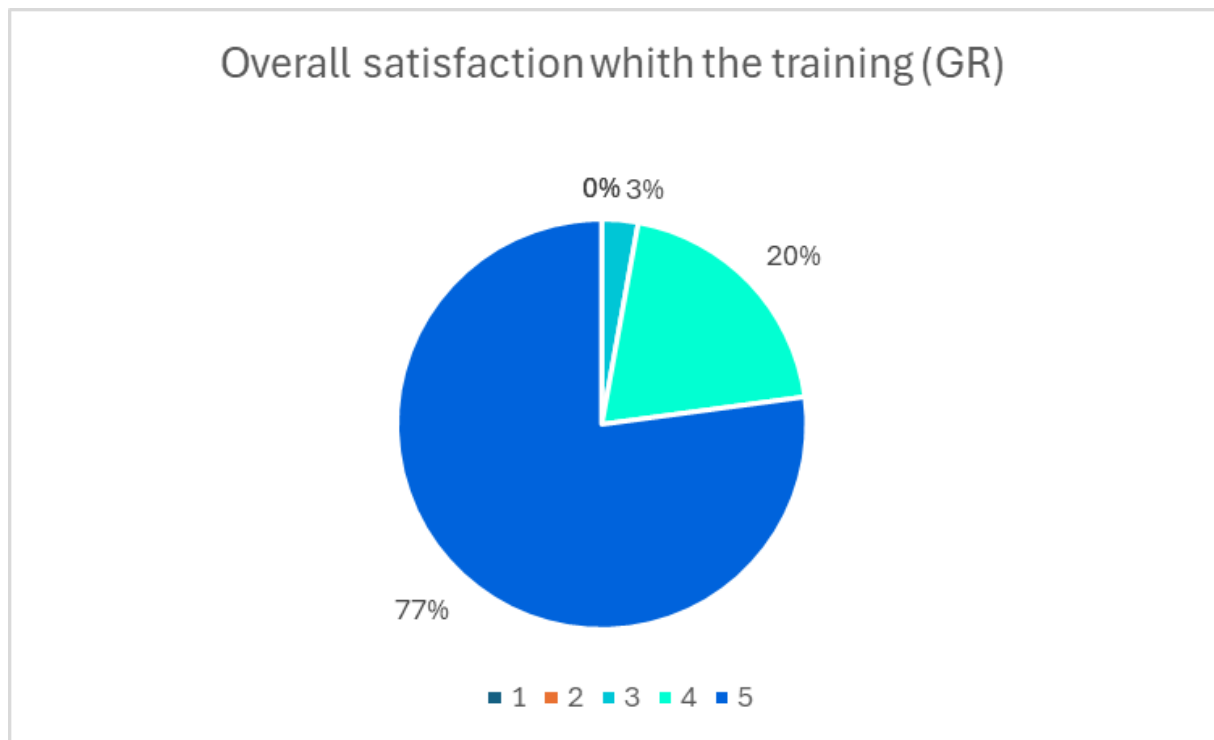


Figure GR-9. Overall satisfaction with the H-PASS training in Greece (n = 70)

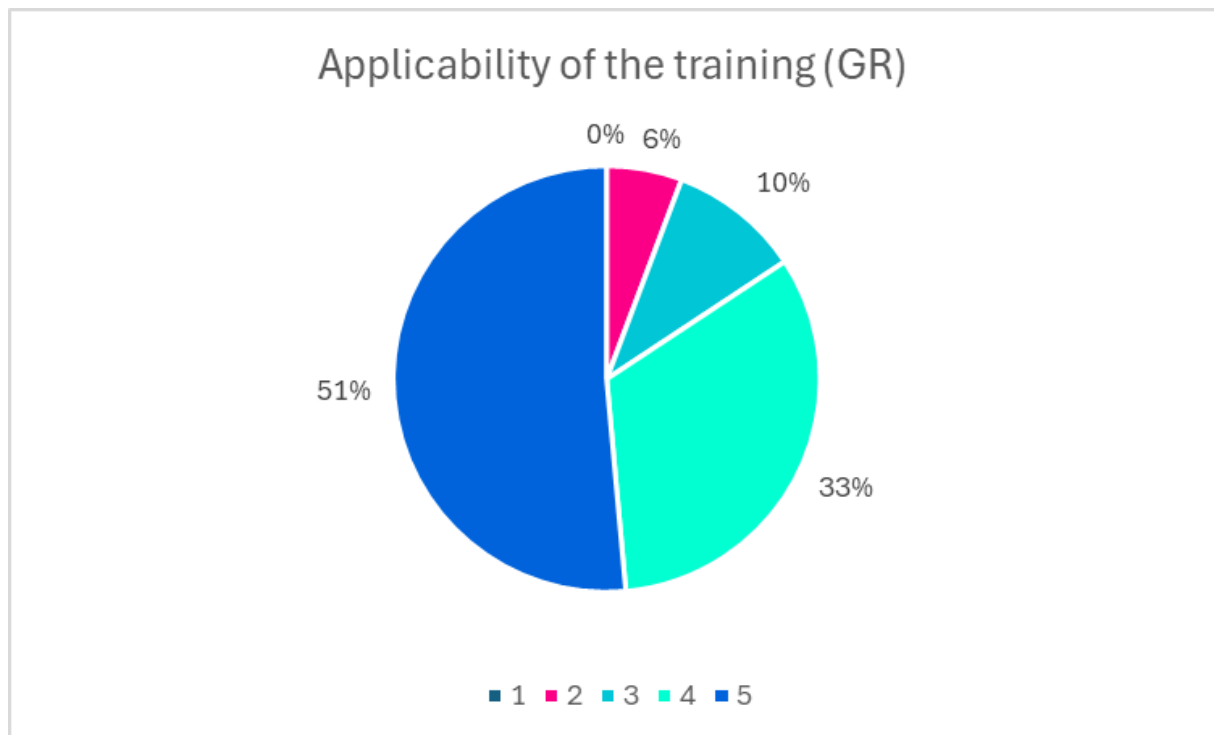


Figure GR-10. Applicability of the H-PASS training in Greece (n = 70)

4.2.4. Digital and transversal skill development

Greek participants reported substantial improvements in their digital skills following the H-PASS training (Figure GR-11.). A large majority indicated high levels of improvement, with 43% reporting significant improvement (4) and another 43% stating that their skills improved to a great extent (5). Additionally, 14% of respondents reported moderate improvement (3), while no participants selected the lower categories. This distribution shows that all participants experienced at least moderate improvement, with the vast majority reporting strong gains in their digital competences.

When examining specific digital competences based on the DigComp 2.2 framework, improvements were observed across all assessed areas (Figure GR-12.). The highest number of participants reported improvements in digital safety (58) and communication and collaboration (53), highlighting strong gains in areas essential for teamwork and secure use of digital technologies. Improvements were also reported in information and data literacy (48) and digital content creation (44). The lowest, though still substantial, number of improvements was observed in problem solving (42).

The results indicate that the H-PASS training in Greece contributed to broad and consistent development of digital competences, particularly in areas related to communication, safety, and data handling. Compared with the consortium-level findings, the Greek results show a strong concentration in higher improvement categories, suggesting a high perceived impact of the training on digital skill development.

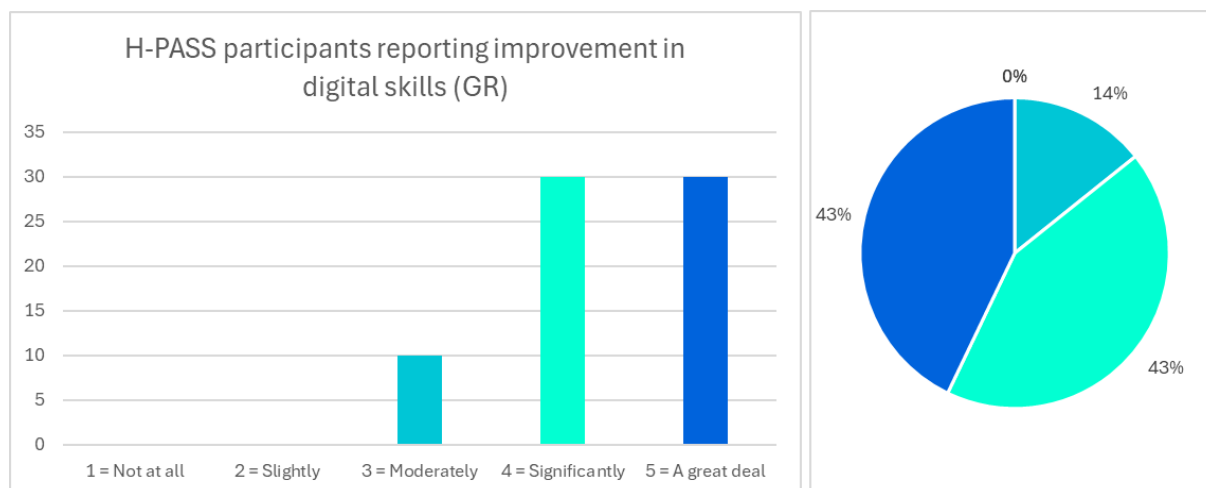


Figure GR-11. H-PASS participants reporting improvement in digital skills in Greece (n = 70)

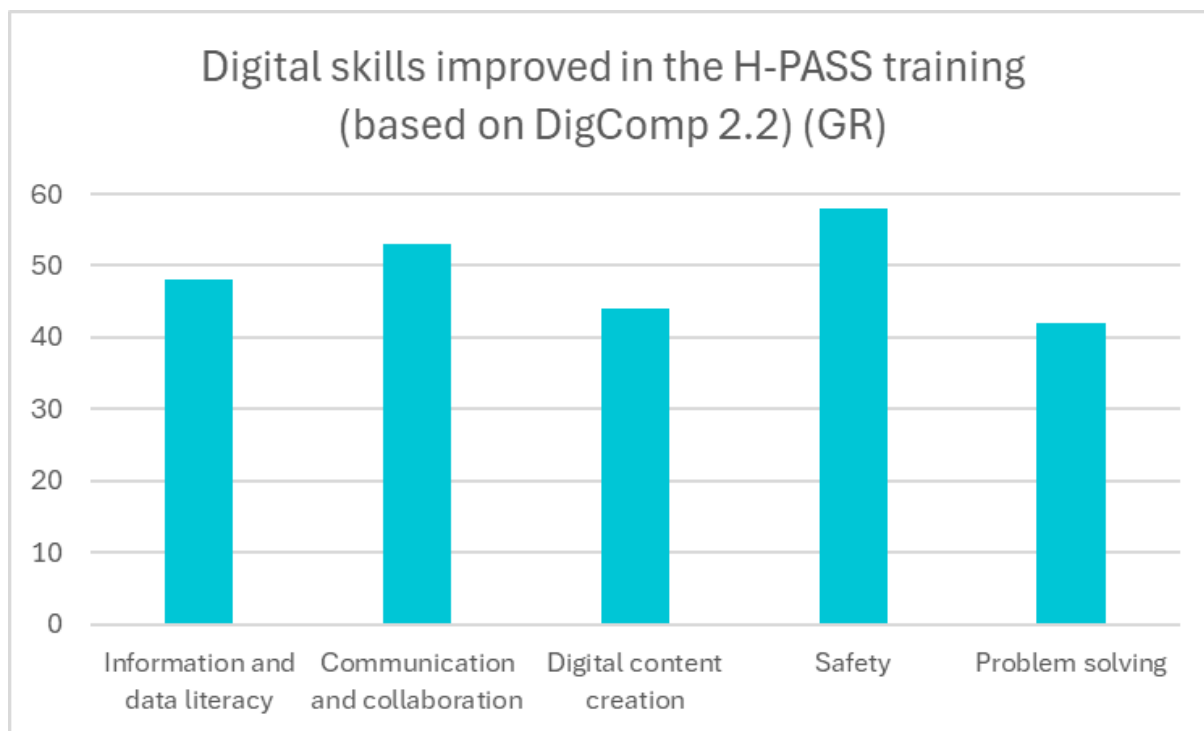


Figure GR-12. Digital skills improved in the H-PASS training based on DigComp 2.2 in Greece (n = 105)

Greek participants reported strong improvements in transversal skills following the H-PASS training (Figure GR-13.). The largest share of respondents (46%) indicated significant improvement (4), while 37% reported that their skills improved to a great extent (5). Additionally, 17% selected moderate improvement (3), and no participants reported lower levels of change. This indicates that all participants experienced at least moderate improvement, with the majority reporting substantial gains in transversal competences.

When examining specific transversal competencies based on the LifeComp framework, improvements were observed across all areas (Figure GR-14.). The most frequently reported improvements were in communication (48 participants) and managing learning (44), followed by flexibility (41). Strong improvements were also observed in critical thinking (38), growth mindset (37), and collaboration (37). Additional gains were reported in wellbeing (29), self-regulation (25), and empathy (25).

The findings indicate that the H-PASS training in Greece contributed to broad development of interpersonal, cognitive, and self-management skills, with particularly strong gains in communication and learning-related competences. Compared with the consortium-level results, the Greek distribution shows a solid concentration in higher improvement categories, confirming the training's effectiveness in enhancing transversal skills relevant for digital transformation in healthcare.

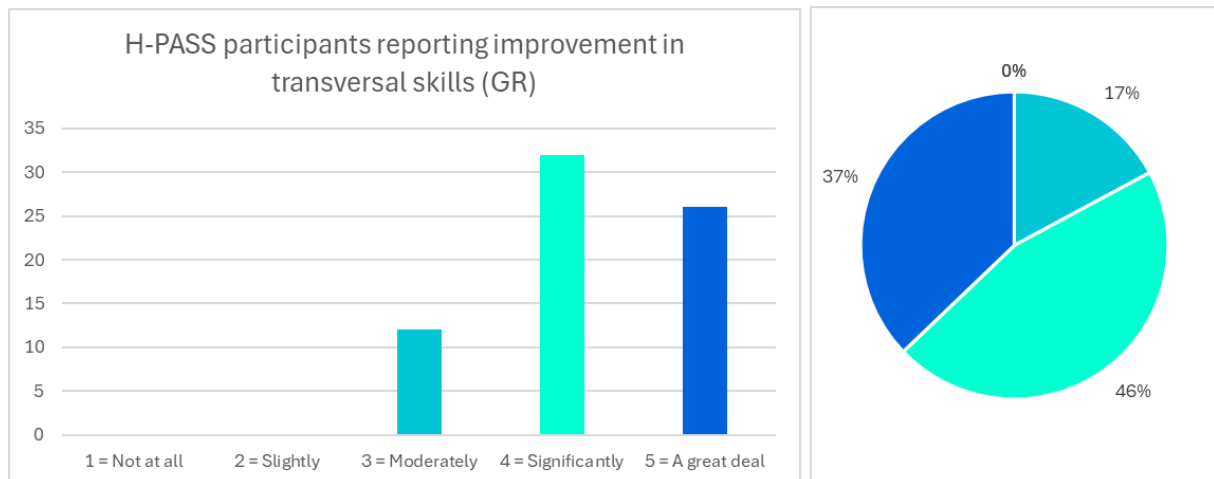


Figure GR-13. H-PASS participants reporting improvement in transversal skills in Greece (n = 70)

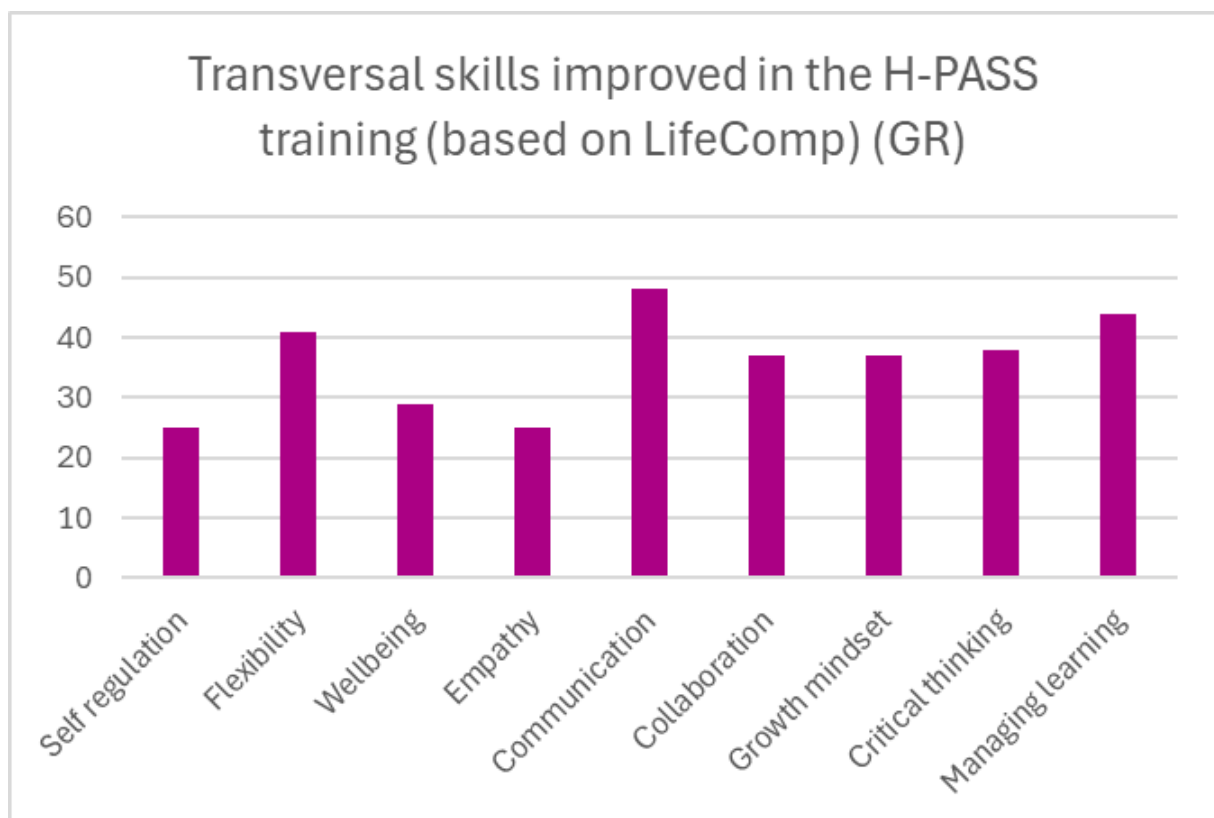


Figure GR-14. Transversal skills improved in the H-PASS training based on LifeComp in Greece (n = 105)

Greek participants reported strong increases in confidence in digital teamwork following the H-PASS training (Figure GR-15.). Nearly half of respondents (47%) selected the highest rating (5 – a great deal), while 43% reported significant improvement (4). A smaller share (9%)

indicated moderate improvement (3), and only 1% selected a low rating, with no responses in the lowest category.

Compared with the consortium-level findings, the Greek results show a similarly strong pattern of improvement, with most participants reporting high levels of increased confidence, though with a slightly more varied distribution including some moderate responses.

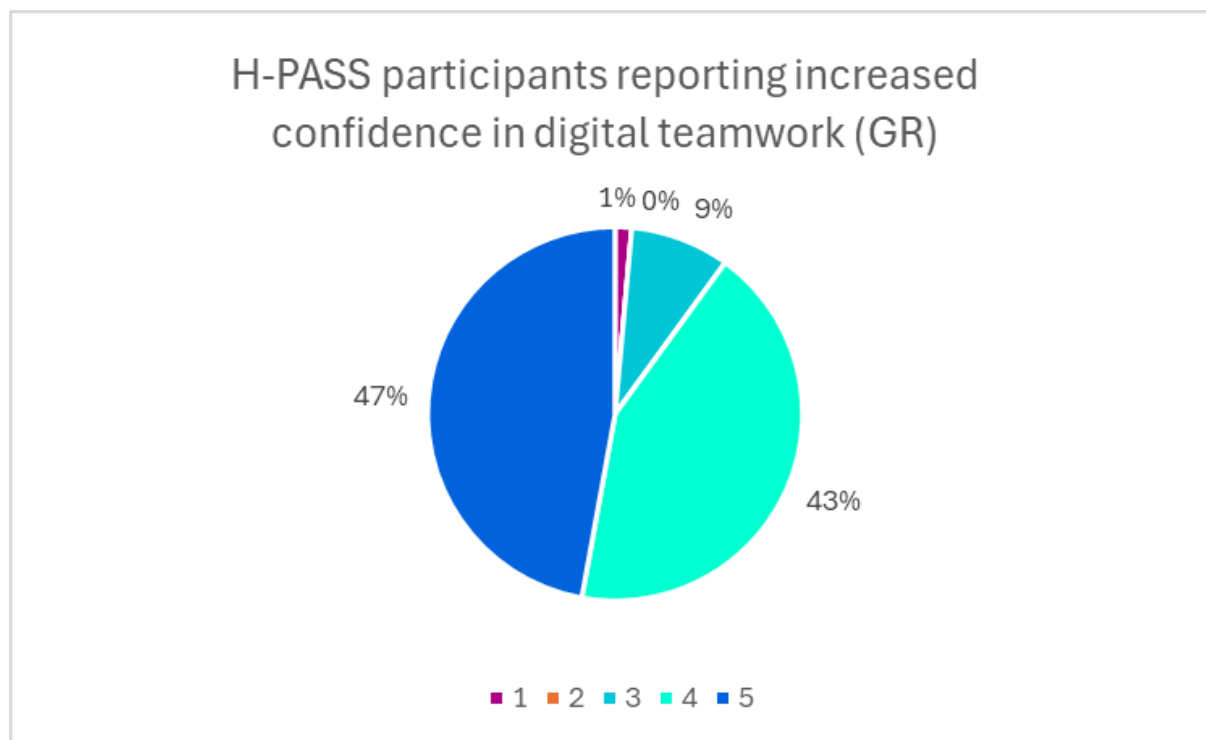


Figure GR-15. H-PASS participants reporting increased confidence in digital teamwork in Greece (n = 70)

4.2.5. Impact on digital tool usage

Greek participants reported a clear increase in the use of digital tools for professional tasks following the H-PASS training (Figure GR-16.). The largest share of respondents (44%) indicated that they use digital tools significantly more, while 31% reported using them slightly more. At the same time, 12% stated that their usage remained the same or decreased, and 13% considered the question not relevant. These results suggest that, while the majority of participants increased their use of digital tools, there is some variation depending on individual roles and contexts of use. In this context, the very short time between completion of training activities and fill-out of Closing Survey should be highlighted.

A similar pattern is observed for administrative tasks, though with slightly more moderate increases (Figure GR-17.). 40% of respondents reported using digital tools significantly more, and 38% indicated slightly increased usage. Meanwhile, 13% reported no increase or reduced use, and 9% considered the question not relevant. Compared with professional tasks, the

increase in administrative usage appears more evenly distributed between moderate and high levels.

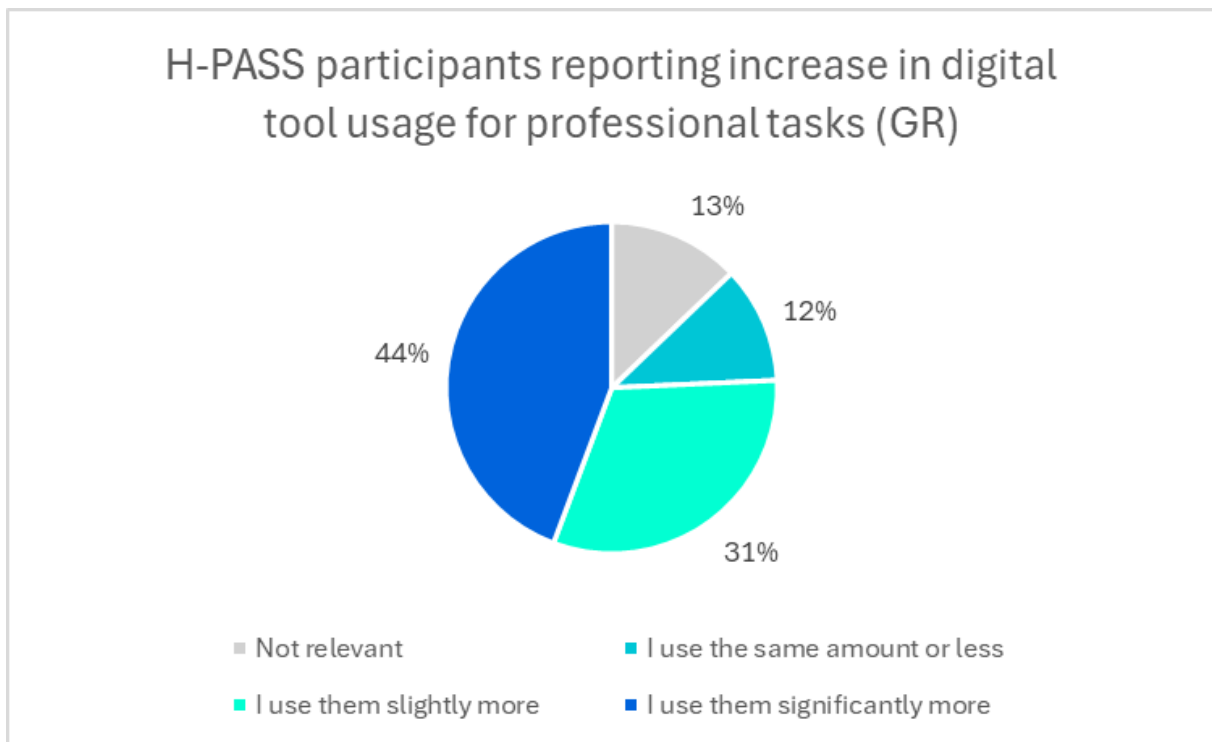


Figure GR-16. H-PASS participants reporting increase in digital tool usage for professional tasks in Greece ($n = 70$)

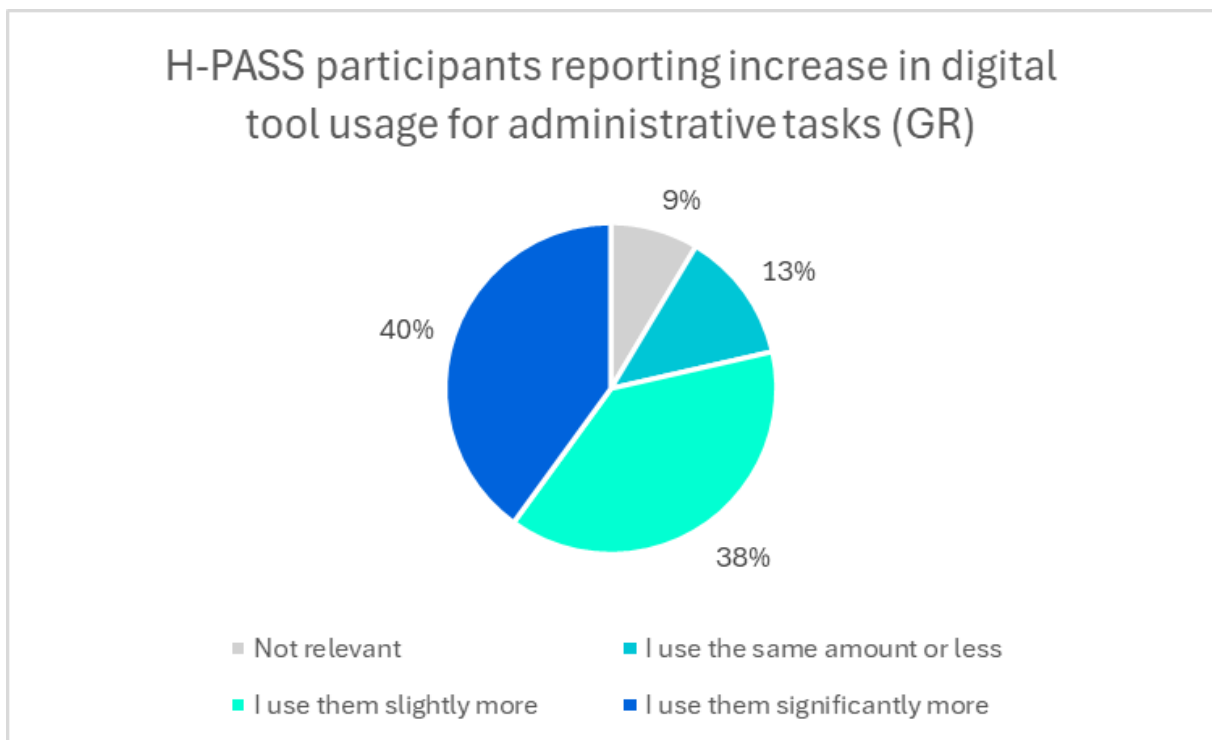


Figure GR-17. H-PASS participants reporting increase in digital tool usage for administrative tasks in Greece ($n = 70$)

4.2.6. Training follow-up results

The follow-up results from Greek participants indicate that the H-PASS training contributed to perceived organisational improvements in the majority of cases (Figure GR-18.). A large share of respondents (88%) reported that they had observed improvements within their organisation as a result of the training, while 12% indicated that no noticeable changes had occurred. This suggests that the course had a substantial impact beyond individual learning, supporting changes in workplace practices and processes.

Participants also identified specific areas where organisational changes were observed (Figure GR-19.). The most frequently reported improvement was in teamwork (17 respondents), followed closely by workflow patterns (16 respondents). Improvements were also noted in workload management (12 respondents) and task-shifting (11 respondents), although to a slightly lesser extent. Respondents marked 1,93 areas on average.

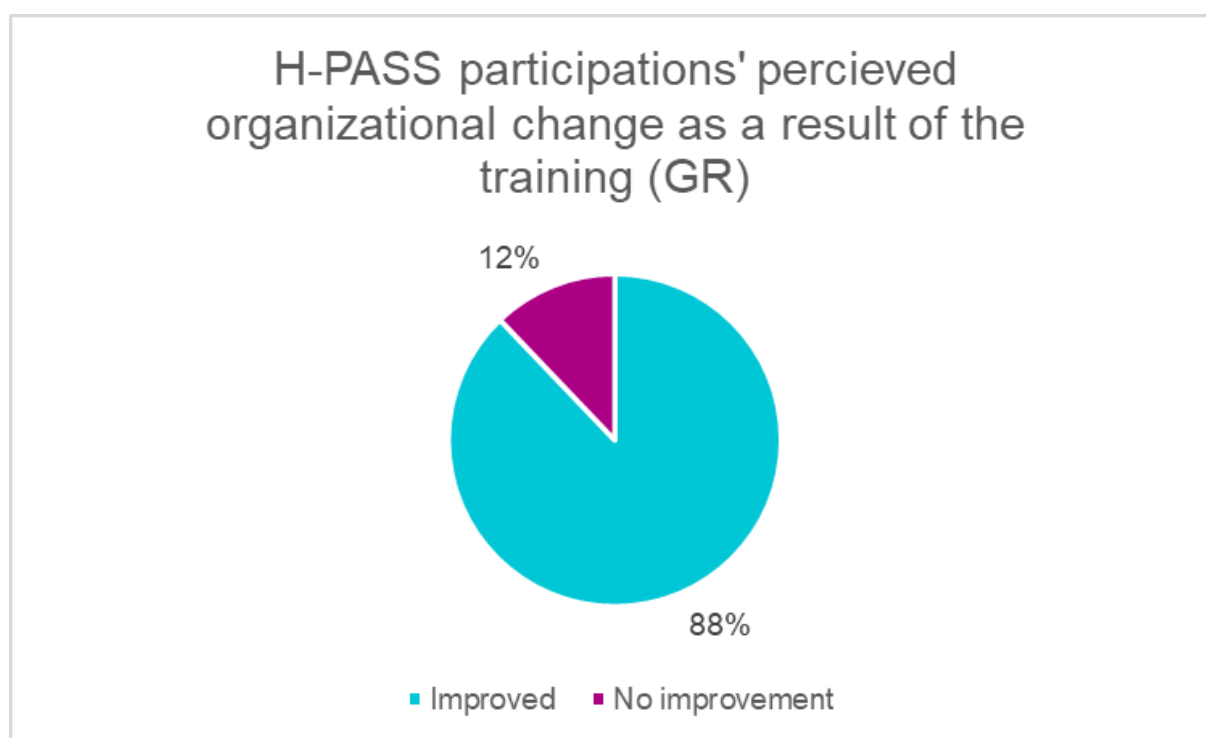


Figure GR-18. H-PASS participants' perceived organisational change as a result of the training in Greece (n = 33)

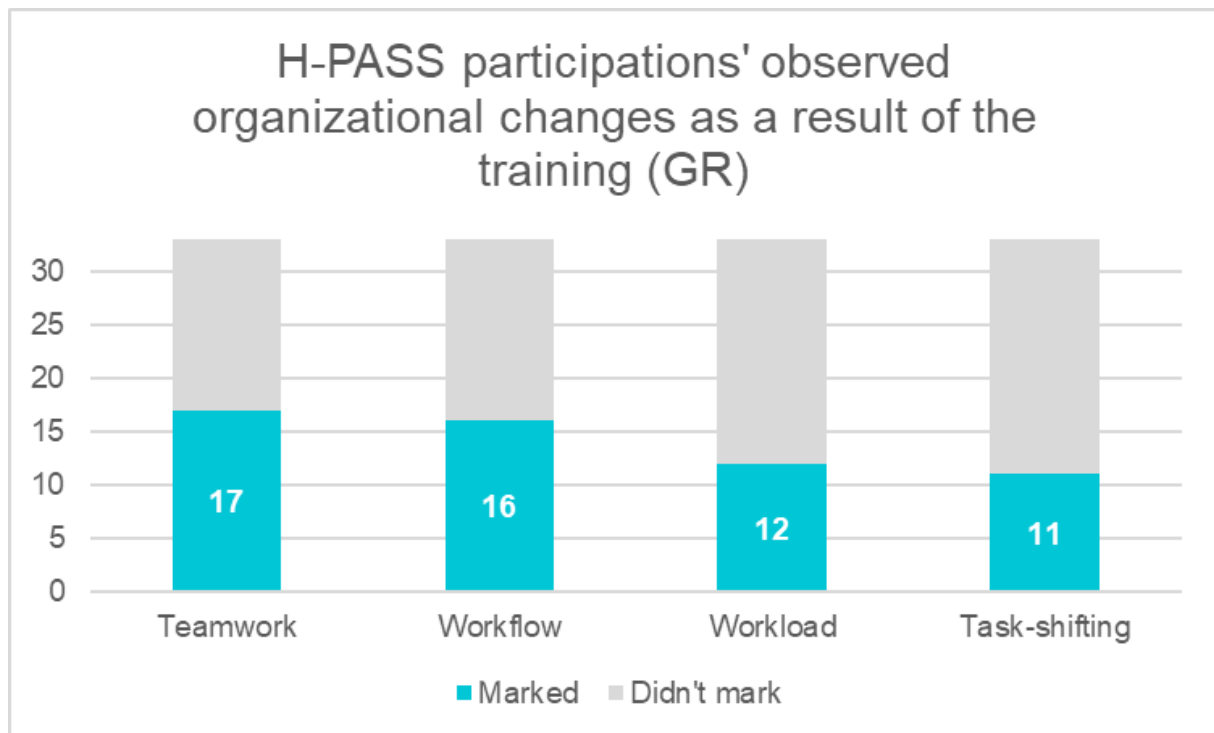


Figure GR-19. Observed organisational changes following the H-PASS training in Greece (n = 33)

4.2.7. Module evaluation overview

The evaluation of the H-PASS modules in Greece indicates a consistently high level of satisfaction across all modules and evaluation dimensions, with average scores generally ranging between 4.5 and 4.8 out of 5 (Figure GR-21.). When comparing modules, M4 emerges as the highest-rated module overall, achieving consistently strong scores across all evaluation aspects; however, module evaluations are very balanced in the Greek pilots, and not all differences are statistically significant.

Across evaluation aspects (Figure GR-20.), relevance and usefulness (ME3) and organisation (ME1) are among the strongest-rated dimensions, indicating that participants found the modules both well-structured and highly applicable to their professional context. Technical aspects (ME2) also receive high scores across all modules, suggesting that the delivery methods and tools were effective. The learning experience (ME5) is consistently rated highly, particularly in M2, M3 and M4, reflecting a positive and engaging participant experience. In contrast, matching development goals (ME4), while still positively evaluated, shows slightly lower scores in earlier modules (notably M1), but improves in later modules, especially in M2 and M4.

Results suggest that the H-PASS training in Greece delivered a very high-quality learning experience across all modules, with a clear pattern of stronger alignment and satisfaction in the later modules, possibly reflecting increased relevance or improved adaptation to participants' needs over time.

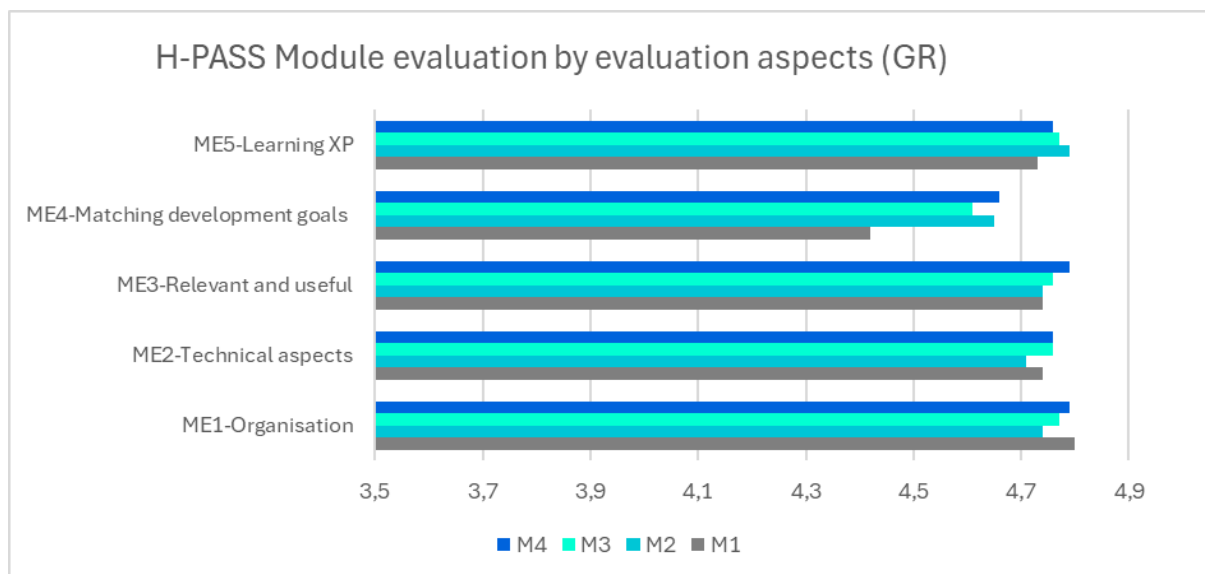


Figure GR-20. H-PASS module evaluation by modules in Greece (n = 83–87)

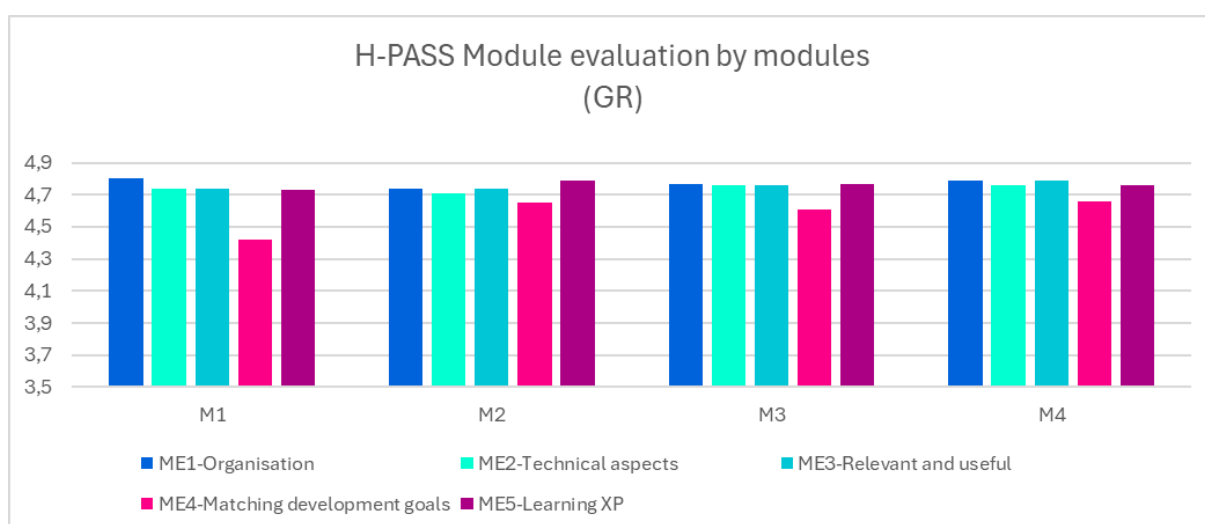


Figure GR-21. H-PASS module evaluation by evaluation aspects in Greece (n = 83–87)

The analysis of individual exercises within the H-PASS modules in Greece shows that all evaluated activities received very high ratings, with even the lowest-rated exercises scoring above 4.4 out of 5, confirming the overall strong quality of the learning content.

The highest-rated exercise is “Developing healthcare solutions” (M3B3) with an average score of 4.88, followed by “Managing healthcare developments” (M3B4) at 4.82, and “The effects of different cultures in Healthcare” (M2B5) at 4.81. These findings indicate that participants particularly valued practical, solution-oriented, and contextually relevant exercises, especially within Module 3.

At the lower end of the ranking, though still positively evaluated, are “AR-in-a-Box” (M4B4) with 4.43, “Complex case study” (M2B7) with 4.59, and “Let’s develop healthcare solutions!” (M3B5) with 4.64. While these scores remain high, they might suggest slightly lower perceived

usefulness or engagement compared to the top-rated exercises. However, with respect to M2B7, it should be taken into account that online group work proved to be a particularly difficult task for participants, due to their overwhelmingly busy everyday work schedules, which significantly limited their ability to sync with fellow trainees.

Lastly, it should be noted that synchronous trainings were graded as standalone learning blocks in the Greek pilots (i.e. each activity included in any given synchronous training was not graded separately). Importantly -although these data are not included in this exercise-specific analysis for consistency reasons- these activities were consistently the highest-graded ones, something that could be viewed as a confirmation that the blended-learning approach (adopted at a consortium-wide level) can indeed carry an add-on value, as compared to a solely e-learning one. Our perception is that this could have significantly contributed to the very highly graded overall learning experience, as special emphasis was given to comprehensive understanding of each Module as a whole during these sessions, with many practical examples and a high degree of interactivity. In addition, the fact that multiple timeslots were provided to participants to enroll in each Module's synchronous activity (10-12 per module for Greek pilots 1 and 2) maximized flexibility, while in parallel being translated into a number of participants per session that was manageable by the trainer and allowed for very comprehensive discussions and feedback.

TOP1	M3B3	Developing healthcare solutions	4,88
TOP2	M3B4	Managing healthcare developments	4,82
TOP3	M2B5	The effects of different cultures in Healthcare	4,81
BOTTOM3	M3B5	Let's develop healthcare solutions!	4,64
BOTTOM2	M2B7	Complex case study	4,59
BOTTOM1	M4B4	AR-in-a-Box	4,43

Table GR-4. Highest and lowest performing training items in the Greek pilot (n = 83–87)

4.2.8. Evaluation results of the DCA training

The pre-post-training evaluation results for DCA participants in Greece (Figure GR-22.) indicate substantial perceived improvement across all assessed areas, despite the relatively small sample size (n = 11). A strong majority of participants reported increased confidence in their understanding of the DCA role (81.82%) and in their change management skills (81.82%), suggesting that the training effectively strengthened both role clarity and practical leadership capacities. The highest level of improvement was observed in knowledge of educational methods (90.91%), highlighting the course's particular effectiveness in enhancing participants' pedagogical competencies.

Findings demonstrate that the DCA training in Greece had a consistently positive impact across all key competency areas, with especially strong gains in educational knowledge.

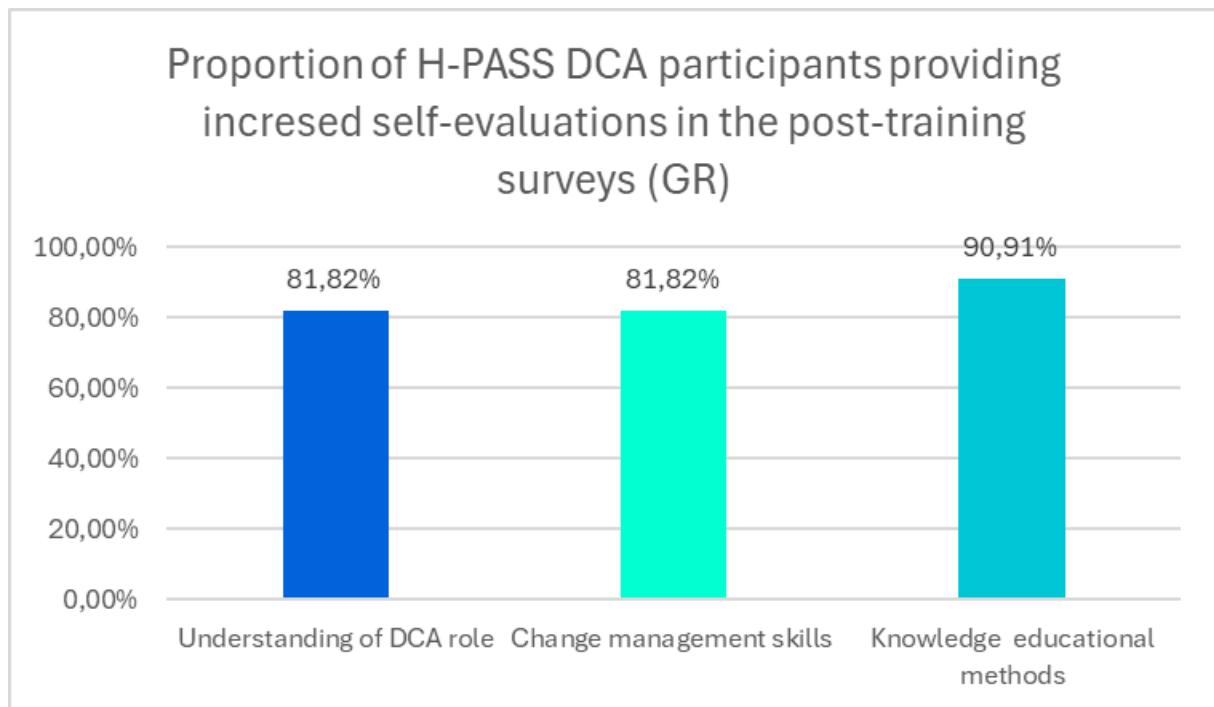


Figure GR-22. Proportion of H-PASS DCA participants reporting increased self-evaluation following the training in Greece (n = 11)

The follow-up survey results for DCA alumni in Greece (Figure GR-23.) indicate that all respondents (9 out of 9) reported an improvement in their leadership capacities after completing the training. This suggests a very strong and consistent perceived impact of the programme on participants' leadership development.

However, when looking at the translation of this improvement into concrete actions, only 3 out of 9 participants reported having taken specific actions following the training. This highlights a noticeable gap between perceived leadership improvement and practical implementation, furthermore, this proportion is significantly lower than the consortium-level average. Nonetheless, the fact that Greek participants in the DCA training course did not -in their majority- possess leadership roles in their actual professional lives could potentially explain this finding, at least to a degree.

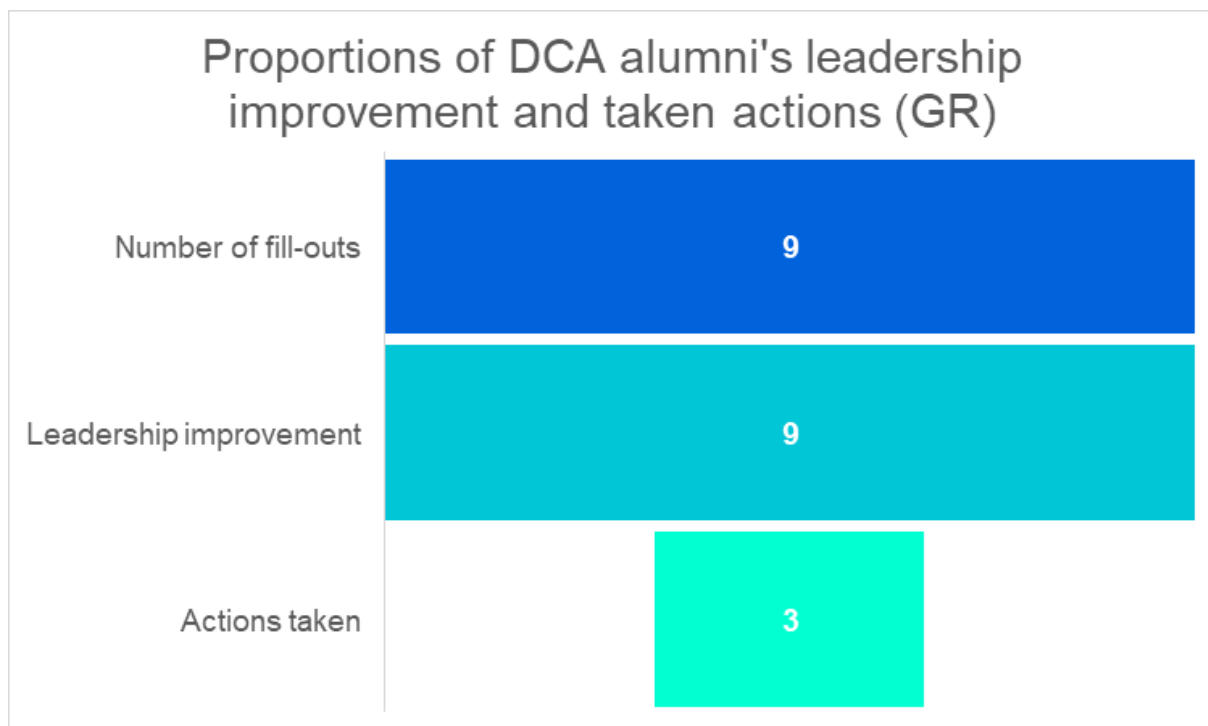


Figure GR-23. Leadership improvement and actions taken among DCA alumni in Greece (n = 9)

4.2.9. Participant testimonials

Responses from the Closing Survey:

"The educational sessions were particularly well-designed and substantial. Perhaps a further reinforcement of the practical dimension would be useful, with more examples and interactive applications."

"Education of all health professionals with courses similar to H-PASS should be obligatory, as developments in healthcare mandate it."

"Congratulations. I did not expect that it would be such an interesting and comprehensive course. I wish that in the future I will have the opportunity to enrol in a similar one."

"The programme should be continued, so that more healthcare professionals can be educated on digital health applications. Perhaps more modules with more recent data on this type of services could be added."

"A fantastic and useful course, which was delivered to its maximum potential due to the instructors' skill."

Answers from the DCA Follow-up survey:

"The H-PASS Digital Change Agent course helped me integrate digital tools in the ordering process, improving organization, speed and accuracy. At the same time, collaboration within my team was reinforced, as we adopted more effective ways of communication and coordination."

4.3. Hungary

4.3.1. Indicator summary

Satisfaction rate (evaluated with 4 or 5): 90,2% (n=102)

Satisfaction rate (evaluated with 5): 54,9% (n=102)

Breakdown	Number of health professionals completing the H-PASS training
In total	75/127
Medical doctors	43
Nurses	46
Allied health professionals	34
Other	4
Pharmacists	0
CME credential attainment	115
TtT participants	26
TtT participants / Trainer pool	13
TtT participants / DCA training course	13

Table HU-1. H-PASS output indicators

Breakdown	Number of health professionals completing the H-PASS training
18–24	0
25–34	14
35–44	23
45–54	56
55–64	28
65 or older	5
No data on age	1
Female	101
Male	26

Table HU-2. H-PASS participants by age groups and by gender

Breakdown	Target/Result
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/99,1%
Improvement in transversal skills among training participants (based on pre- and post-training surveys)	75%/100%
Improved capabilities for teamwork for teamwork in digital settings (based on post-training surveys)	75%/100%

Increased use of digital tools in clinical work (based on post-training survey)	75%/77,91%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/80,46%
Utilization of acquired digital and transversal skills in practice (based on post-training survey)	50%/67,50%
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/87,34%
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/84,81%
Utilization of acquired digital and transversal skills in practice (based on post-training survey) <i>Improved capabilities for leadership in digital settings among participants of train-the-trainer courses</i>	50%/100%

Table HU-3. H-PASS outcome indicators

4.3.2. Demographics of the H-PASS training courses

The demographic profile of participants in the Hungarian H-PASS pilot training shows some differences compared with the consortium-level distribution. The age structure (Figure HU-1.) is strongly concentrated in mid-career groups: 45–54-year-olds represent the largest group (45%), followed by 55–64 (22%), 35–44 (17%), and 25–34 (11%), while 4% were aged 65+ and 1% belonged to the youngest age group (18–24). Compared with the consortium-level pattern, the Hungarian cohort appears older on average, with a particularly large proportion of participants in the 45–54 and 55–64 age groups.

The gender distribution (Figure HU-2.) shows a strong female majority (78% female, 22% male), which closely reflects the general consortium trend where women represented the majority of participants in the training.

In terms of educational background (Figure HU-3.), most participants held higher education qualifications, with 33% reporting a Master's degree and 25% a Bachelor's degree, while 20% reported a doctorate/PhD. In addition, 17% indicated a high school or equivalent qualification and 5% reported vocational education and training (VET). Compared with the consortium-level results, the Hungarian sample includes a notably higher share of doctoral-level participants, suggesting strong representation of highly educated healthcare professionals.

Regarding professional roles (Figure HU-4.), nurses constituted the largest group (35%), followed by physicians (28%) and administrative staff (16%). Smaller groups included allied health professionals (9%), technicians (4%), pharmacists (2%), and other roles (6%). This distribution broadly follows the consortium-level pattern, where nurses and physicians represented the largest professional groups, though Hungary shows a slightly higher proportion of administrative staff among participants.

The distribution of work experience indicates a very experienced participant cohort (Figure HU-5.). The majority (60%) reported more than 20 years of professional experience, while 26%

had 11–20 years, 7% had 6–10 years, 6% reported 1–5 years, and 1% had less than one year of experience. Compared with the consortium-level results, the Hungarian cohort appears even more strongly dominated by highly experienced professionals, with a particularly high share of participants with more than two decades of experience.

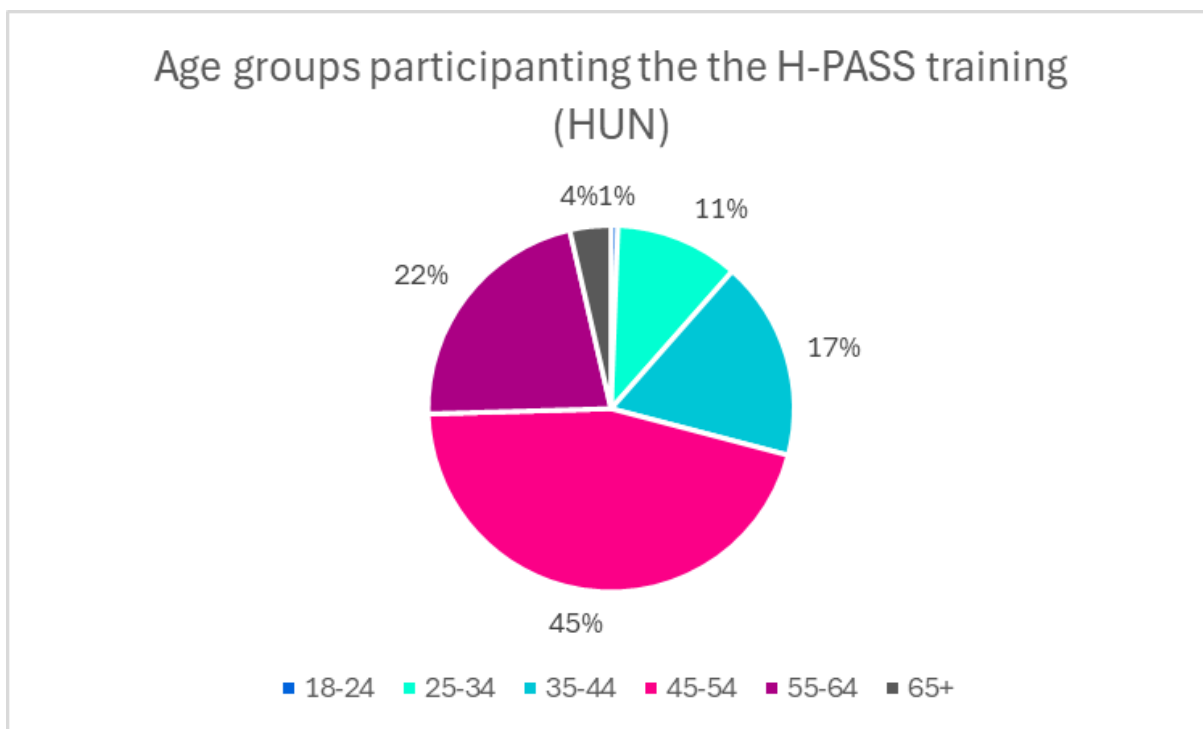


Figure HU-1. Age distribution of H-PASS training participants in Hungary ($n = 165$)

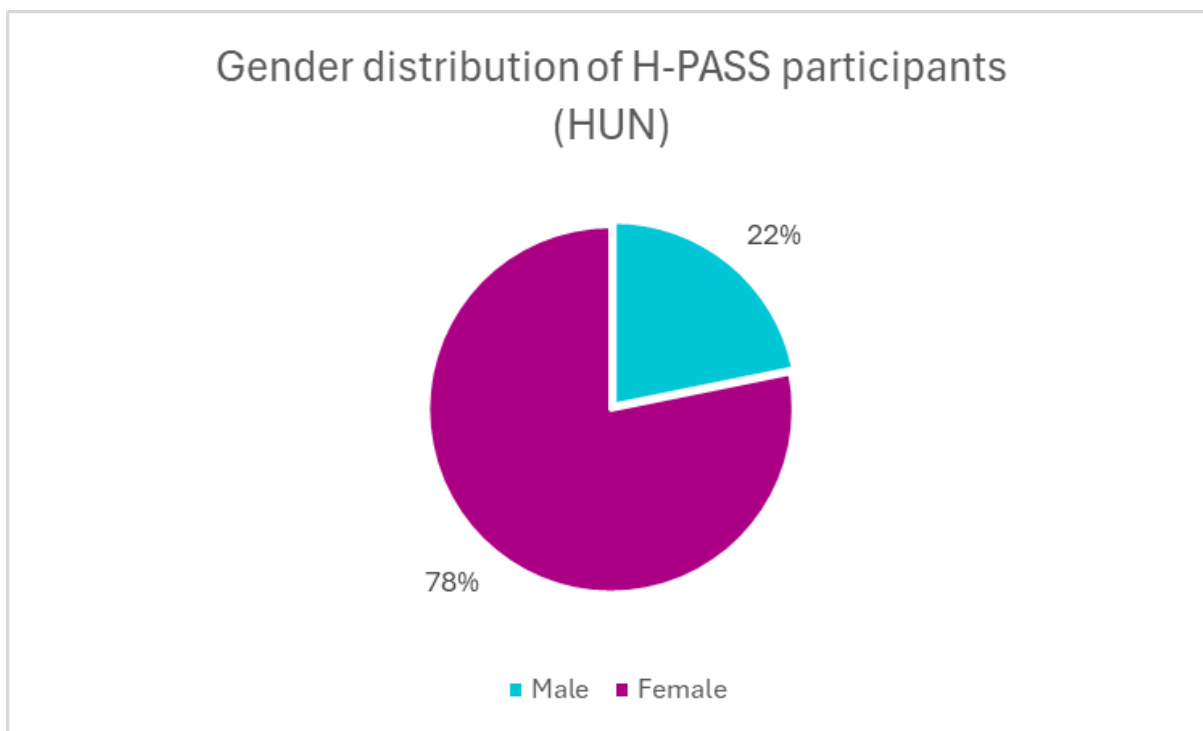


Figure HU-2. Gender distribution of H-PASS training participants in Hungary ($n = 165$)

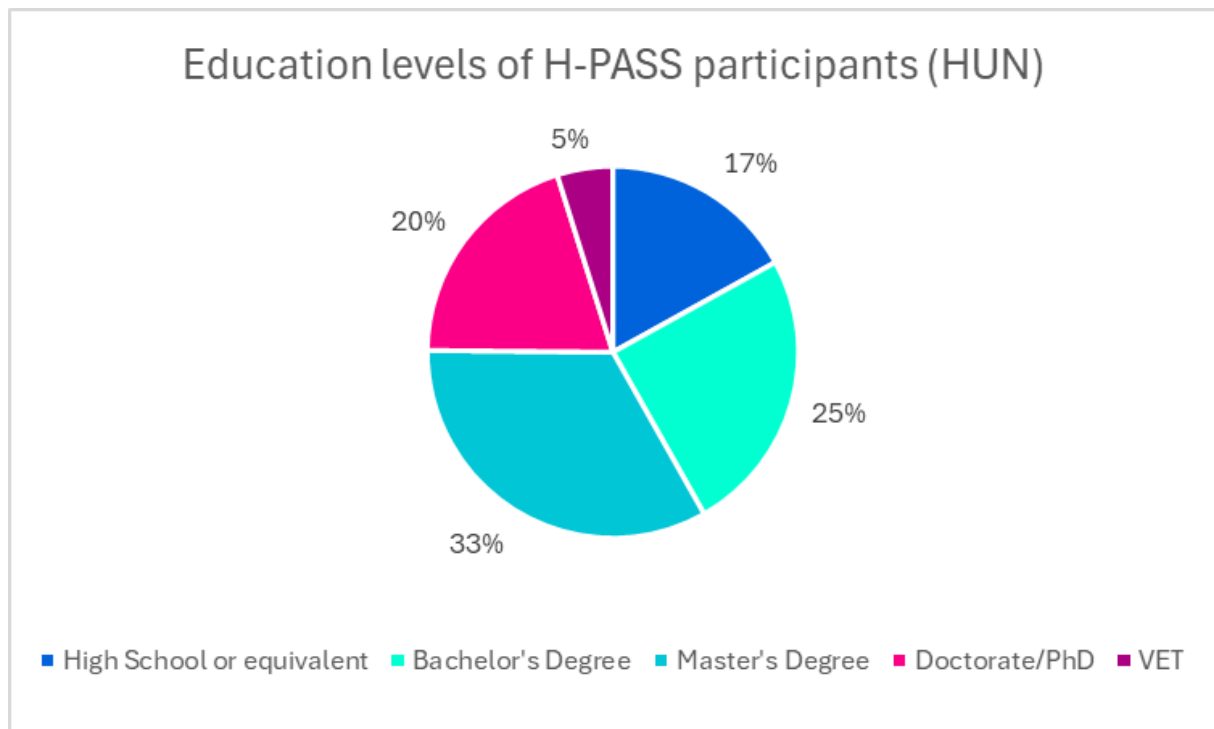


Figure HU-3. Education levels of H-PASS training participants in Hungary (n = 165)

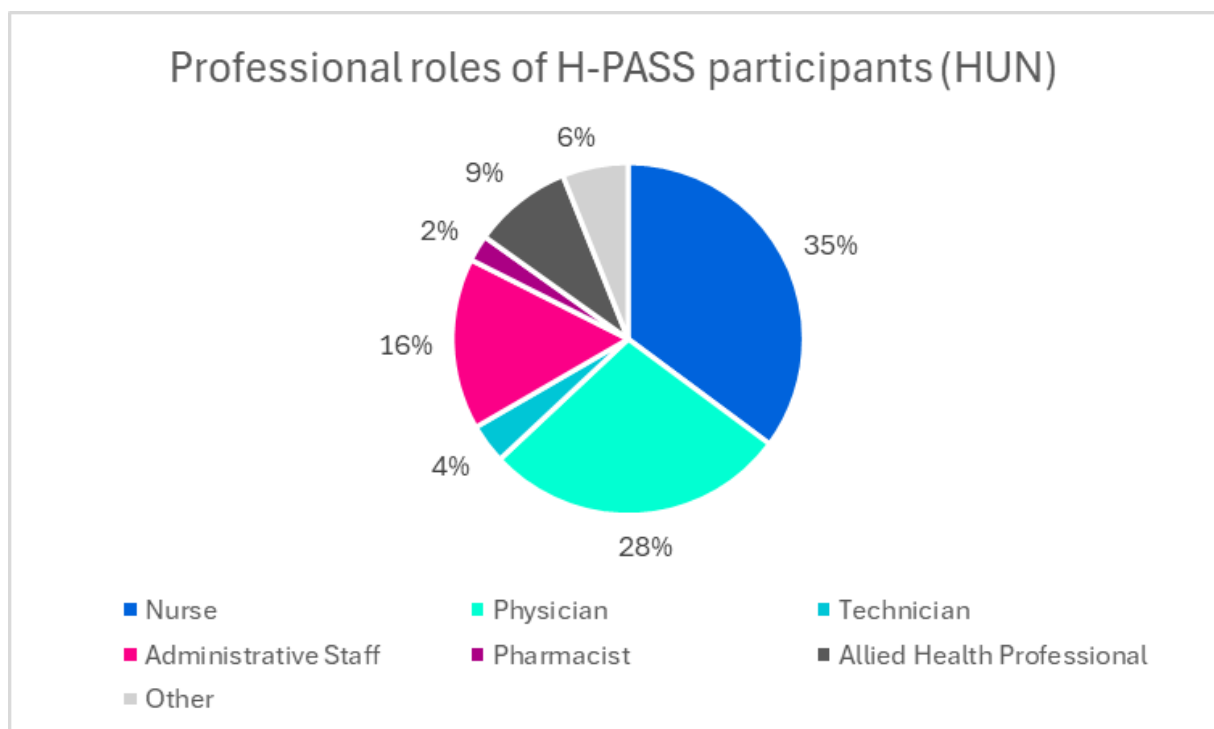


Figure HU-4. Professional roles of H-PASS training participants in Hungary (n = 165)

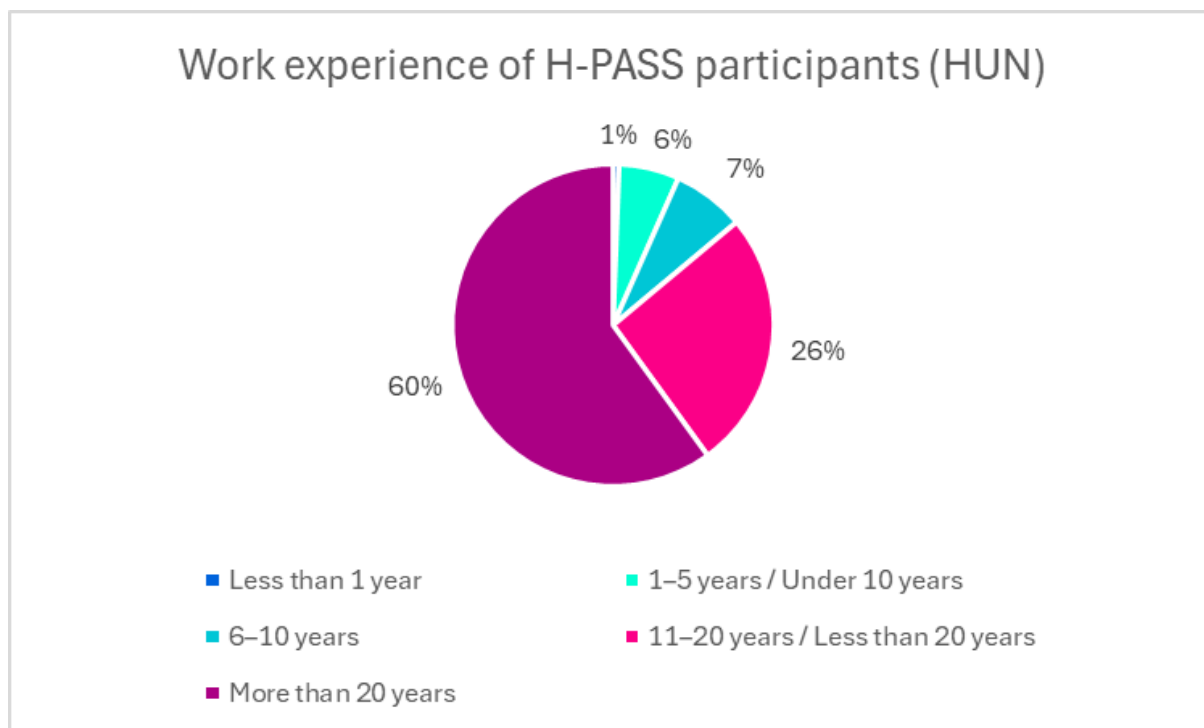


Figure HU-5. Work experience of H-PASS training participants in Hungary (n = 165)

The work environment characteristics of Hungarian H-PASS participants show patterns broadly consistent with the consortium-level results, with a strong dominance of public-sector healthcare institutions (Figure HU-6.). The vast majority of participants (89%) reported working in public institutions, while 4% worked in private institutions, 3% reported working in both public and private settings, and 4% selected other categories.

Regarding employment status (Figure HU-7.), the Hungarian cohort consisted almost entirely of full-time professionals (89%), while 8% reported part-time employment, 2% worked on contract, and 1% indicated being currently unemployed. Similar to the consortium-level pattern, the training primarily reached participants who were actively employed in the healthcare workforce.

In terms of work location (Figure HU-8.), 73% of participants reported working in urban areas, 26% in suburban areas, and 1% in rural settings. This distribution follows the overall consortium trend of predominantly urban participation, although the Hungarian sample shows a relatively higher share of suburban workplaces, suggesting participation from healthcare professionals working in peri-urban healthcare environments.

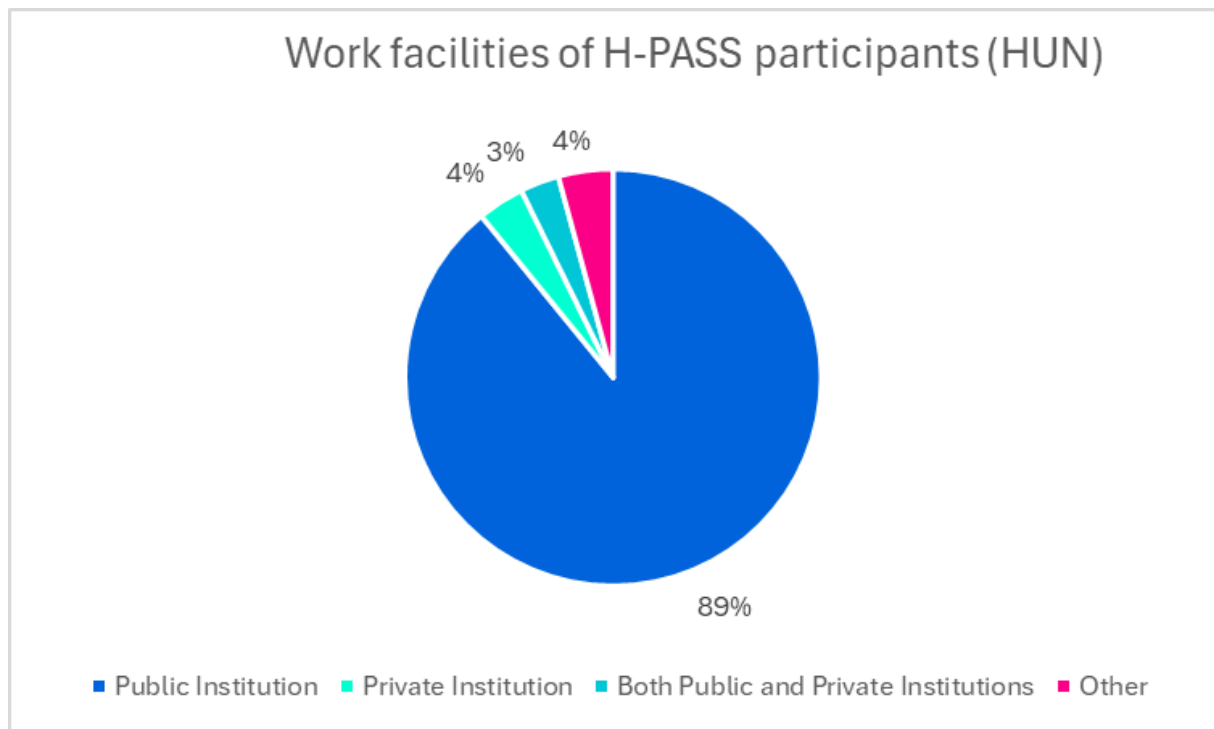


Figure HU-6. Work facilities of H-PASS training participants in Hungary (n = 165)

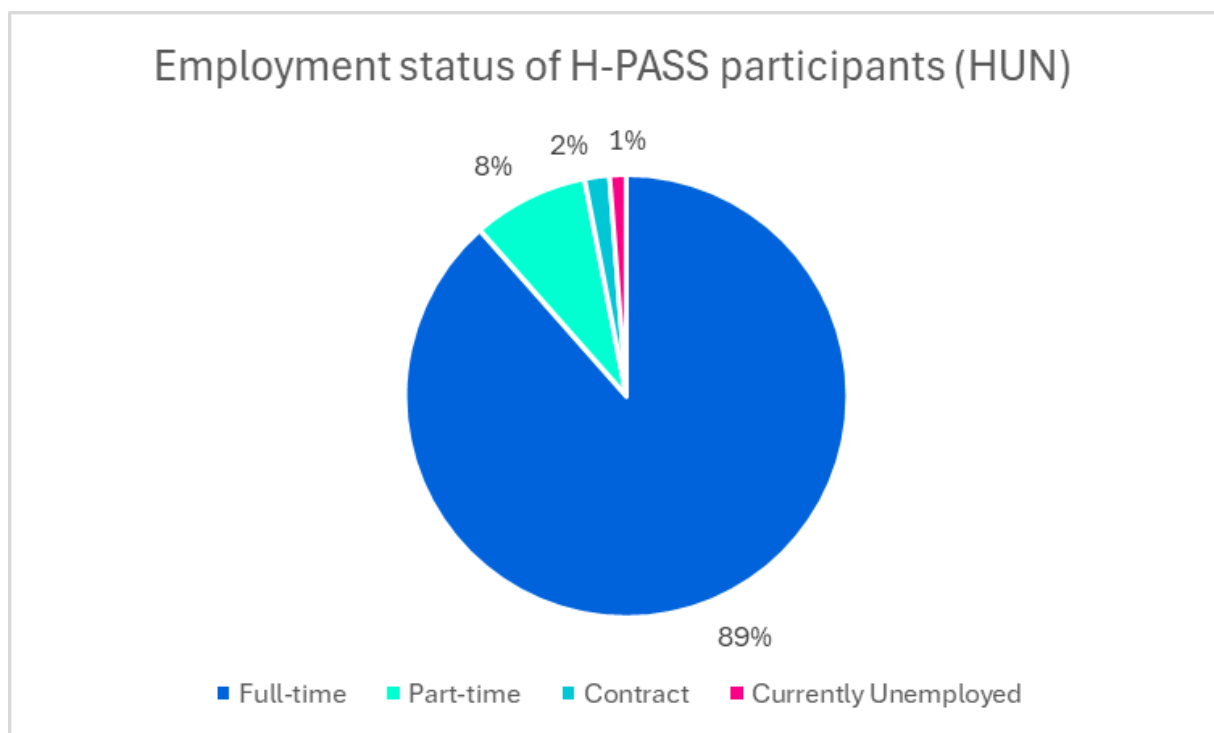


Figure HU-7. Employment status of H-PASS training participants in Hungary (n = 165)

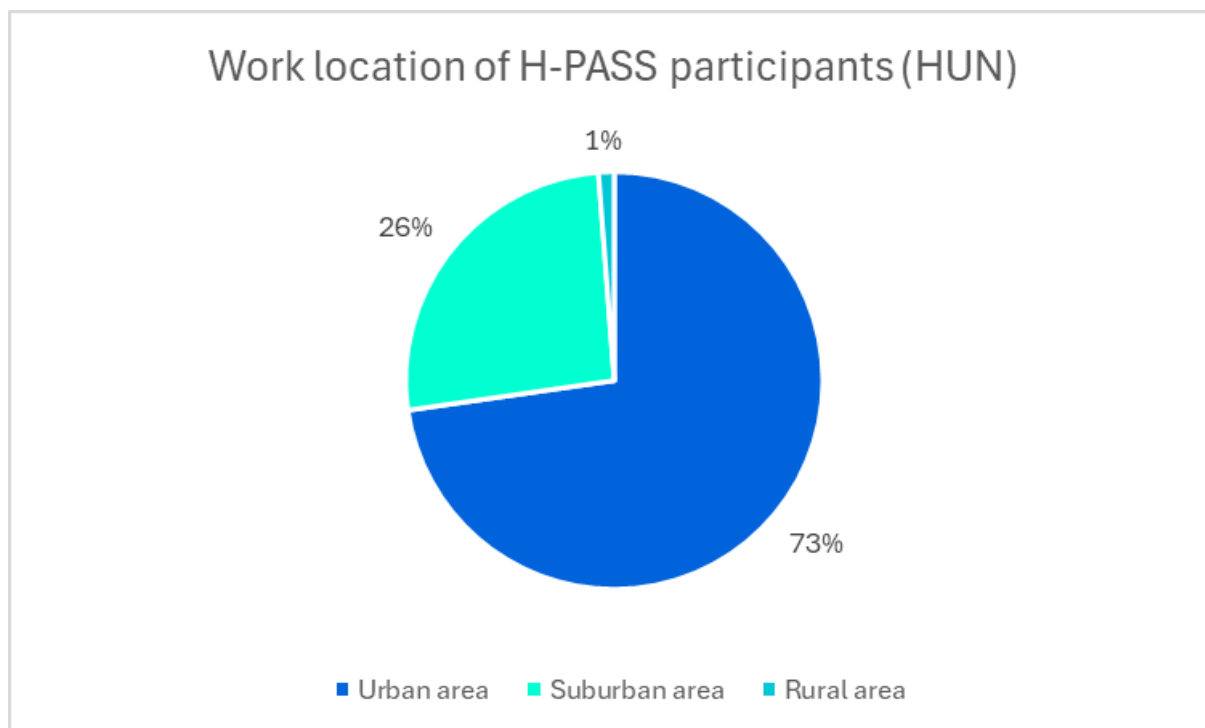


Figure HU-8. Work location of H-PASS training participants in Hungary (n = 165)

4.3.3. Satisfaction with the H-PASS training

The evaluation results from the Hungarian H-PASS pilot training show a high level of participant satisfaction (Figure HU-9.). 55% of respondents rated their overall satisfaction with the training at the highest level (5), while 35% rated it 4, meaning that 90% of participants evaluated the training very positively. Only 7% selected the neutral score (3) and 3% rated it 2, indicating that negative evaluations were rare. This distribution closely follows the consortium-level trend of very high overall satisfaction with the programme.

Participants also reported strong perceived applicability of the training to their daily professional work (Figure HU-10.). The largest share (48%) rated applicability with the highest score (5), followed by 32% rating it 4 and 14% selecting 3. Only 5% and 1% of respondents selected the lower scores 2 and 1, respectively. Compared with the consortium-level pattern, Hungarian participants appear slightly more likely to give the highest rating (5) when evaluating applicability, suggesting that the training content was perceived as particularly relevant to their professional practice.

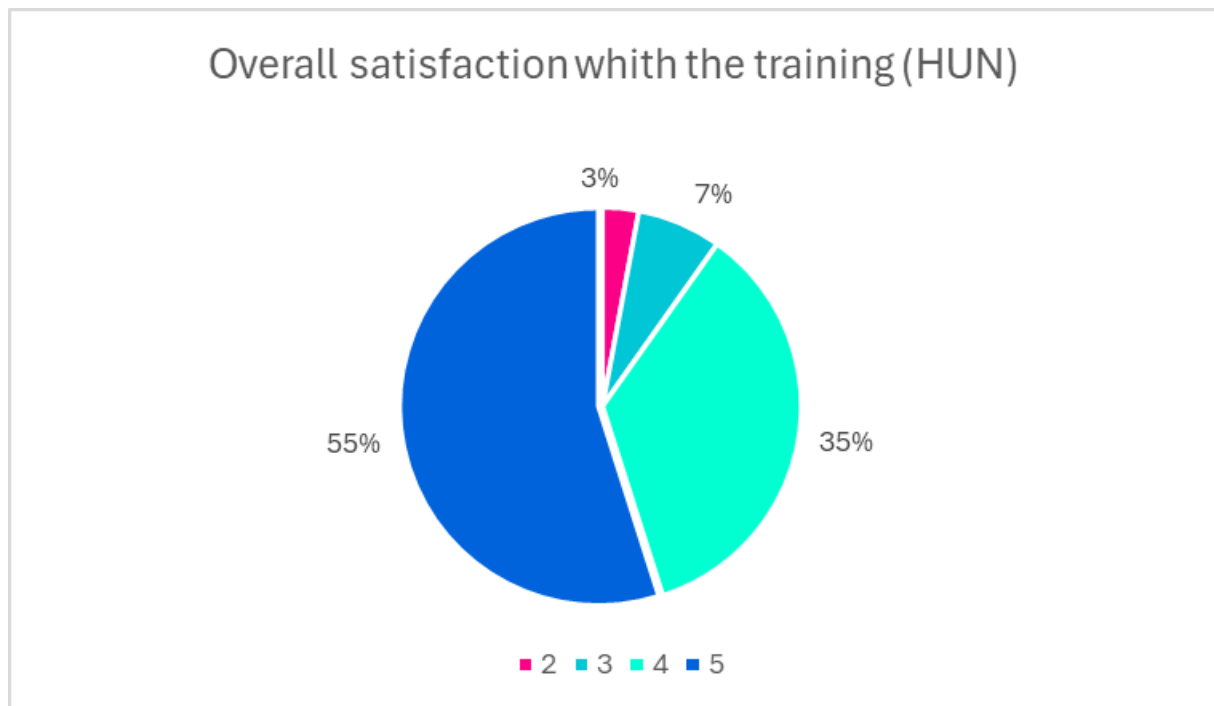


Figure HU-9. Overall satisfaction with the H-PASS training among participants in Hungary (n = 102)

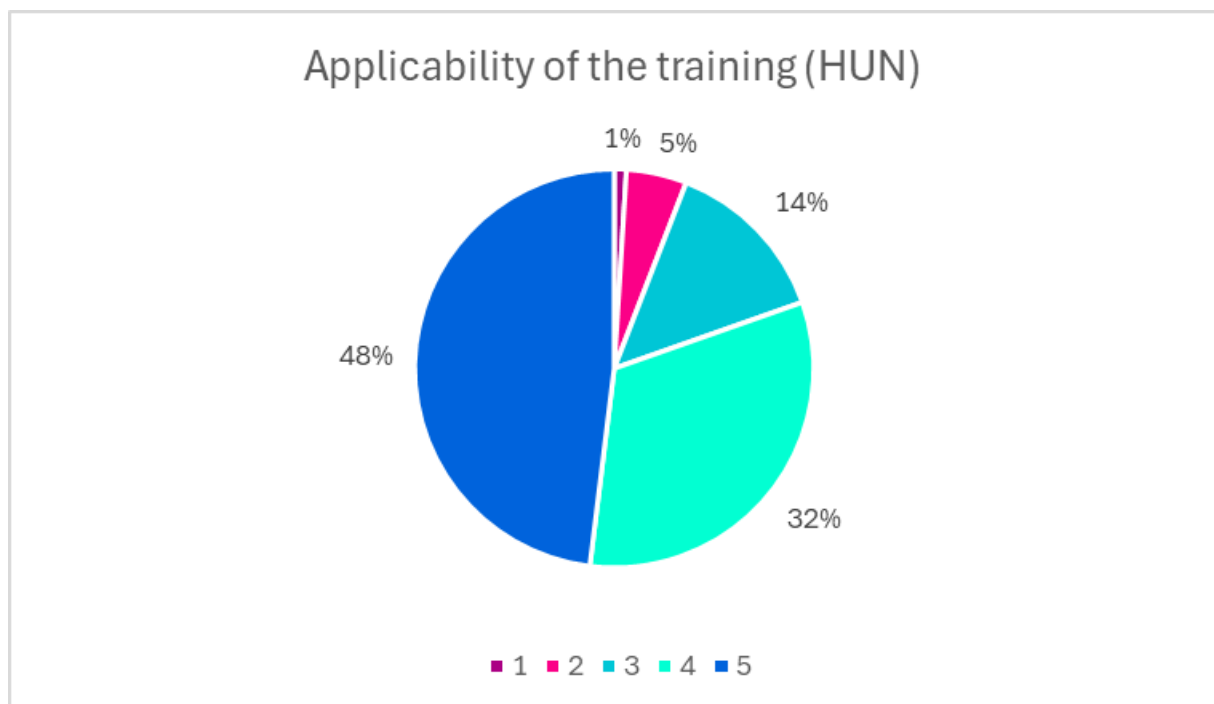


Figure HU-10. Perceived applicability of the H-PASS training to daily work among participants in Hungary (n = 102)

4.3.4. Digital and transversal skill development

Participants in the Hungarian H-PASS training reported substantial improvement in their digital competences (Figure HU-11.). The majority indicated a significant improvement (51%), while 10% reported improvement to a great extent. A further 21% perceived moderate improvement, and 17% indicated only slight improvement, while 1% reported no improvement at all. Overall, this means that over 61% of respondents perceived strong improvements in their digital skills, which is by 9 percentage points lower than the consortium-level results.

Looking at specific digital competence areas based on the DigComp 2.2 framework, the most frequently reported improvements were in communication and collaboration and problem solving, followed by safety and digital content creation (Figure HU-12.). Information and data literacy was the least frequently selected area of improvement, although it still received a notable number of responses.

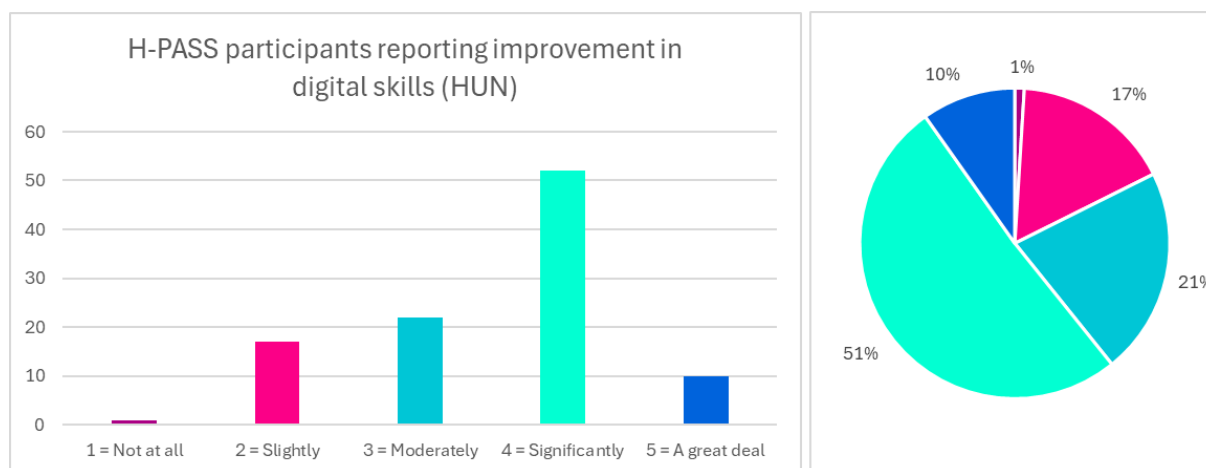


Figure HU-11. H-PASS participants reporting improvement in digital skills in Hungary (n = 102)

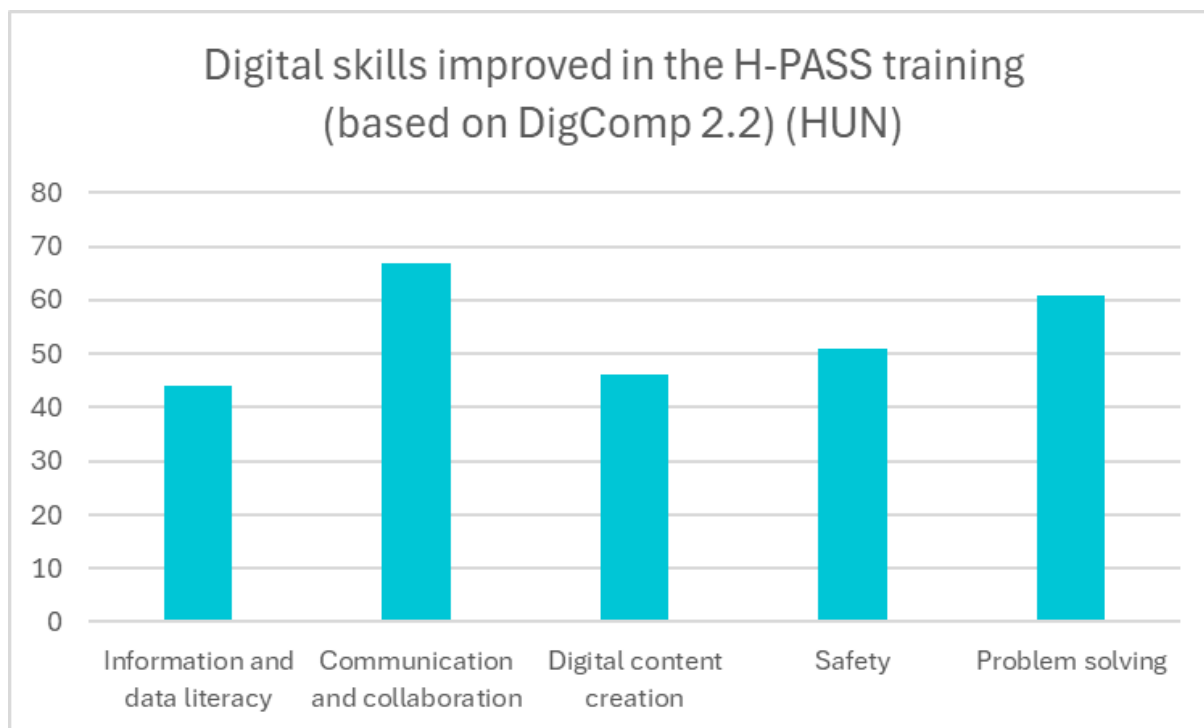


Figure HU-12. Digital competence areas improved through the H-PASS training based on DigComp 2.2 in Hungary (n = 178)

Hungarian participants also reported notable improvements in transversal competences following the H-PASS training (Figure HU-13.). The largest share of respondents (41%) indicated that their transversal skills improved significantly, while 5% reported improvement to a great extent. Additionally, 37% perceived moderate improvement, and 17% reported slight improvement, meaning that the majority experienced at least moderate development in these skills. Here the higher rating of 4 or 5 is 28 percentage points lower than in the consortium-level evaluation.

When examining specific competences based on the LifeComp framework, the most frequently reported improvements were in collaboration, communication, and critical thinking, followed by managing learning and growth mindset (Figure HU-14.). Lower but still notable improvements were reported for flexibility, self-regulation, wellbeing, and empathy. The Hungarian results highlight the strong impact of the training on collaborative and communication-related competences, however, results are less balanced among the competence field than in the consortium-level results.

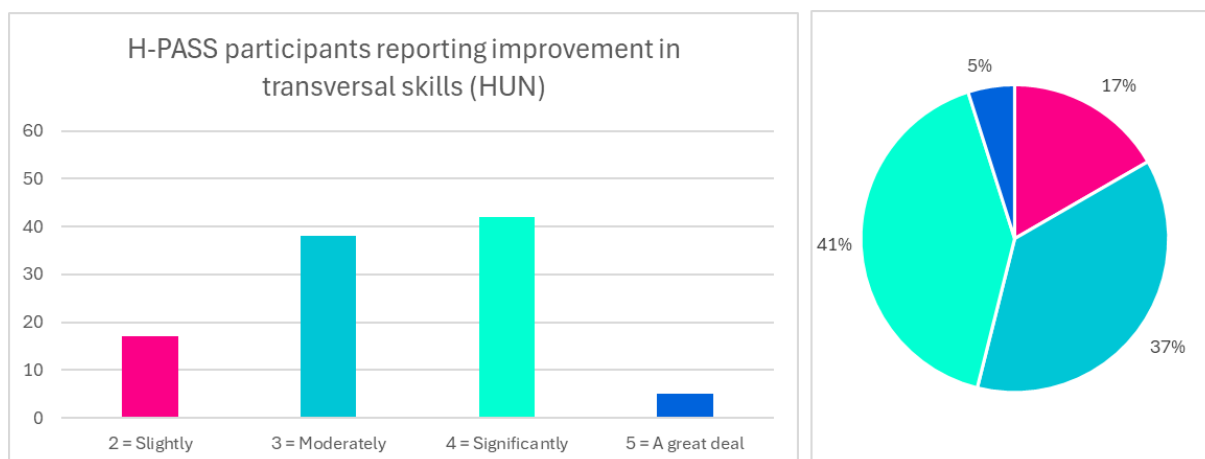


Figure HU-13. H-PASS participants reporting improvement in transversal skills in Hungary (n = 102)

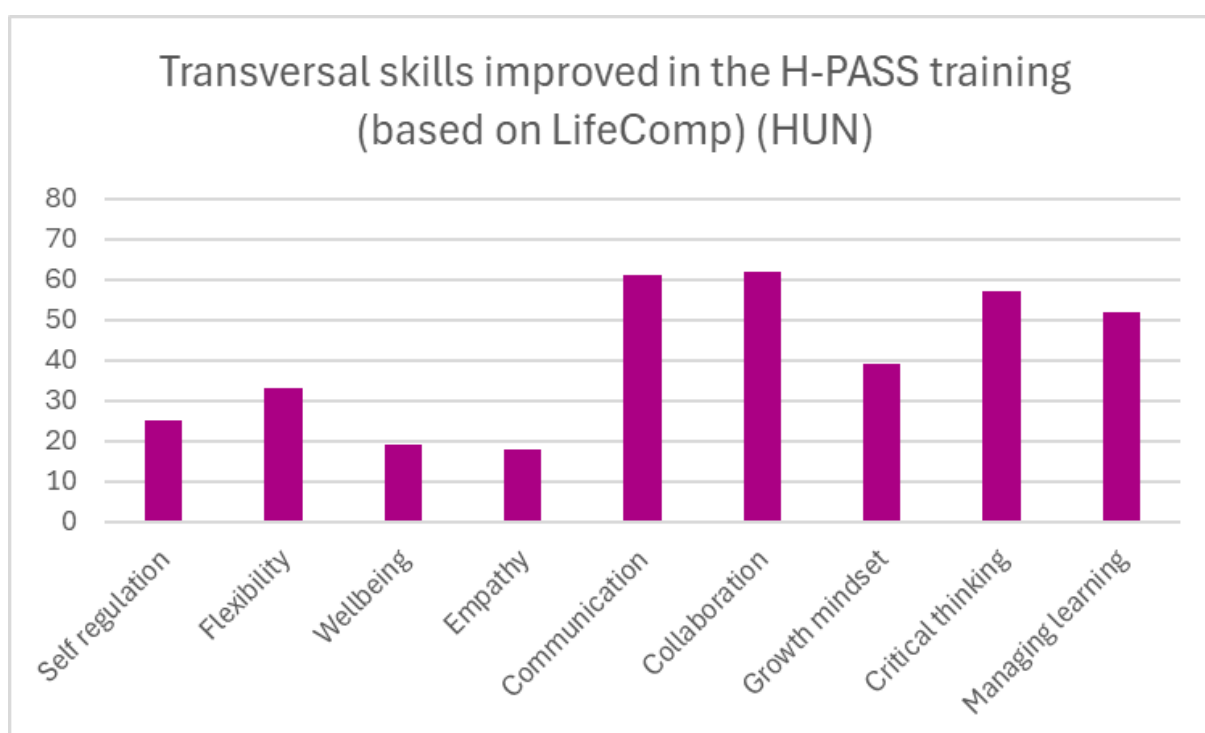


Figure HU-14. Transversal competence areas improved through the H-PASS training based on LifeComp in Hungary (n = 178)

Hungarian participants also reported increased confidence in working within digital teams after completing the H-PASS training (Figure HU-15.). The majority of respondents (54%) rated their improvement at level 4, while 20% selected the highest score (5), meaning that 74% perceived strong growth in their confidence in digital teamwork. A further 21% reported moderate improvement (3) and 5% selected score 2, while no respondents indicated the lowest score. This distribution is mostly consistent with the consortium-level evaluation.

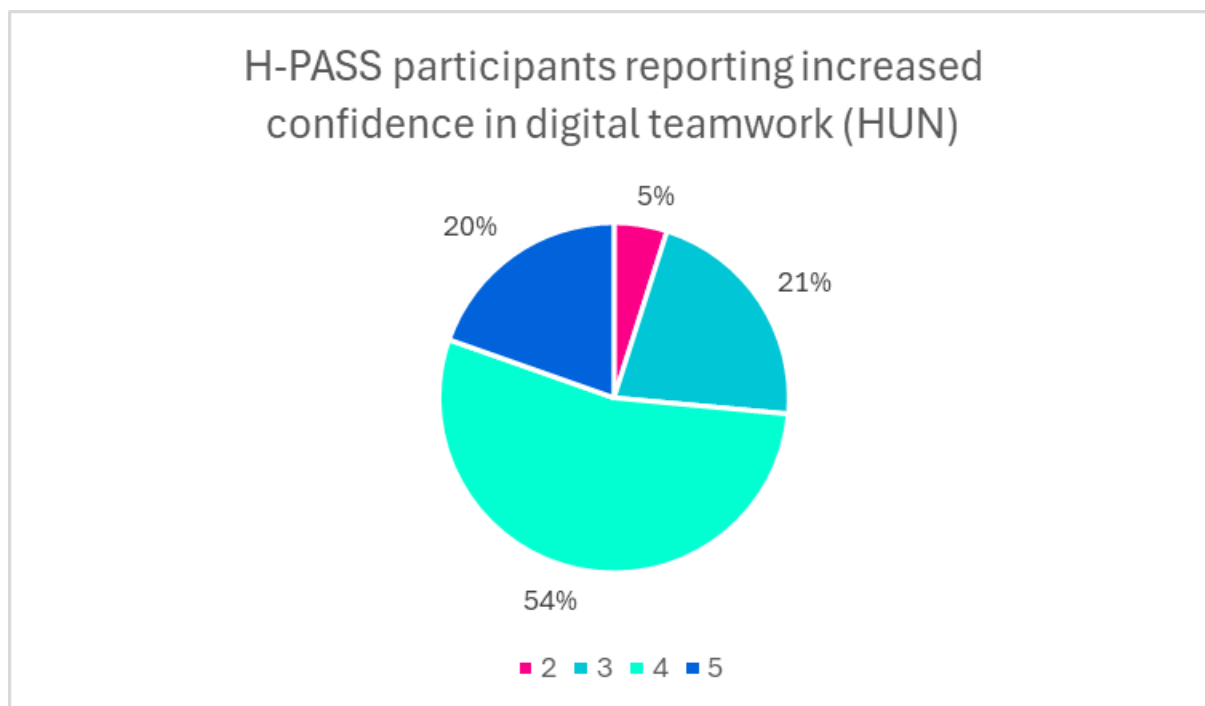


Figure HU-15. Self-reported increase in confidence in digital teamwork among H-PASS participants in Hungary (n = 102)

4.3.5. Impact on digital tool usage

Hungarian participants reported an increase in the use of digital tools in their professional activities following the H-PASS training (Figure HU-16.). Nearly half of the respondents (49%) indicated that they use digital tools slightly more frequently for professional tasks, while 17% reported using them significantly more. At the same time, 18% stated that their usage remained the same or decreased, and 16% considered the question not relevant to their work. These results suggest that the training contributed to a moderate but noticeable increase in the integration of digital tools into everyday professional tasks. Thus, Hungarian participants increased their digital tools usage by 17 percentage points less than the evaluation on the consortium-level suggests.

A similar pattern can be observed regarding administrative tasks (Figure HU-17.). The majority of respondents (56%) reported that they use digital tools slightly more frequently for administrative activities, while 13% stated that they use them significantly more. 17% reported no change or a decrease, and 14% indicated that the question was not relevant to their work. Compared with professional tasks, the increase in digital tool usage appears slightly more pronounced in administrative contexts, suggesting that participants may have more immediate opportunities to apply newly acquired digital skills in organisational processes. The difference is also smaller compared to consortium level results, the difference here is only 10 percentage points.

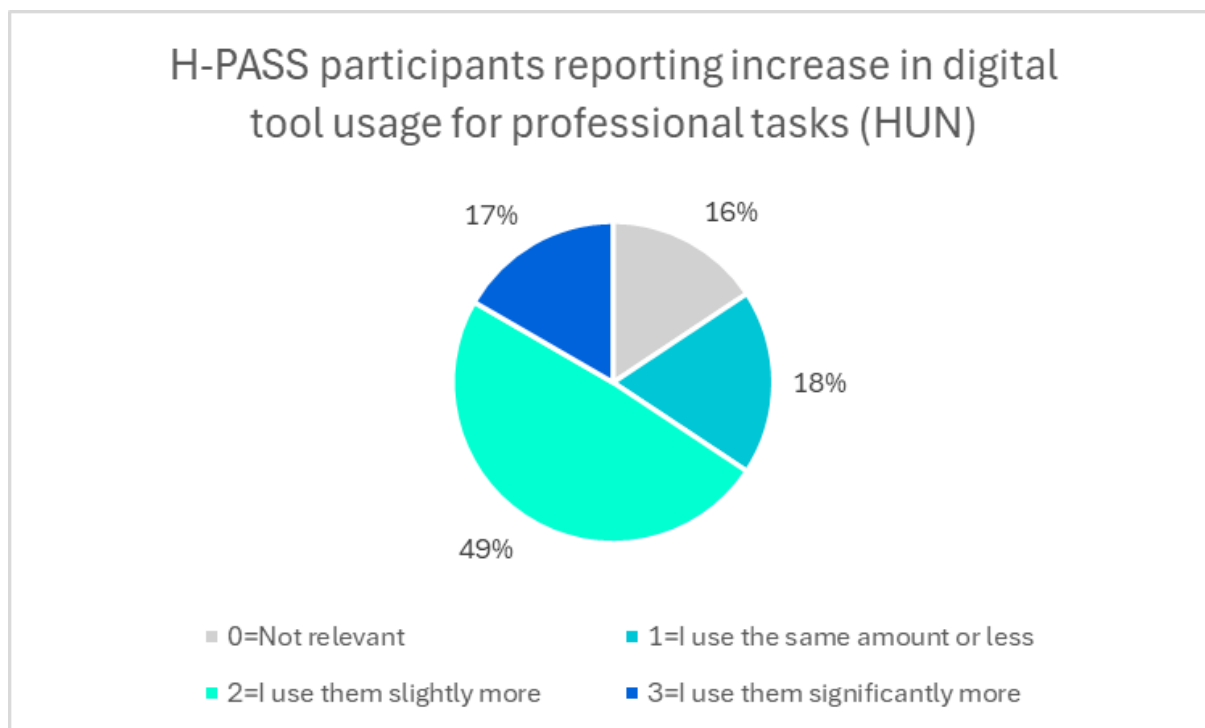


Figure HU-16. Increase in digital tool usage for professional tasks among H-PASS participants in Hungary (n = 102)

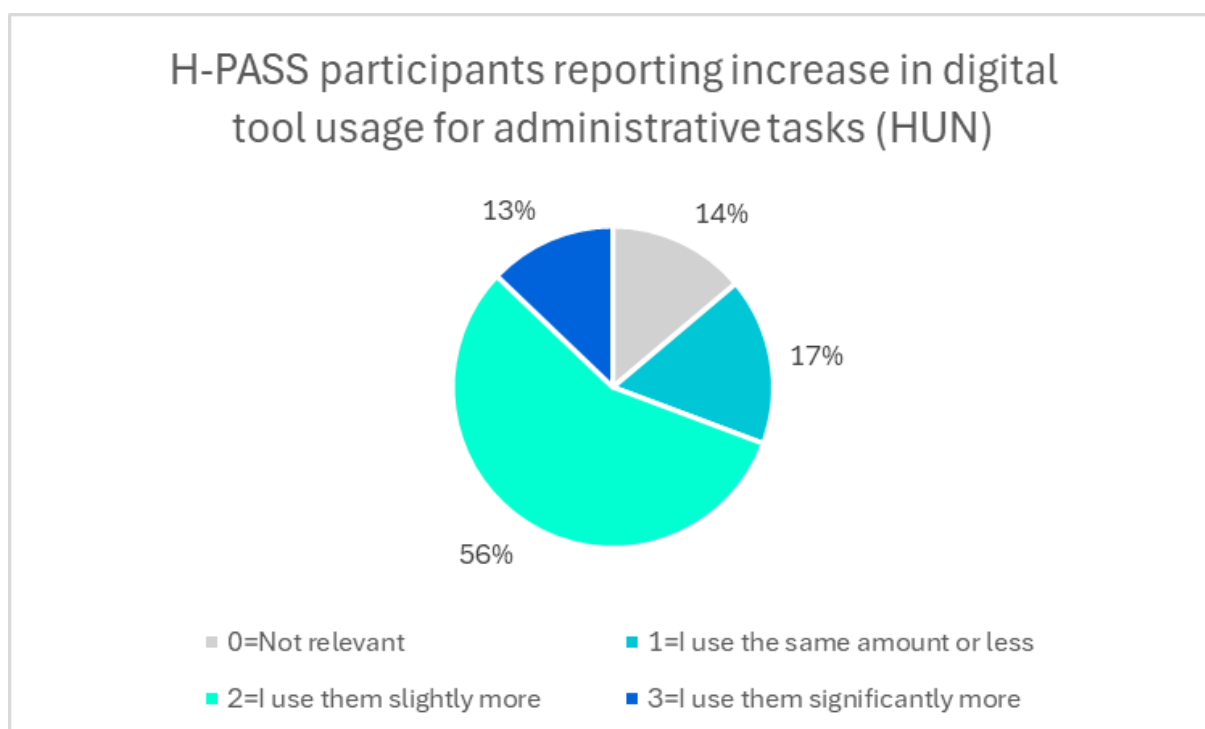


Figure HU-17. Increase in digital tool usage for administrative tasks among H-PASS participants in Hungary (n = 101)

4.3.6. Training follow-up results

The follow-up survey among Hungarian H-PASS participants indicates that the majority perceived positive organisational changes following the training (Figure HU-18.). 67% of respondents reported that organisational processes had improved, while 33% did not observe any noticeable improvement. This suggests that for roughly two-thirds of the respondents the training contributed to perceivable changes in their working environment, which is 14 percentage points lower than on the consortium-level.

When looking at specific areas of organisational change, the most frequently observed improvements were related to workflow and task-shifting, both marked by 18 respondents (Figure HU-19.). Improvements in teamwork were reported by 10 participants, while 9 respondents indicated changes in workload. These results suggest that the most visible impacts of the training were associated with operational processes and the redistribution of tasks.

The number of areas that respondents marked are on the average 2,04, which is slightly higher than on the consortium level.

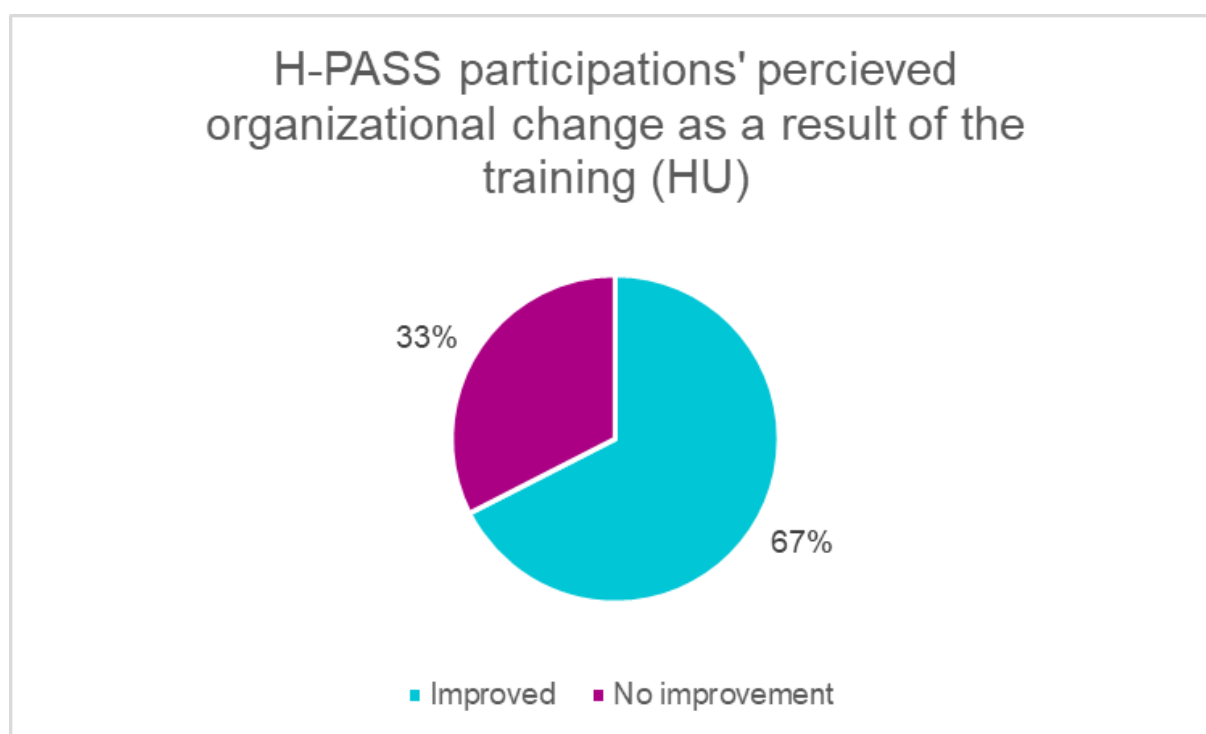


Figure HU-18. H-PASS participants' perceived organisational change as a result of the training in Hungary (n = 40)

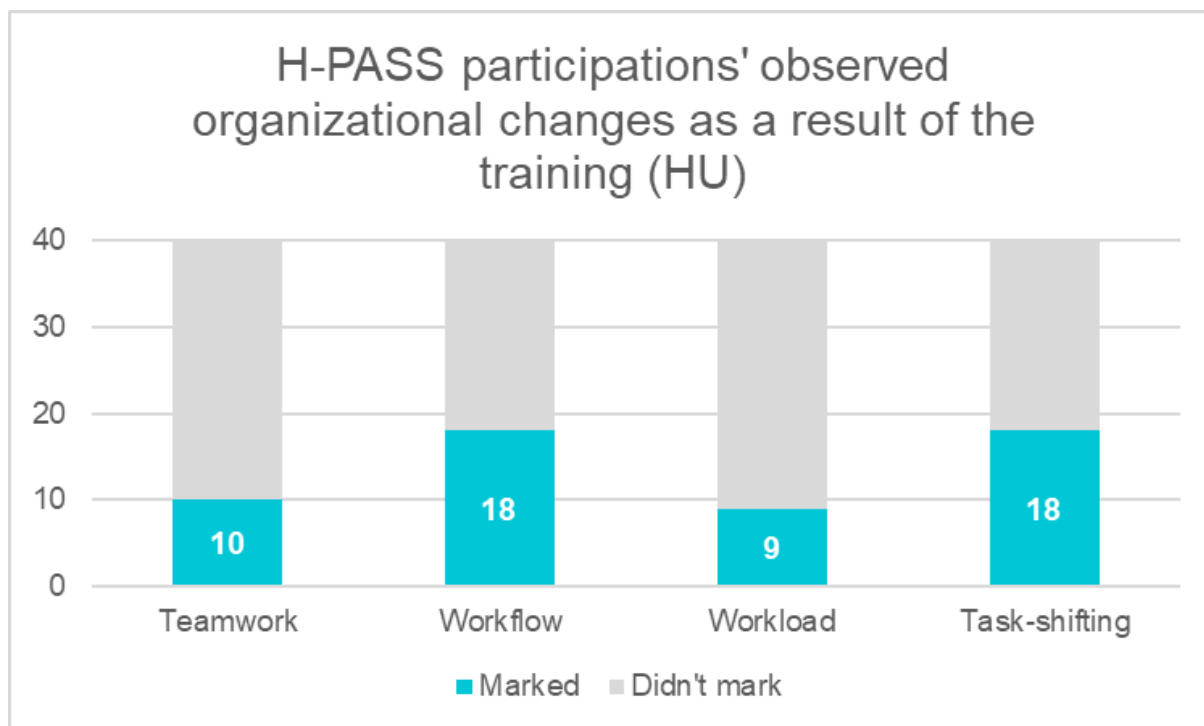


Figure HU-19. Observed organisational changes in specific work processes following the H-PASS training in Hungary (n = 40)

4.3.7. Module evaluation overview

The evaluation of the H-PASS training modules in Hungary shows consistently high ratings across all evaluation aspects (Figure HU-20.). Among the assessed dimensions, relevance and usefulness (ME3) received the highest scores across the modules, followed closely by technical aspects (ME2) and organisation (ME1). Ratings for matching participants' development goals (ME4) and overall learning experience (ME5) were slightly lower, indicating generally strong satisfaction with the structure and delivery of the modules.

Looking at the modules individually, Module 2 and Module 4 received the highest overall evaluations, particularly in terms of relevance and usefulness (Figure HU-21.). Module 3 showed slightly lower results, especially regarding the learning experience and alignment with development goals, although the ratings still remained relatively high. Module 1 demonstrated stable evaluations across all aspects, with somewhat stronger ratings in technical aspects and organisation.

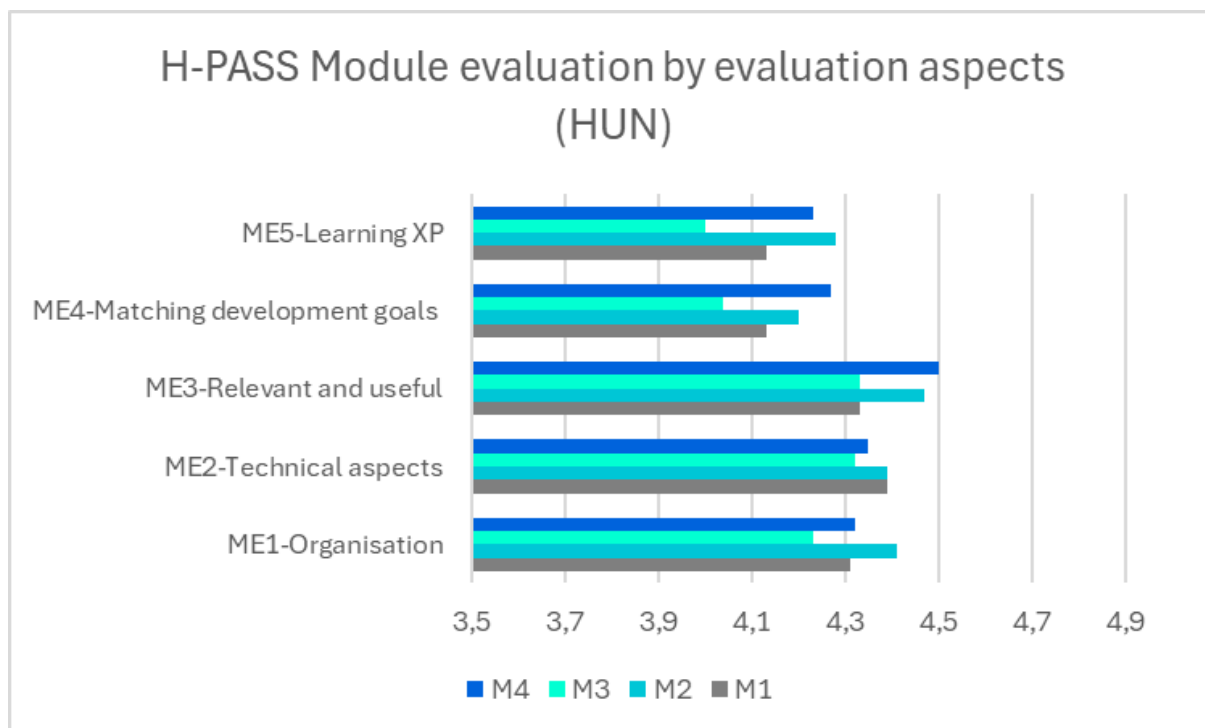


Figure HU-20. Evaluation of H-PASS training modules by evaluation aspects in Hungary (n = 101–150)

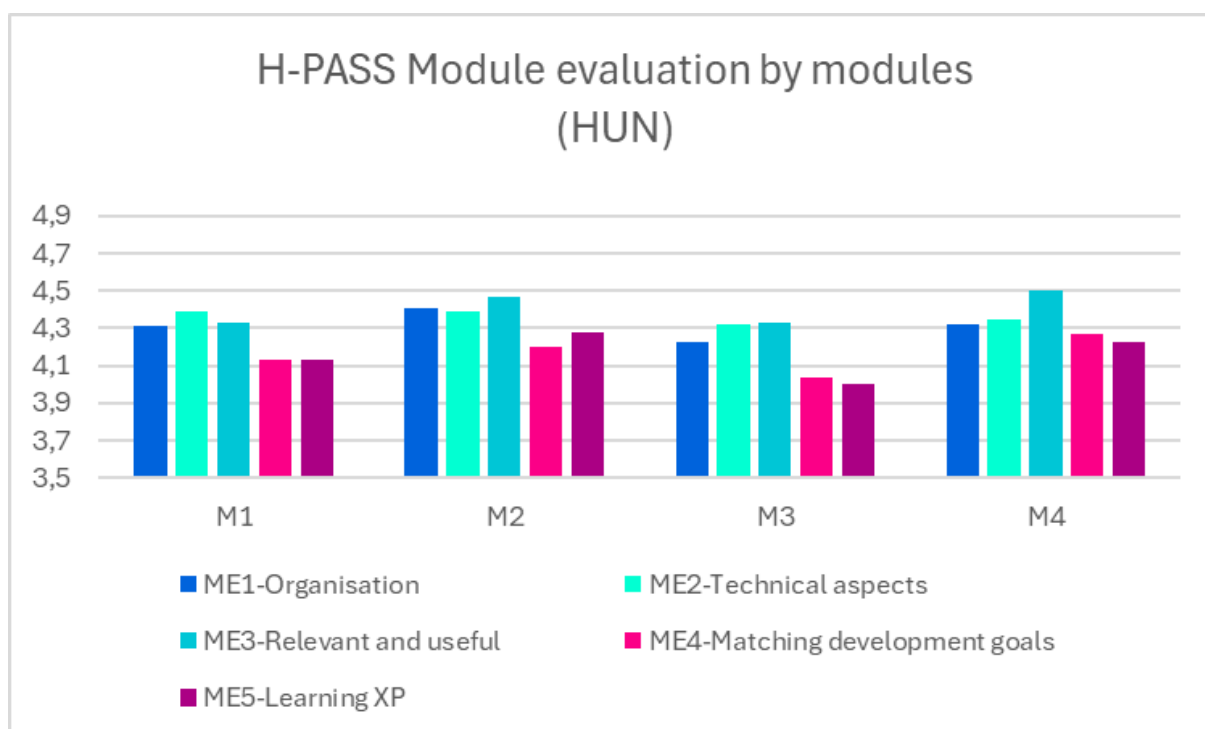


Figure HU-21. Evaluation of H-PASS training modules by module in Hungary (n = 101–150)

The evaluation of individual training exercises in Hungary (Table HU-4.) shows a clear preference for activities focusing on practical digital health applications and teamwork. The highest-rated exercise was “Cyber security and digital wellbeing” (4.48) from Module 4, indicating strong appreciation for applied examples of digital healthcare solutions. This was followed by “Communication in Healthcare” (4.41) and “Teamwork in Healthcare” (4.39), both from Module 2, highlighting the importance participants attributed to collaborative and communication-related competences within healthcare environments.

At the lower end of the ranking, exercises from Module 3 received the lowest scores among the internally developed activities. “Forum debate” (3.50) and “Let’s provide feedback” (3.39) were rated lower than other exercises, suggesting that participants may have perceived these activities as less engaging or less directly applicable to their daily professional practice. The lowest-rated exercise overall was “AR-in-a-Box” (2.21) from Module 4. As mentioned in the consortium-level analysis, this activity was not originally developed within the H-PASS project but adapted from external material. The relatively low evaluation may therefore reflect differences in structure, style, or perceived relevance compared with the otherwise highly consistent training exercises.

TOP1	M4B2	Cyber security and digital wellbeing	4,48
TOP2	M2B1	Communication in Healthcare	4,41
TOP3	M2B3	Teamwork in Healthcare	4,39
BOTTOM3	M3B2	Forum debate	3,5
BOTTOM2	M3B6	Let's provide feedback	3,39
BOTTOM1	M4B4	AR-in-a-Box	2,21

Table HU-4. *Highest and lowest performing training items in the Hungarian pilot (n = 18–150)*

4.3.8. Evaluation results of the DCA training

The Hungarian participants of the DCA training reported very high satisfaction with the programme (Figure HU-22.). The majority of respondents (69%) rated their overall satisfaction with the highest score (5), while 23% rated it 4 and 8% selected 3. No respondents indicated dissatisfaction. These results demonstrate a very positive reception of the DCA training among Hungarian participants; satisfaction is even slightly higher than the consortium-level tendency.

Participants also reported a high level of readiness to foster collaboration within the H-PASS network (Figure HU-23.). More than half of respondents (54%) selected the highest score (5) when evaluating their preparedness to support collaboration, while 15% rated it 4 and 23% selected 3. A small share (8%) selected score 2, indicating limited agreement with the

statement. A greatly higher proportion of respondents marked 5 than on the consortium-level evaluation (by 18 percentage points), however, due to the sample size ($n=13$) we can't see this as significant.

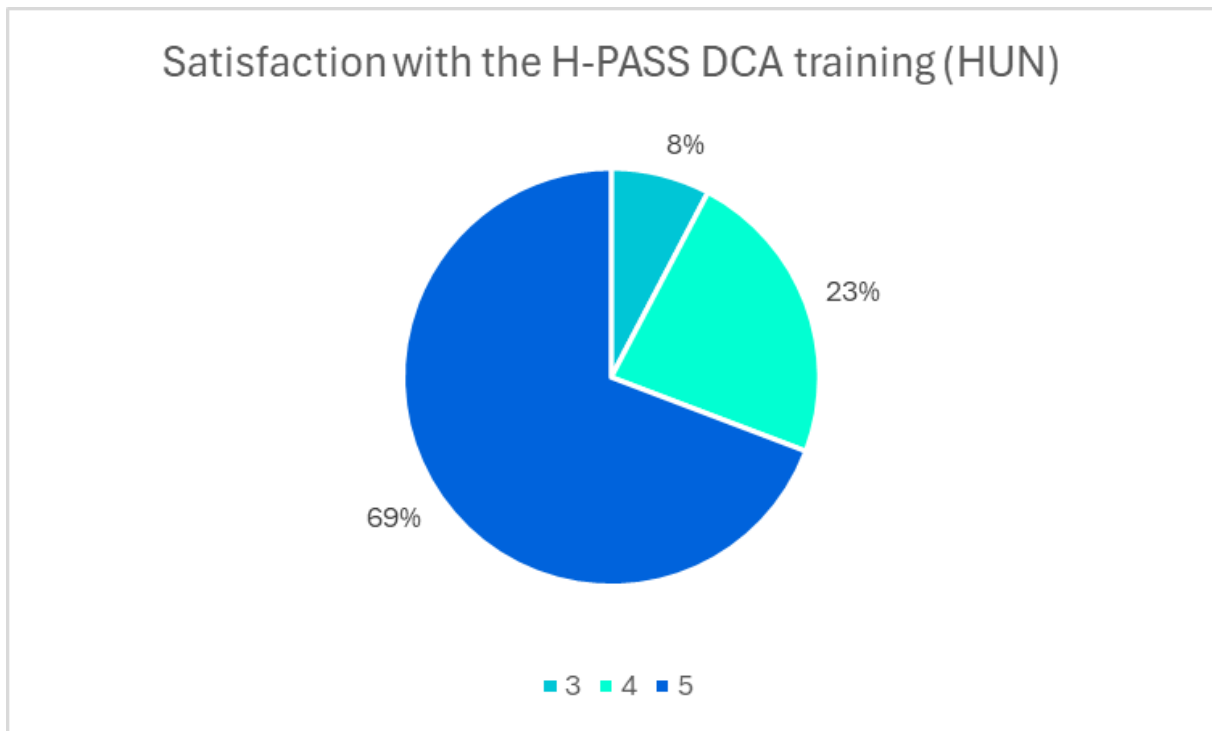


Figure HU-22. Satisfaction with the H-PASS Digital Change Agent training in Hungary ($n = 13$)

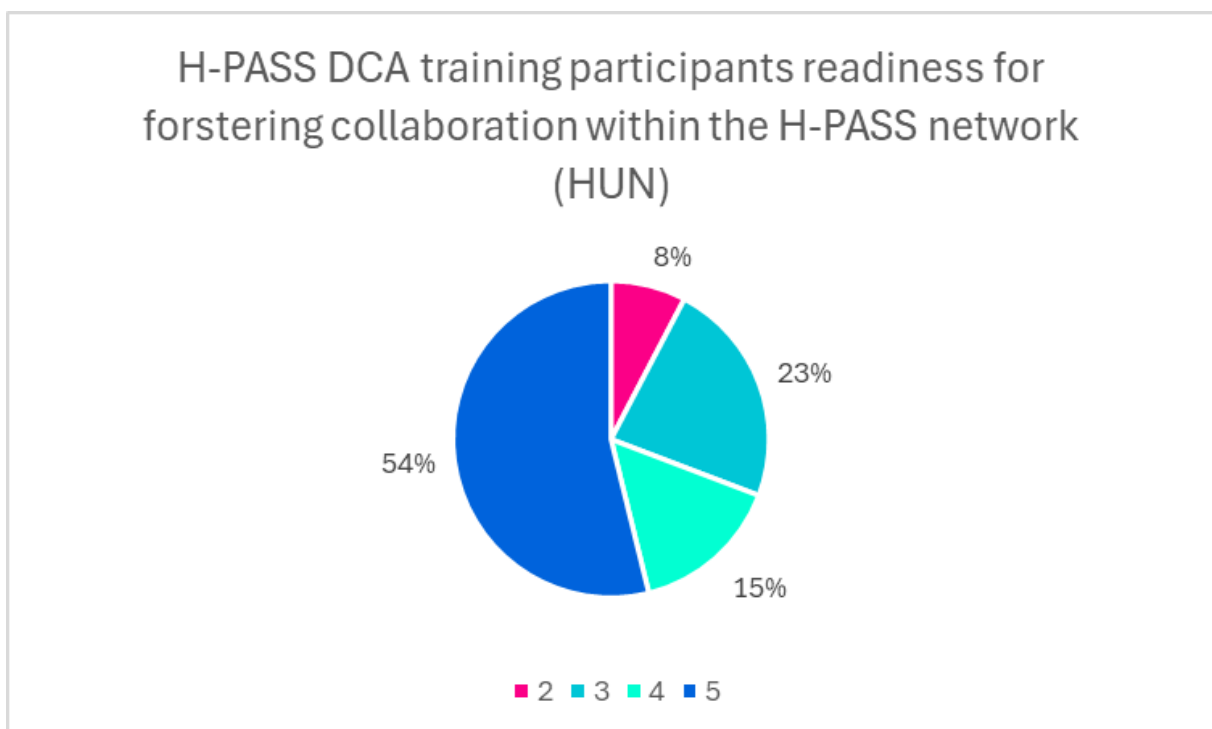


Figure HU-23. H-PASS DCA training participants' readiness to foster collaboration within the H-PASS network in Hungary ($n = 13$)

The comparison of pre- and post-training self-evaluations among Hungarian DCA participants indicates very strong perceived improvements in the key competences addressed by the training (Figure HU-24.). All respondents (100%) reported the same or higher post-training scores in both understanding the role of a Digital Change Agent and change management skills, suggesting that the training successfully strengthened participants' confidence in these areas. For knowledge of educational methods, 89% of respondents reported the same or higher score in the post-training survey. The results suggest that the DCA training had a consistently positive perceived impact on participants' understanding of the DCA role and their change management capabilities, while improvements in educational methods were also reported by the majority of respondents.

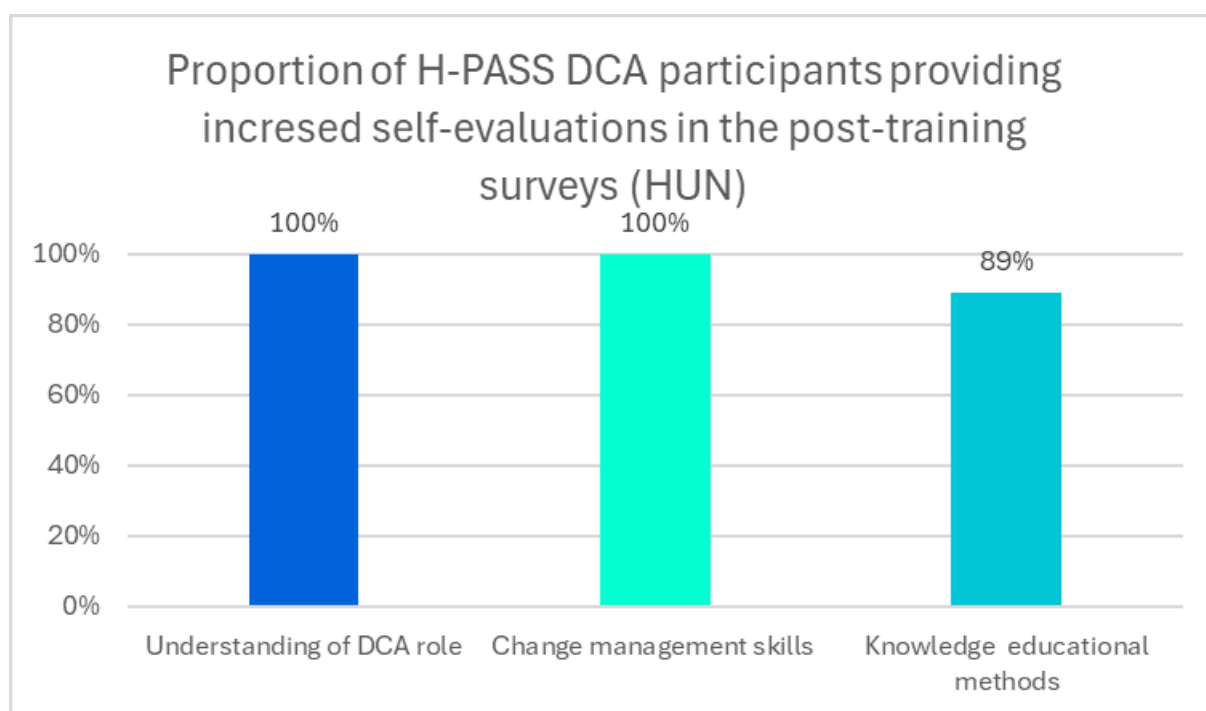


Figure HU-24. Proportion of Hungarian H-PASS DCA participants reporting increased or unchanged self-evaluations in post-training surveys (n = 9)

The follow-up survey of Hungarian DCA alumni provides insight into how participants applied the training outcomes in their professional environments (Figure HU-25.). A total of 9 alumni completed the follow-up survey with complete data, and all 9 respondents reported that the DCA training strengthened their leadership skills in facilitating digital transformation within their work environment. In addition, 6 respondents indicated that they had already taken concrete actions in their professional settings to support digital innovation or improve teamwork and collaboration.

These results are slightly higher than the consortium-level results, however, considering the small sample size (n = 9), this difference cannot be considered significant.

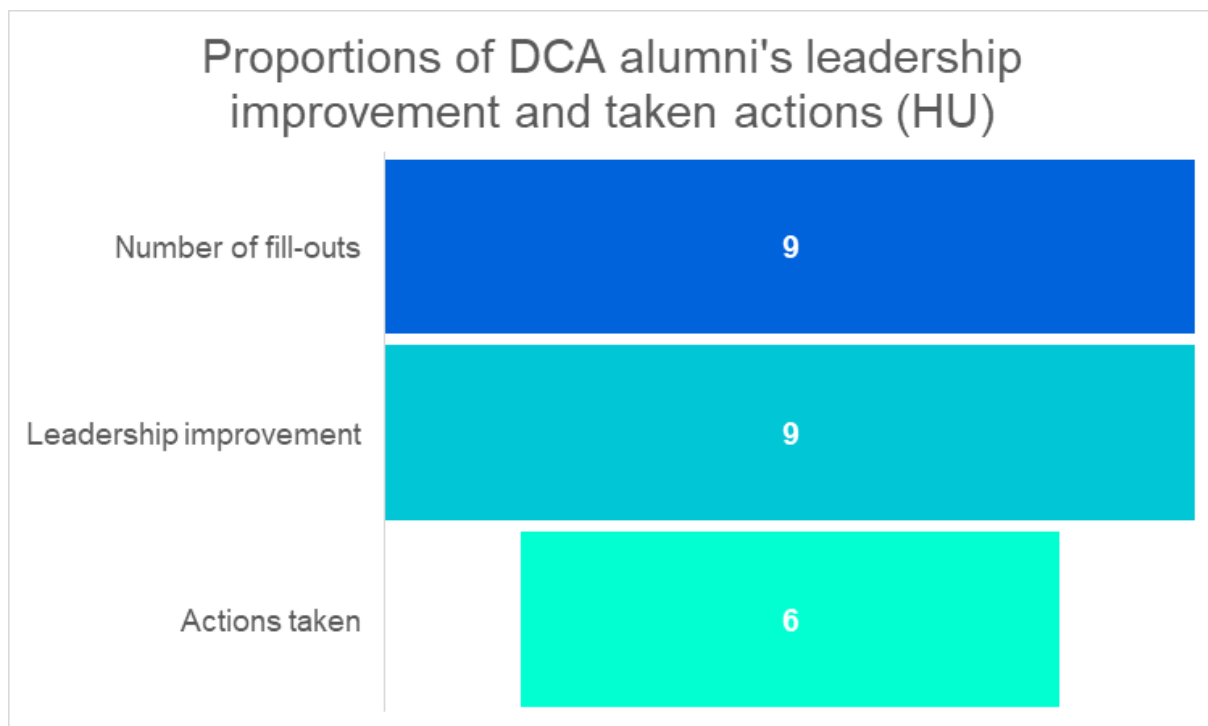


Figure HU-25. Leadership improvement and actions taken among Hungarian H-PASS DCA alumni (follow-up survey, n = 9)

4.3.9. Participant testimonials

Answers from the Closing survey:

"I found the assigned individual tasks very useful. A considerable amount of background information had to be gathered in order to complete them. The YouTube videos and written articles attached to the slides provided additional knowledge and context.

Personally, I began to feel the perspective-shaping impact of the slides from Module 2 onward. Communication is almost always a component of most trainings, and although there were some new elements here as well, the truly new knowledge appeared from Module 2 onwards. From that point, the learning material formed a coherent framework, and I noted down several ideas that I plan to introduce into my daily work.

In a few months, I plan to return to this and reflect on what I have been able to implement from the course. It was very useful. Thank you."

"Congratulations! The training was excellent. I gained a lot of useful information and, through the group tasks, I also had the opportunity to get to know many people and different perspectives."

Answers from the DCA Post-training survey:

“My attitude towards change has improved, although I generally prefer predictability and well-established, carefully considered systems. Whenever a change becomes necessary, I always hope that it will have positive long-term effects. The training has given me a new perspective and momentum.”

Answers from the DCA Follow-up survey:

“I have started reorganizing and restructuring the work processes of the outpatient department’s healthcare staff. The results are encouraging and have already become visible within one month. We are now operating more efficiently and in a more organized way.

We have also launched a pain project in which I can apply and make use of what I learned here. In this project, I mainly apply the concepts related to process design and development that were covered during the training.”

“We introduced the organization of professional meetings and briefings in an online format. I try to take every opportunity to become familiar with and experiment with digital applications and AI tools.”

4.4. Italy

4.4.1. Indicator summary

Satisfaction rate (evaluated with 4 or 5): 85,8% (n=141)

Satisfaction rate (evaluated with 5): 56% (n=141)

Breakdown	Number of health professionals completing the H-PASS training
In total	75/142
Medical doctors	20
Nurses	41
Allied health professionals	78
Other	1
Pharmacists	2
CME credential attainment	141
TtT participants	82
TtT participants / Trainer pool	9
TtT participants / DCA training course	73

Table IT-1. H-PASS output indicators

Breakdown	Number of health professionals completing the H-PASS training
18–24	0
25–34	14
35–44	41
45–54	46
55–64	36
65 or older	5
No data on age	0
Female	107
Male	35

Table IT-2. H-PASS participants by age groups and by gender

Breakdown	Target/Result
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/97,8%
Improvement in transversal skills among training participants (based on pre- and post-training surveys)	75%/98,5%
Improved capabilities for teamwork for teamwork in digital settings (based on post-training surveys)	75%/99,3%

Increased use of digital tools in clinical work (based on post-training survey)	75%/85,1%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/75,7%
Utilization of acquired digital and transversal skills in practice (based on post-training survey)	50%/92,27%
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/83%
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/94%
Utilization of acquired digital and transversal skills in practice (based on post-training survey) <i>Improved capabilities for leadership in digital settings among participants of train-the-trainer courses</i>	50%/80,95%

Table IT-3. H-PASS outcome indicators

4.4.2. Demographics of the H-PASS training courses

The demographic profile of participants in the Italian H-PASS pilot training broadly follows the consortium-level patterns, with a few notable differences. The age distribution (Figure IT-1.) shows that the largest group of participants belonged to the 45–54 age group (32%), followed by 35–44 (26%) and 55–64 (24%), while younger professionals aged 25–34 accounted for 15% and 3% were aged 65 or above. Compared with the consortium-level results, the Italian cohort appears slightly more concentrated in mid- to late-career age groups, with relatively fewer younger participants.

The gender distribution (Figure IT-2.) also reflects the general pattern observed across the consortium, with a female majority (71%), although the proportion of male participants (29%) is somewhat higher than at consortium level. In terms of educational background, Italian participants were highly qualified (Figure IT-3.), with the majority holding a Master's degree (57%), followed by Bachelor's degrees (35%), while 5% reported a doctorate/PhD and 3% a high school or equivalent qualification. Compared with the overall consortium profile, the Italian sample shows a higher share of Master's-level qualifications, suggesting a particularly highly educated participant group.

Regarding professional roles (Figure IT-4.), the largest group consisted of nurses (28%), followed by physicians (15%) and technicians (11%), while smaller proportions included allied health professionals (8%), administrative staff (2%), and pharmacists (1%). A relatively large proportion (35%) selected "other" roles, which differs from the consortium-level distribution and suggests a broader diversity of professional backgrounds among Italian participants.

The distribution of work experience (Figure IT-5.) indicates a highly experienced participant group: 48% reported more than 20 years of experience, and 28% had between 11 and 20 years, while 14% reported 6–10 years, 9% reported 1–5 years, and 1% had less than one year

of experience. Compared with the consortium-level results, the Italian cohort appears even more experienced, with a particularly large share of professionals with over two decades of work experience. Overall, the Italian pilot training primarily reached mid- to late-career healthcare professionals with high educational attainment and substantial professional experience, broadly reflecting but slightly amplifying the trends observed across the consortium.

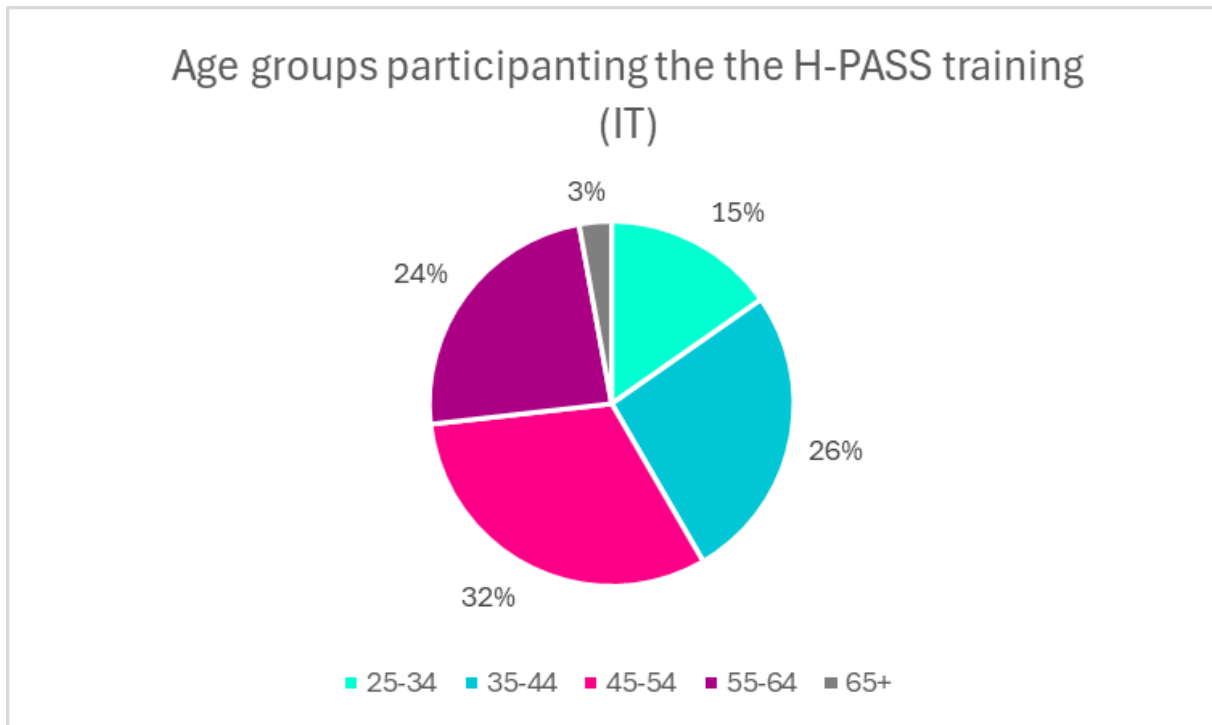


Figure IT-1. Age distribution of H-PASS training participants in Italy (n = 209)

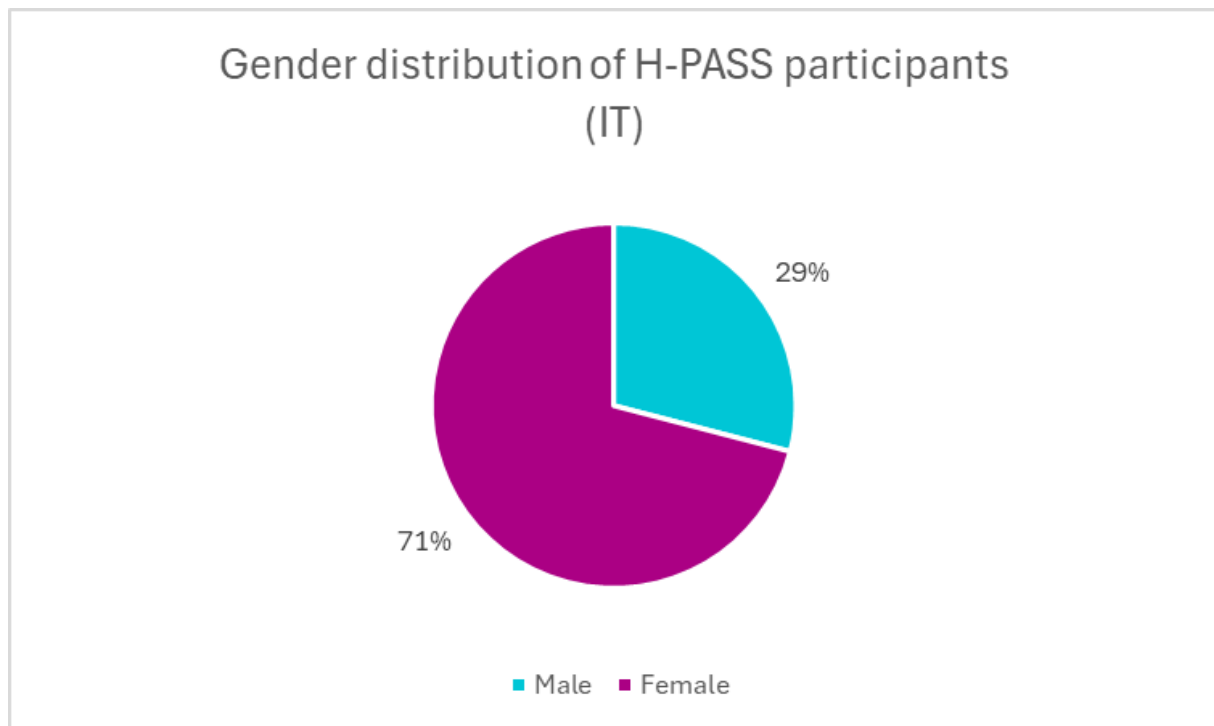


Figure IT-2. Gender distribution of H-PASS training participants in Italy (n = 210)

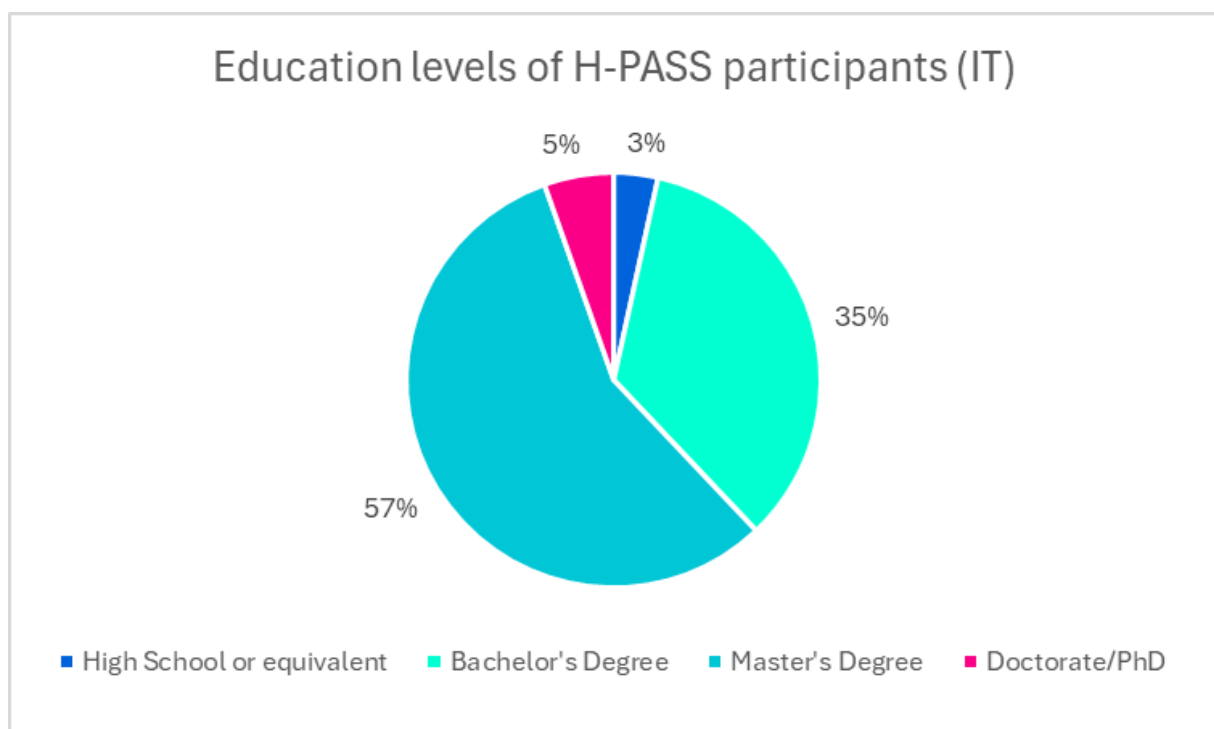


Figure IT-3. Education levels of H-PASS training participants in Italy (n = 203)

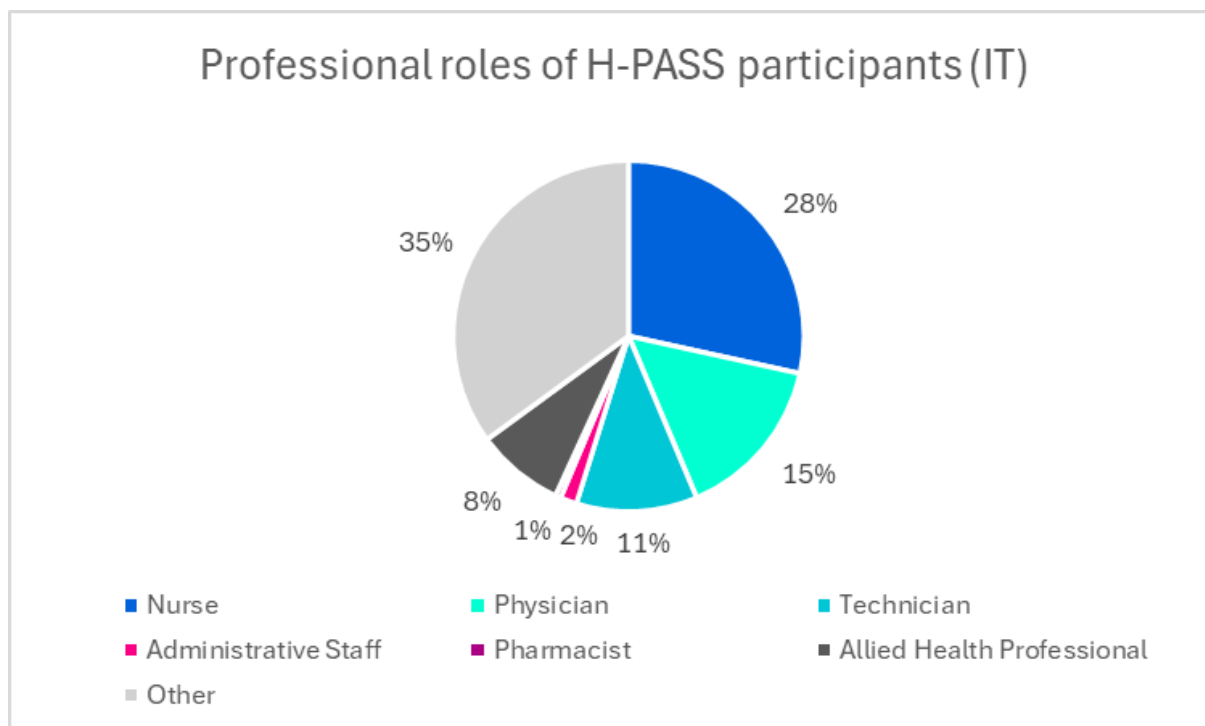


Figure IT-4. Professional roles of H-PASS training participants in Italy (n = 197)

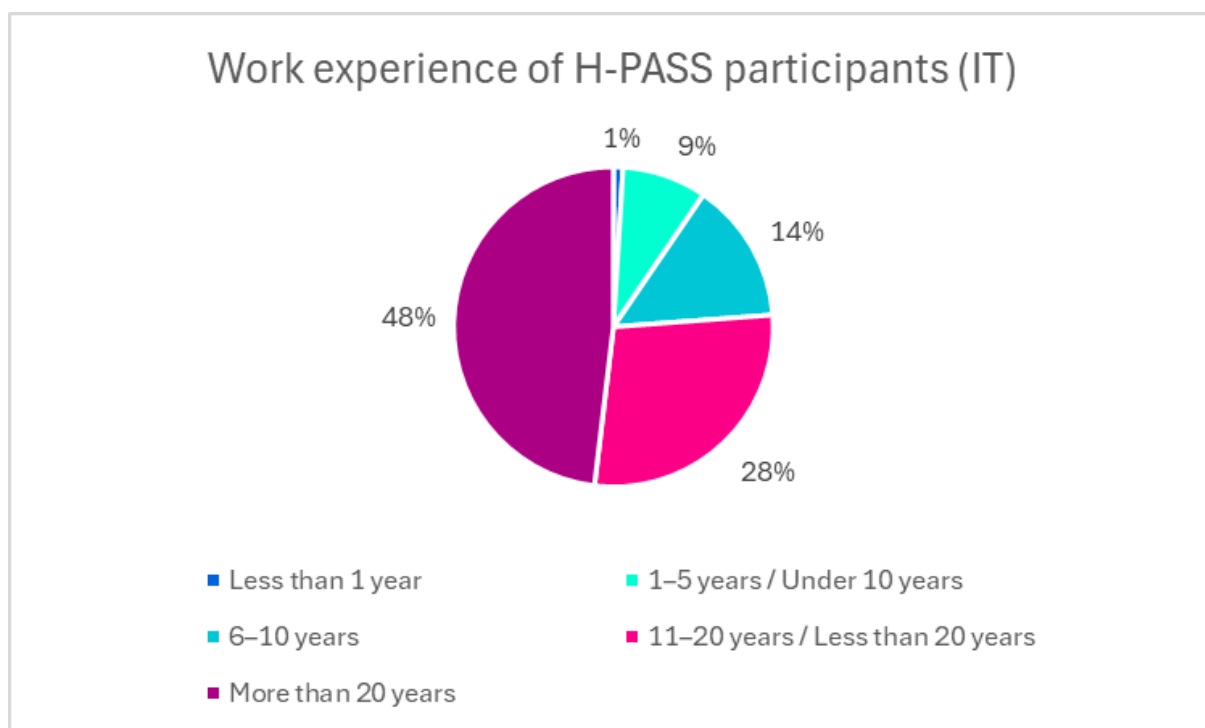


Figure IT-5. Work experience of H-PASS training participants in Italy (n = 210)

The work environment characteristics of the Italian H-PASS participants show some differences compared with the consortium-level patterns (Figure IT-6.). The vast majority of participants (94%) reported working in public institutions, while 4% worked in research or

other institutions and 2% selected other categories. This indicates an even stronger representation of the public healthcare sector than observed at consortium level.

Regarding employment status (Figure IT-7.), the Italian cohort was almost entirely composed of full-time professionals (95%), with only 3% working part-time and 2% selecting other employment arrangements. This is slightly higher than the consortium-level proportion of full-time workers, suggesting that the Italian training reached participants who were very actively engaged in the workforce.

In terms of work location (Figure IT-8.), 77% of participants worked in urban areas, 19% in suburban areas, and 4% in rural settings. While the dominance of urban workplaces follows the general consortium trend, the share of suburban workplaces appears somewhat higher in Italy, indicating a broader geographic spread across peri-urban healthcare environments.

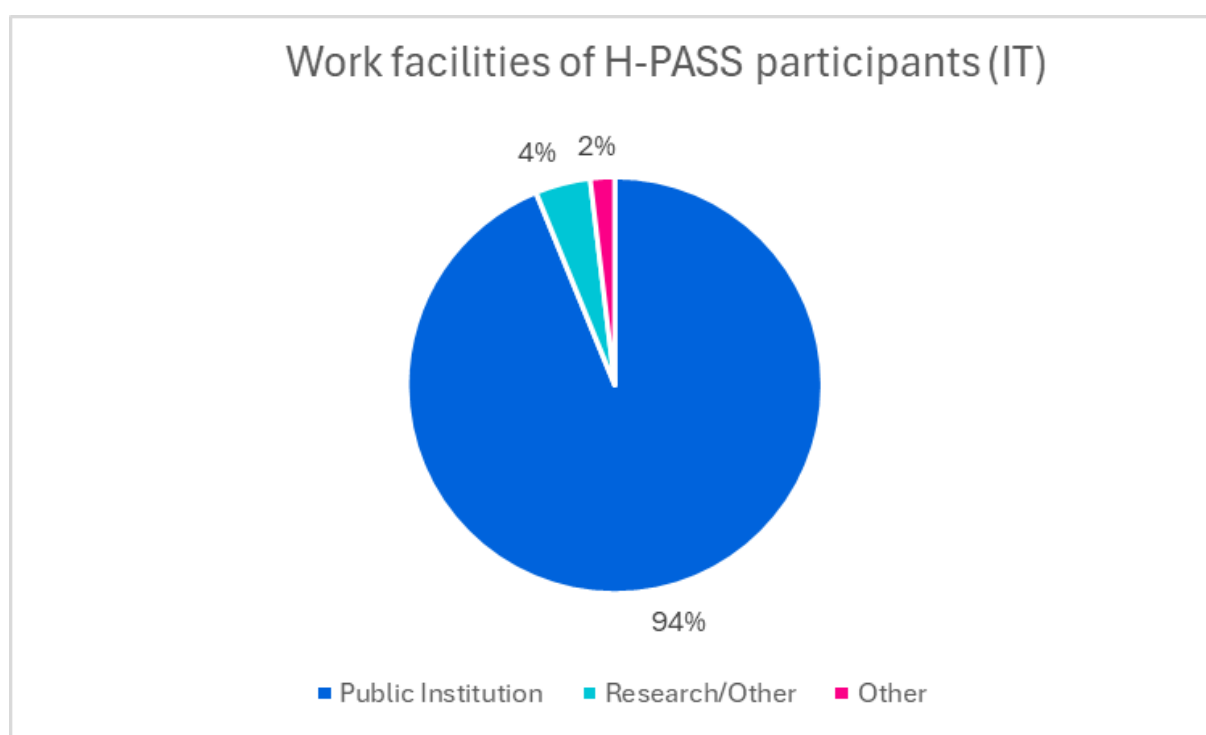


Figure IT-6. Work facilities of H-PASS training participants in Italy (n = 210)

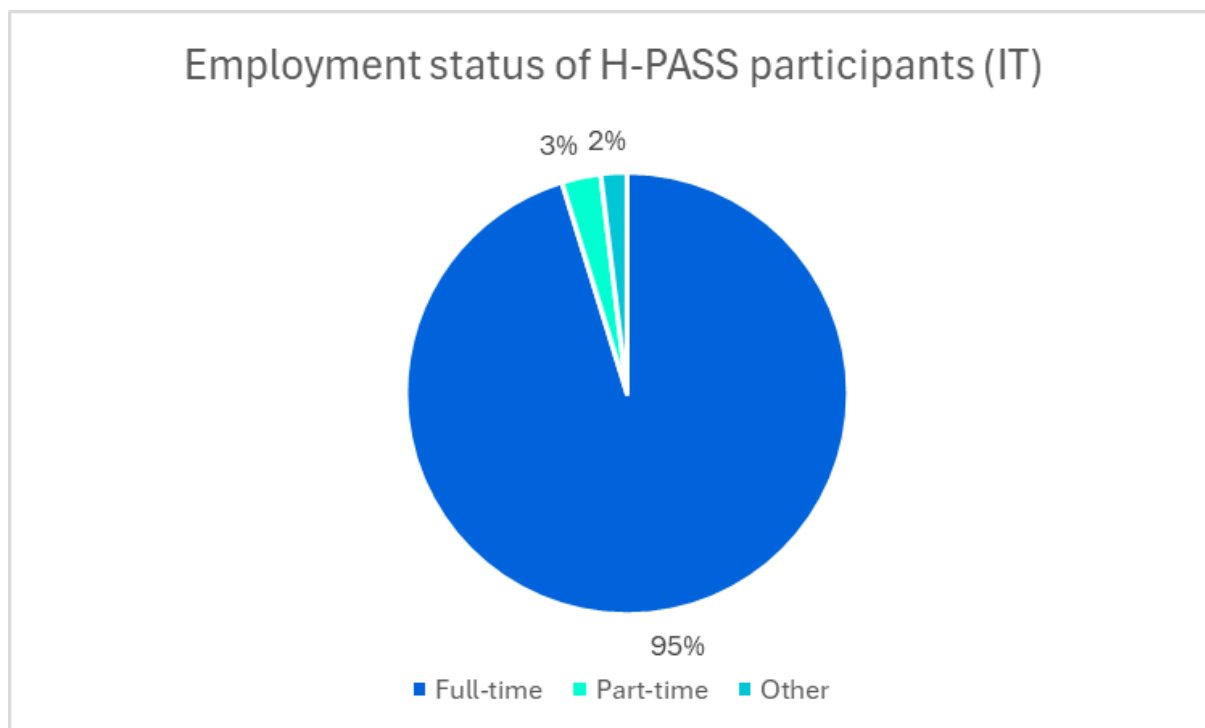


Figure IT-7. Employment status of H-PASS training participants in Italy (n = 210)

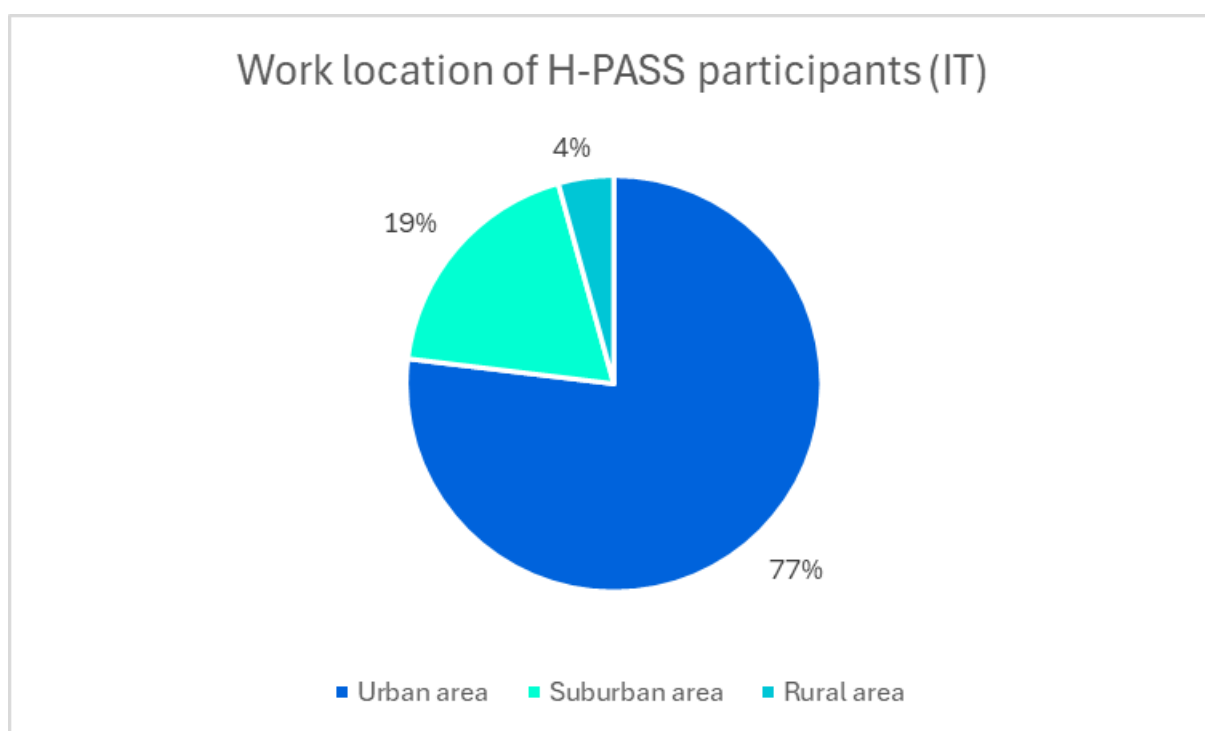


Figure IT-8. Work location of H-PASS training participants in Italy (n = 208)

4.4.3. Satisfaction with the H-PASS training

The evaluation results from the Italian H-PASS pilot training indicate a high level of satisfaction among participants (Figure IT-9.). Regarding overall satisfaction with the training, 56% of respondents rated the training with the highest score (5) and 30% rated it 4, meaning that

86% of participants reported high satisfaction. Lower scores were rare, with 8% selecting 3, 4% selecting 2, and 2% selecting 1. This distribution closely mirrors the consortium-level trend of very high satisfaction, indicating that the Italian implementation was similarly well received.

Participants also rated the applicability of the training to their daily work positively (Figure IT-10.). The largest share (45%) rated applicability as 4, while 31% gave the highest score (5) and 15% selected 3. Only 6% rated applicability as 2 and 3% as 1, showing that most participants perceived the training as relevant to their professional tasks. Compared with the consortium-level results, the Italian responses show a slightly larger share of score 4 compared with score 5, suggesting that while applicability was widely recognised, participants somewhat more frequently evaluated it as “very applicable” rather than “completely applicable.”

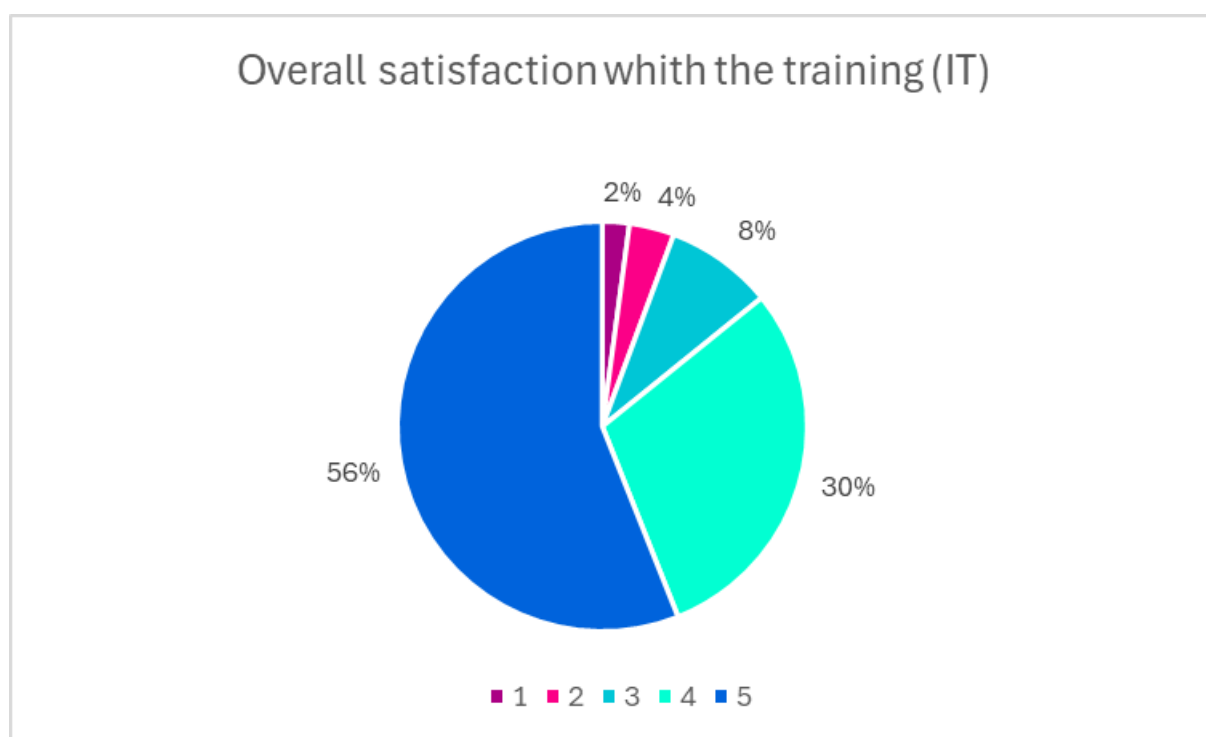


Figure IT-9. Overall satisfaction with the H-PASS training among participants in Italy (n = 141)

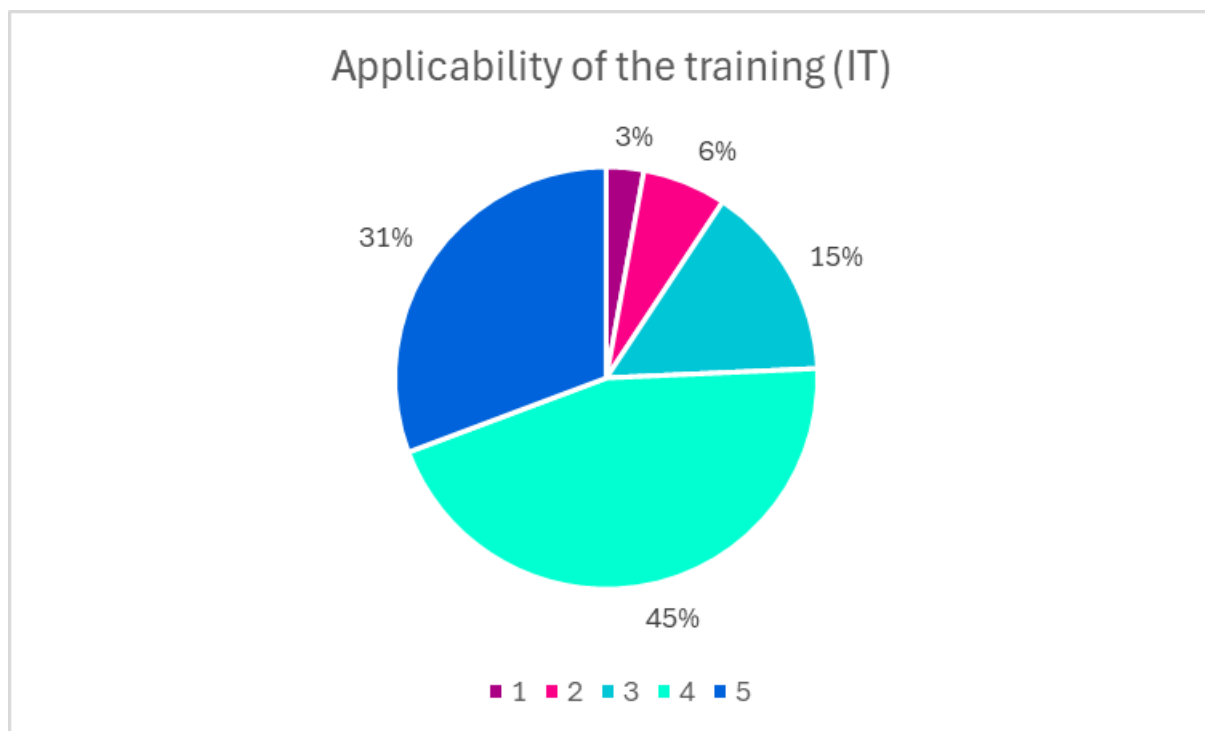


Figure IT-10. Perceived applicability of the H-PASS training to daily work among participants in Italy (n = 140)

4.4.4. Digital and transversal skill development

Participants in the Italian H-PASS pilot training reported substantial improvements in their digital skills (Figure IT-11.). The majority indicated significant improvement (45%) or improvement “to a great deal” (34%), while 15% reported moderate improvement and only 6% reported slight or no improvement. This distribution closely reflects the overall consortium-level trend, with most participants perceiving meaningful development in their digital competences as a result of the training.

When asked to identify specific areas of digital competence improvement based on the DigComp 2.2 framework, participants most frequently reported gains in problem solving and digital content creation, followed by communication and collaboration (Figure IT-12.). Improvements in information and data literacy were reported less frequently, while digital safety also received a relatively lower number of selections compared with the other competence areas. The Information and data literacy competence was omitted from the survey by the Italian team, as the connected Module 4 was not delivered in the local pilot.

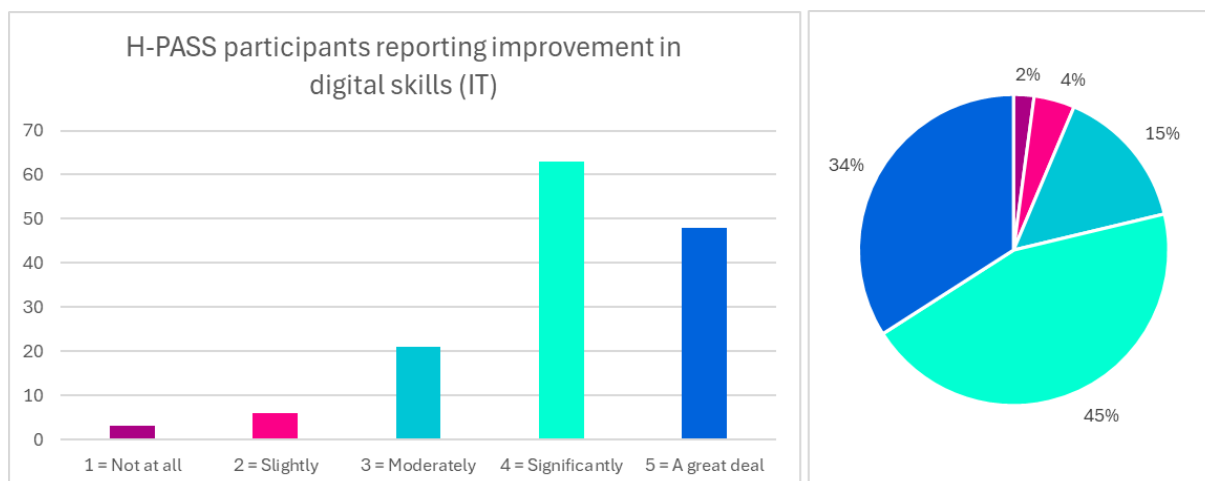


Figure IT-11. Self-reported improvement in digital skills among H-PASS participants in Italy (n = 141)

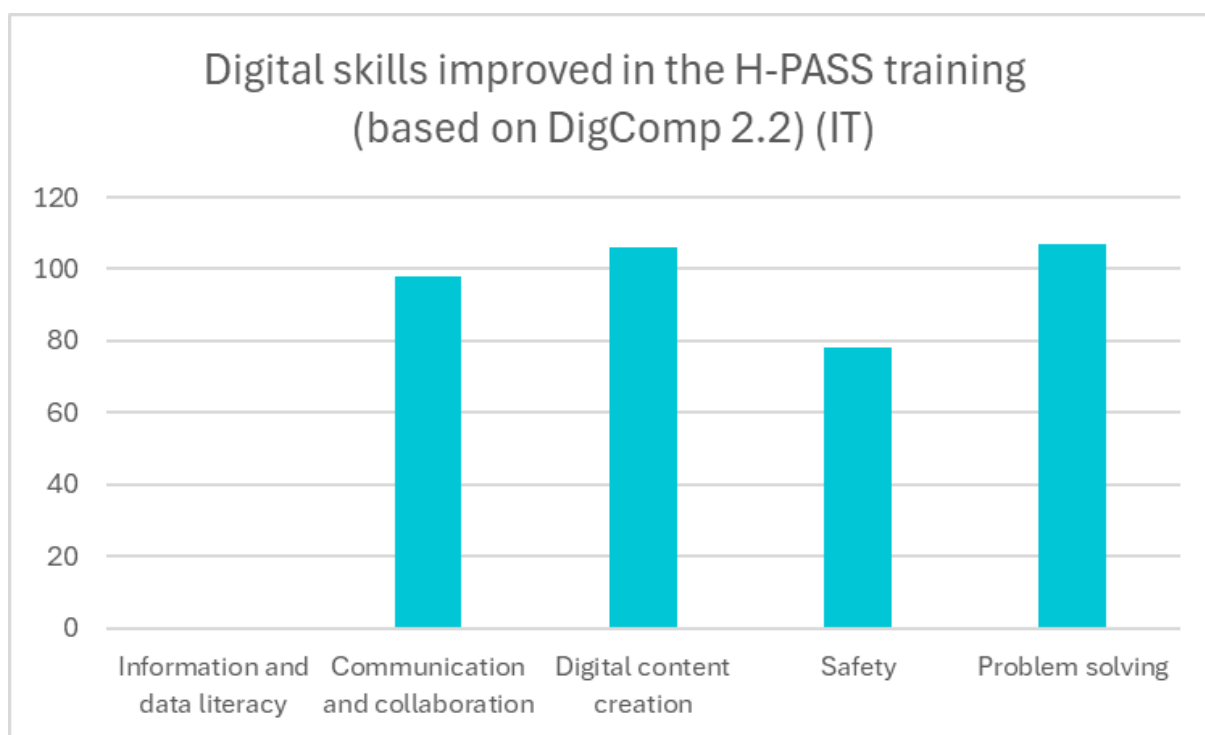


Figure IT-12. Digital competence areas improved during the H-PASS training based on the DigComp 2.2 framework – Italy (n = 184)

Italian participants also reported strong improvements in transversal skills as a result of the H-PASS training (Figure IT-13.). Most respondents indicated significant improvement (48%) or improvement “to a great deal” (33%), while 16% reported moderate improvement. Only a very small proportion reported slight (2%) or no improvement (1%), reflecting a pattern very similar to the consortium-level results.

When asked to identify specific transversal competences improved during the training based on the LifeComp framework, participants most frequently selected critical thinking, communication, collaboration, flexibility, and growth mindset (Figure IT-14.). Other competences such as managing learning, empathy, wellbeing, and self-regulation were also commonly reported, though slightly less frequently. Overall, the Italian responses show a very balanced improvement across most transversal competence areas, closely mirroring the general tendencies observed across the consortium.

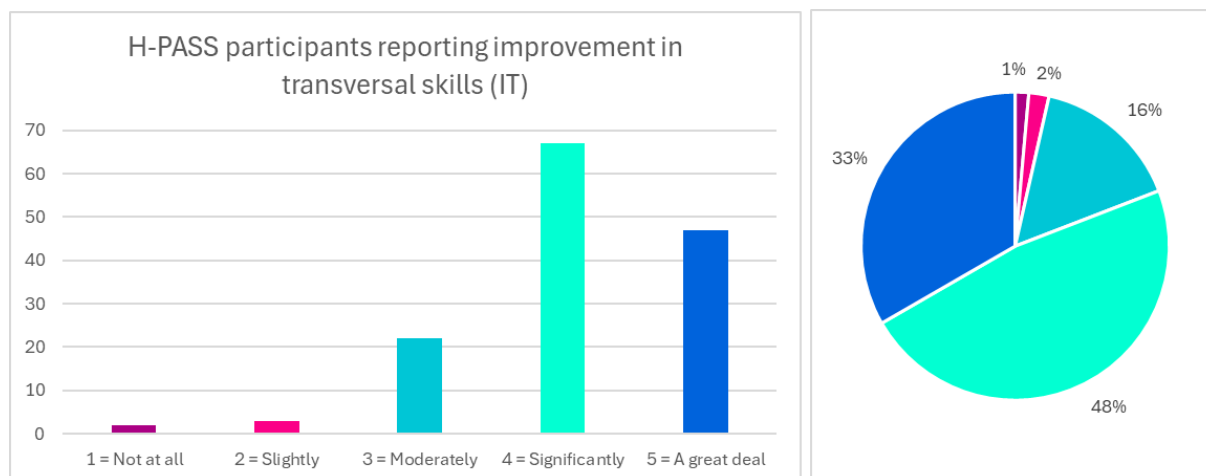


Figure IT-13. Self-reported improvement in transversal skills among H-PASS participants in Italy (n = 141)

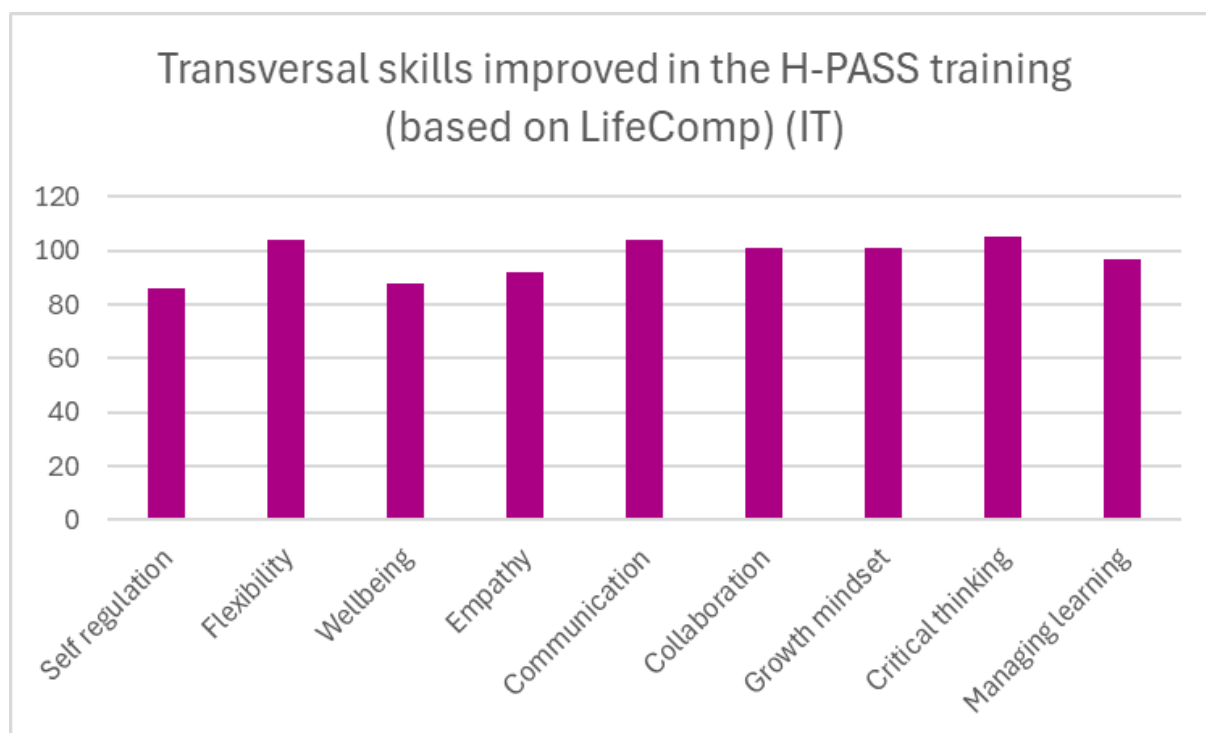


Figure IT-14. Transversal competence areas improved during the H-PASS training based on the LifeComp framework – Italy (n = 184)

Participants in the Italian H-PASS pilot training also reported increased confidence in teamwork in digital environments following the training (Figure IT-15.). Half of the respondents (50%) rated the improvement as 4, while 27% indicated the highest level of improvement (5) and 16% reported moderate improvement (3). Only 6% reported slight improvement (2) and 1% indicated no change (1).

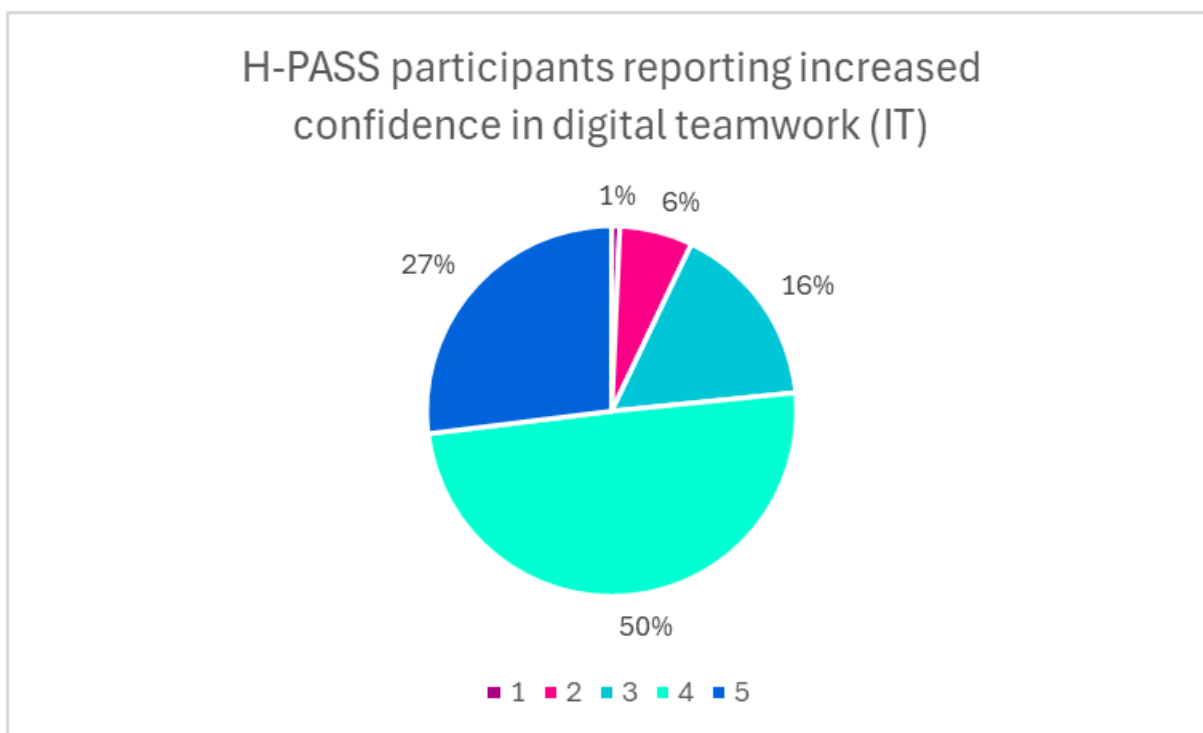


Figure IT-15. Self-reported increase in confidence in digital teamwork among H-PASS participants in Italy (n = 141)

4.4.5. Impact on digital tool usage

Participants in the Italian H-PASS pilot training also reported increased use of digital tools in their professional activities following the training (Figure IT-16.). For professional (clinical) tasks, 52% of respondents reported using digital tools slightly more often, while 33% reported using them significantly more, meaning that 85% of participants indicated increased use overall. Only 15% reported using digital tools the same amount or less. This distribution closely aligns with the consortium-level findings, indicating a strong practical uptake of digital tools after the training.

A similar trend was observed for administrative tasks, although with slightly more moderate changes (Figure IT-17.). 44% of participants reported using digital tools slightly more, and 32% reported using them significantly more, while 24% indicated no increase in usage. Compared with the consortium-level results, the Italian responses suggest a somewhat higher share of participants reporting no change in administrative digital tool use, while the proportion reporting significant increases remains comparable.

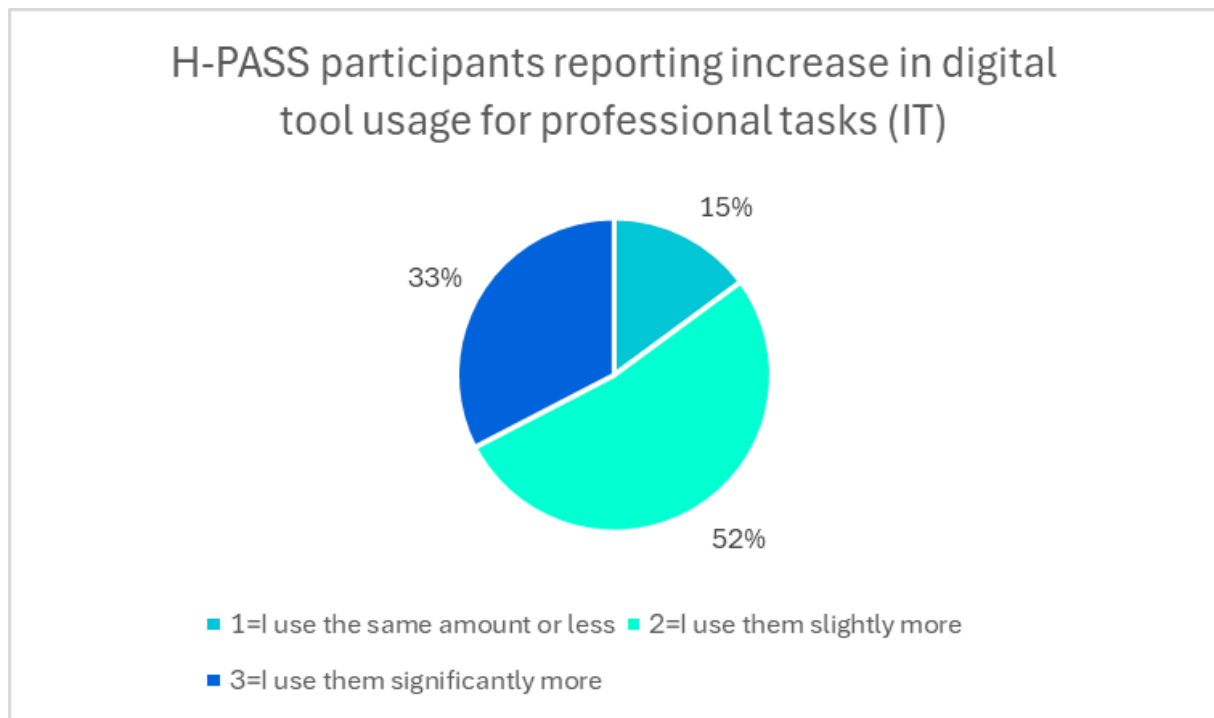


Figure IT-16. Self-reported increase in digital tool usage for professional tasks among H-PASS participants in Italy (n = 141)

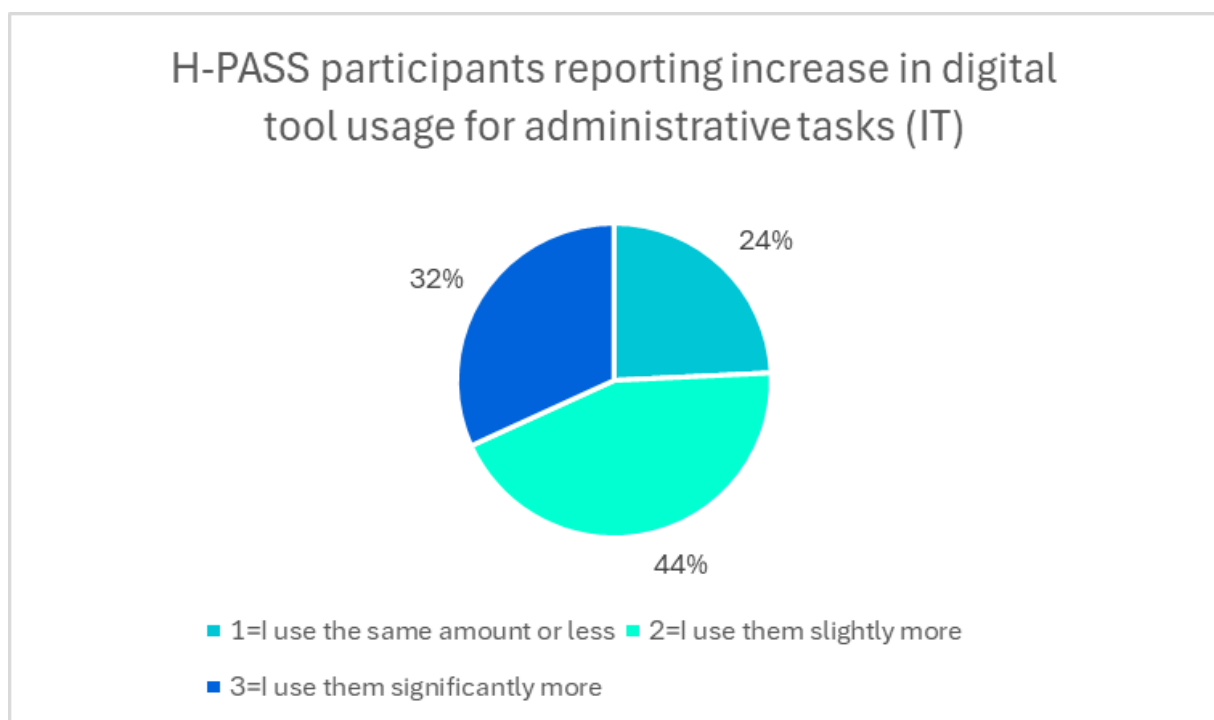


Figure IT-17. Self-reported increase in digital tool usage for administrative tasks among H-PASS participants in Italy (n = 132)

4.4.6. Training follow-up results

The follow-up survey among Italian H-PASS training alumni indicates that most respondents perceived positive organisational effects resulting from the training. Among the 60 participants who completed the follow-up questionnaire, 73% reported observing improvements in their organisation, while 27% did not report noticeable changes (Figure IT-18.). This suggests that the majority of respondents perceived at least some organisational-level impact following their participation in the training.

When asked to identify specific areas of organisational change, improvements were most frequently reported in teamwork patterns, with 30 participants indicating positive changes in collaboration among healthcare professionals (Figure IT-19.). Workflow and processes were the second most frequently reported area (10 responses), followed by workload distribution among health professionals (3 responses) and task-shifting practices (1 response). These results indicate that the most visible impact of the training in Italy was perceived in teamwork and collaborative practices, while structural changes such as workload redistribution or task shifting were reported less frequently. It is essential to add that all respondents marked only one area of improvement, although the survey allowed for multiple-choice answers.

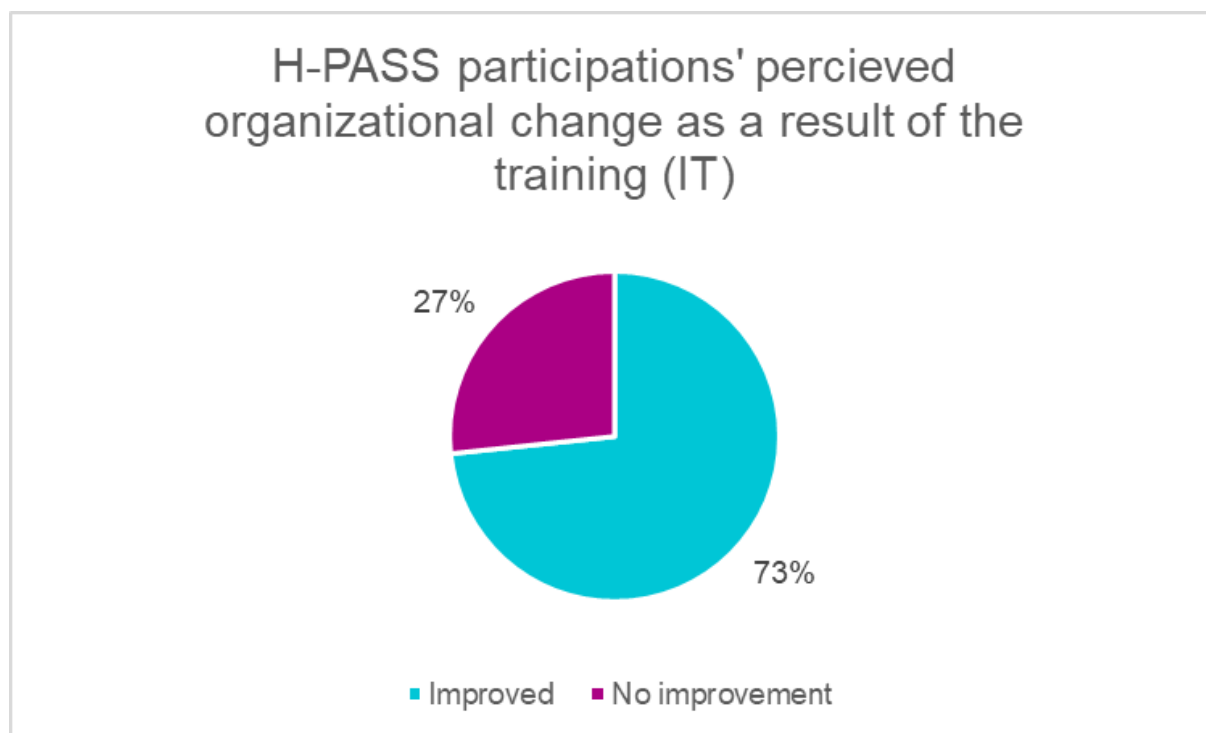


Figure IT-18. H-PASS participants' perceived organisational change as a result of the training in Italy (n = 60)

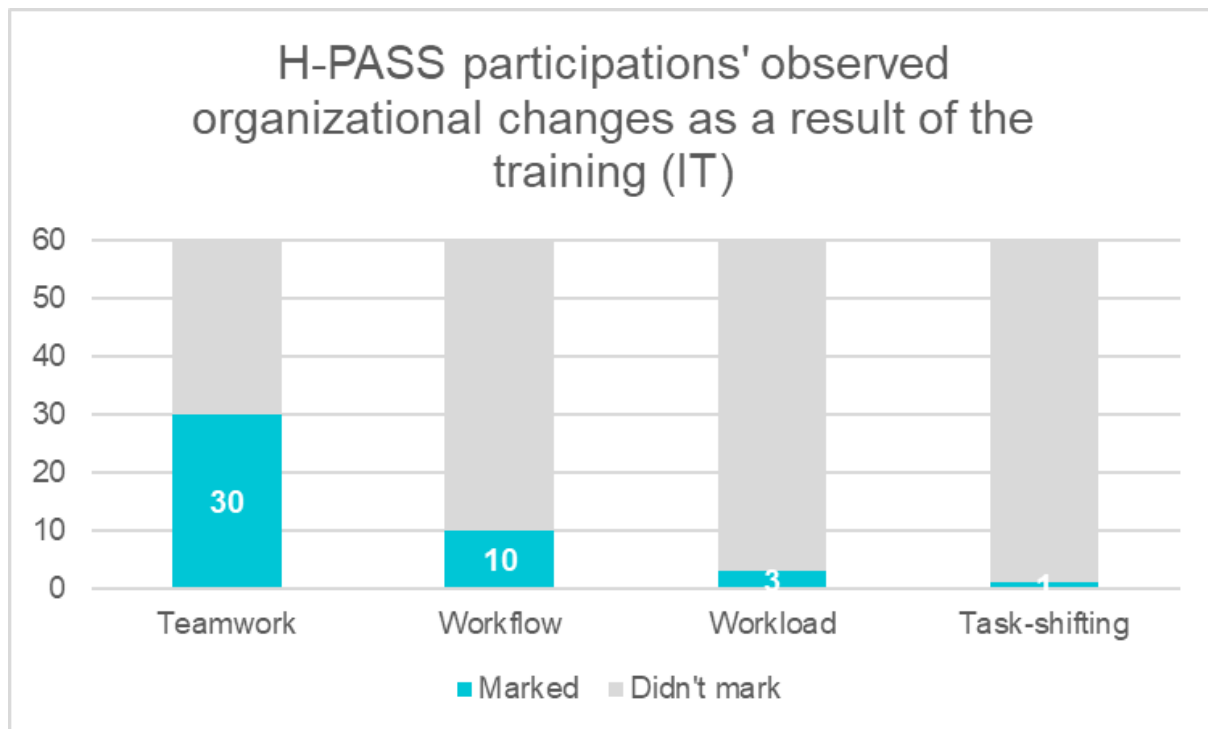


Figure IT-19. Observed organisational changes following the H-PASS training in Italy (n = 60)

4.4.7. Module evaluation overview

Participants in the Italian pilot training evaluated the delivered H-PASS modules positively across all assessed aspects (Figure IT-20.). Average scores for organisation (ME1), technical aspects (ME2), relevance and usefulness of the content (ME3), alignment with personal development goals (ME4), and overall learning experience (ME5) ranged roughly between 4.1 and 4.5, indicating consistently high satisfaction. Among the evaluation aspects, relevance and usefulness of the content (ME3) and alignment with development goals (ME4) received the highest scores across modules.

Looking at the modules individually (Figure IT-21.), Module 2 achieved the highest ratings overall, particularly in terms of content relevance and alignment with participants' development goals, followed closely by Module 3. Module 1 received slightly lower scores, especially regarding technical aspects, although all ratings remained clearly above 4. Compared with the consortium-level results, the Italian module evaluations show a similar overall positive pattern, though the highest ratings appear more concentrated in Module 2 rather than Module 4, reflecting the fact that the Italian pilot delivered Modules 1–3 only.

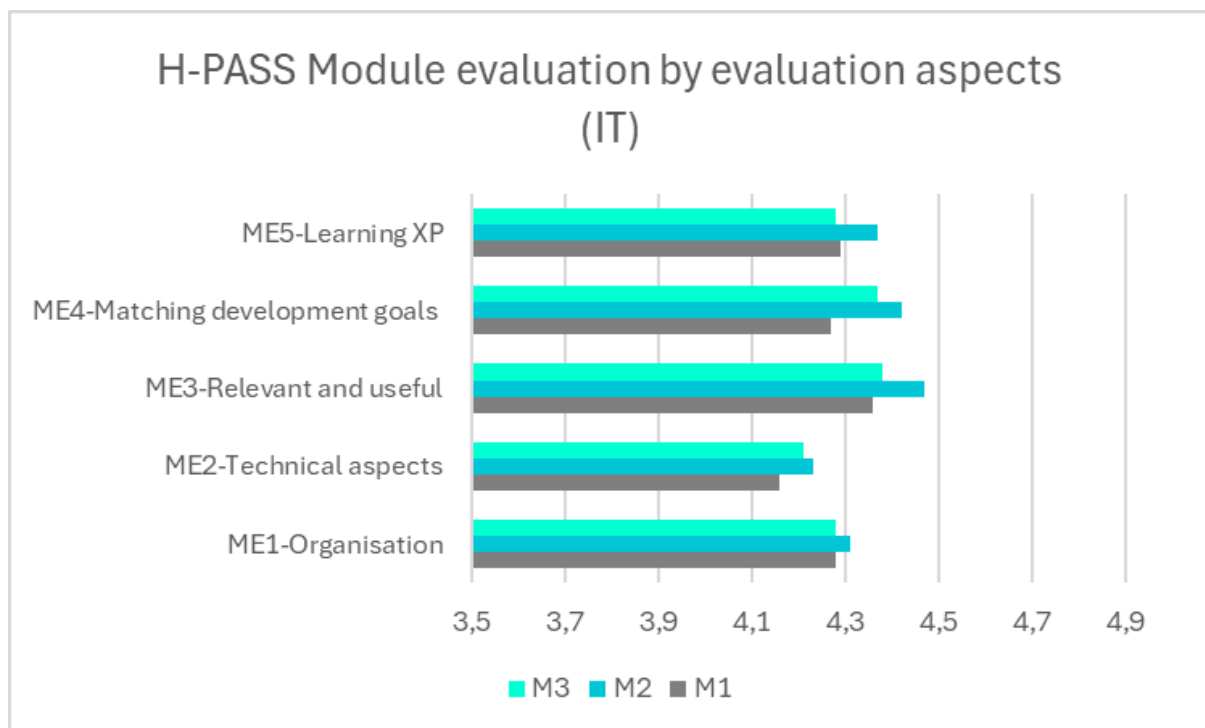


Figure IT-20. Evaluation of H-PASS training modules by evaluation aspects in Italy (n = 144–145)

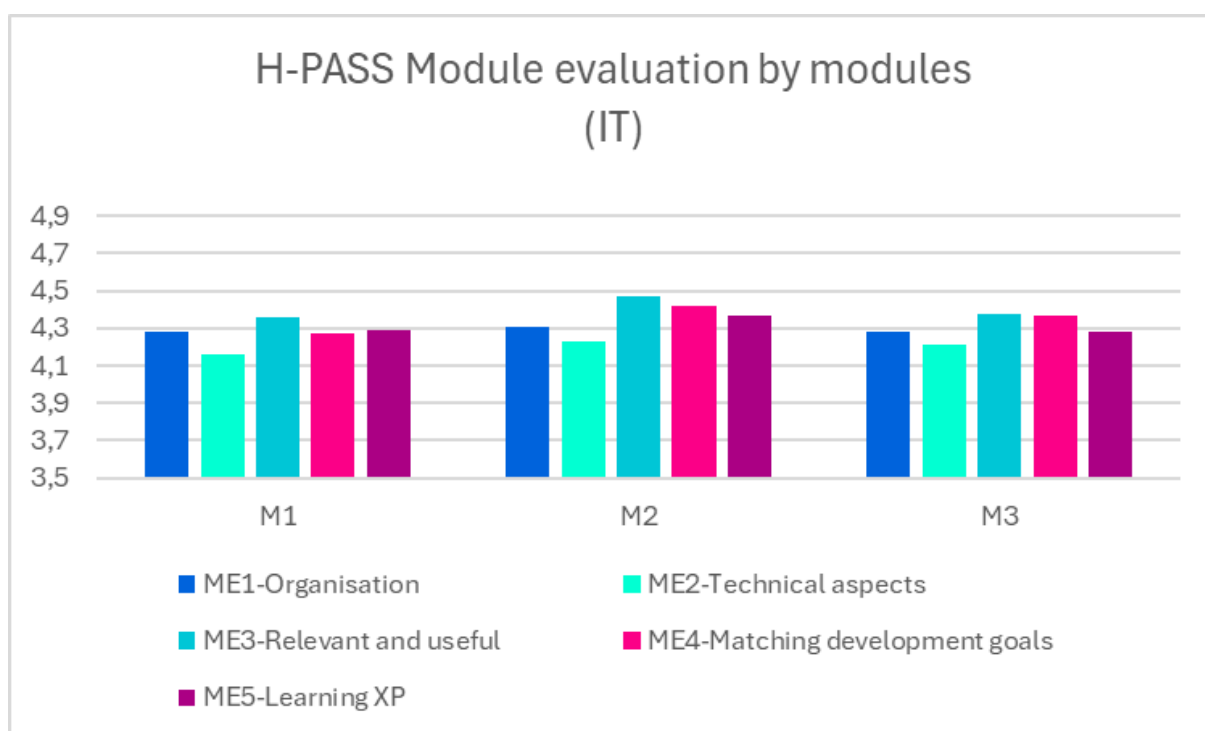


Figure IT-21. Average evaluation scores of H-PASS training modules in Italy (n = 144–145)

Based on the list of the highest- and lowest-performing training items presented in Table IT-4., the Italian results show a different pattern compared with the consortium-level findings

due to Module 4 exercises missing from the evaluation. The three highest-rated exercises originated from Modules 2 and 3, with “Conflict in healthcare teams” (4.48) receiving the highest score, followed by “Developing healthcare solutions” (4.45) and “Reflection on digital communication and collaboration” (4.44). These results indicate that participants particularly valued exercises that focused on practical teamwork dynamics and the application of digital communication skills in healthcare contexts. The popularity of the otherwise lower scoring M3B3 exercise can be attributed to the different methodology of delivery that was applied in Italy.

At the lower end of the ranking, the exercises “Introduction to Digital Technology in Healthcare” (4.29), “Let’s provide feedback” (4.28), and “Generative AI use exercise (patient-/professional perspective)” (4.27) received the lowest scores among the evaluated items. However, similarly to the consortium-level results, even the lowest-rated exercises still received relatively high evaluations on the five-point scale, suggesting that all activities were generally well received by participants.

TOP1	M2B4	Conflict in healthcare teams	4,48
TOP2	M3B3	Developing healthcare solutions	4,45
TOP3	M2B8	Reflection on digital communication and collaboration	4,44
BOTTOM3	M1B1	Introduction to Digital Technology in Healthcare	4,29
BOTTOM2	M3B6	Let's provide feedback	4,28
BOTTOM1	M1B3	Generative AI use exercise (patient-/professional perspective)	4,27

Table IT-4. Highest and lowest performing training items in the Italian pilot (n = 140–143)

4.4.8. Evaluation results of the DCA training

Participants in the Italian Digital Change Agent (DCA) training reported a high level of satisfaction with the course (Figure IT-22.). Nearly half of respondents (48%) rated their overall satisfaction with the training at the highest level (5), while 37% rated it 4 and 14% rated it 3, with only 1% selecting 2. This indicates that the large majority of participants evaluated the training positively, reflecting a pattern similar to the strong satisfaction observed at consortium level.

Participants also reported high readiness to foster collaboration within the H-PASS professional network after completing the training (Figure IT-23.). 47% rated their readiness at the highest level (5) and 39% rated it 4, while 14% selected 3, indicating moderate readiness. No lower ratings were reported in this category. These results suggest that the DCA

training in Italy successfully strengthened participants' confidence in supporting collaboration and engagement within the broader H-PASS network.

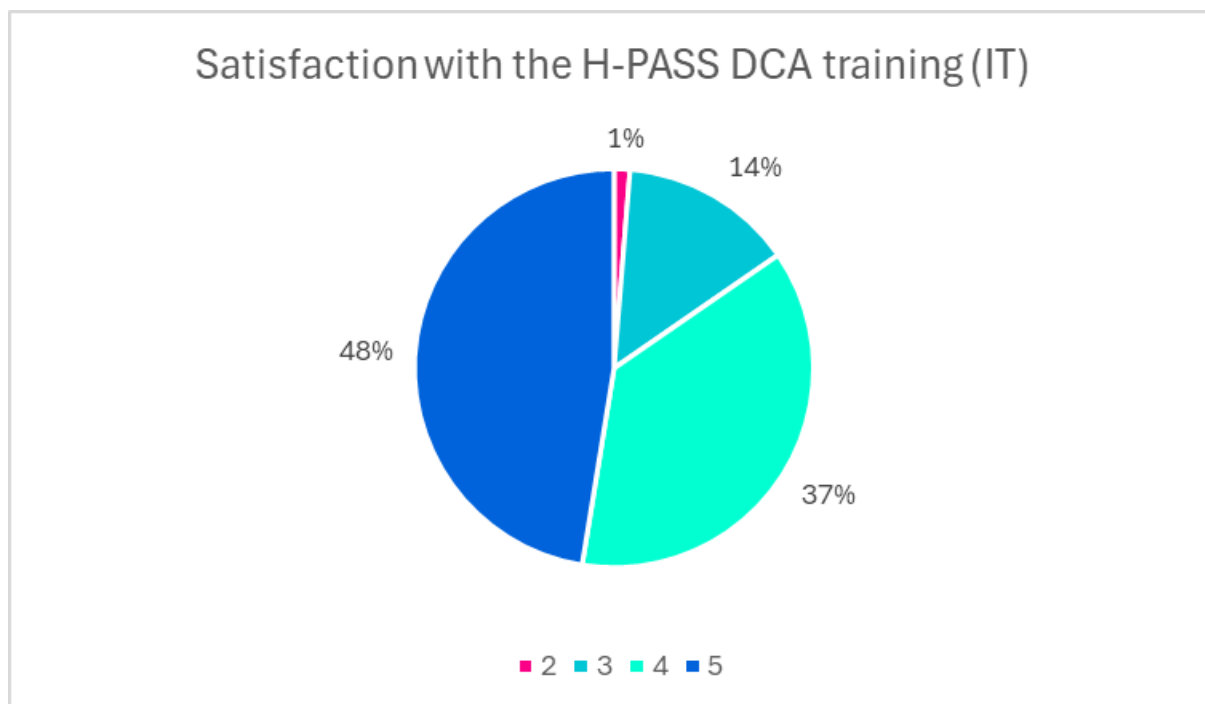


Figure IT-22. Overall satisfaction with the H-PASS Digital Change Agent training among participants in Italy (n = 78)

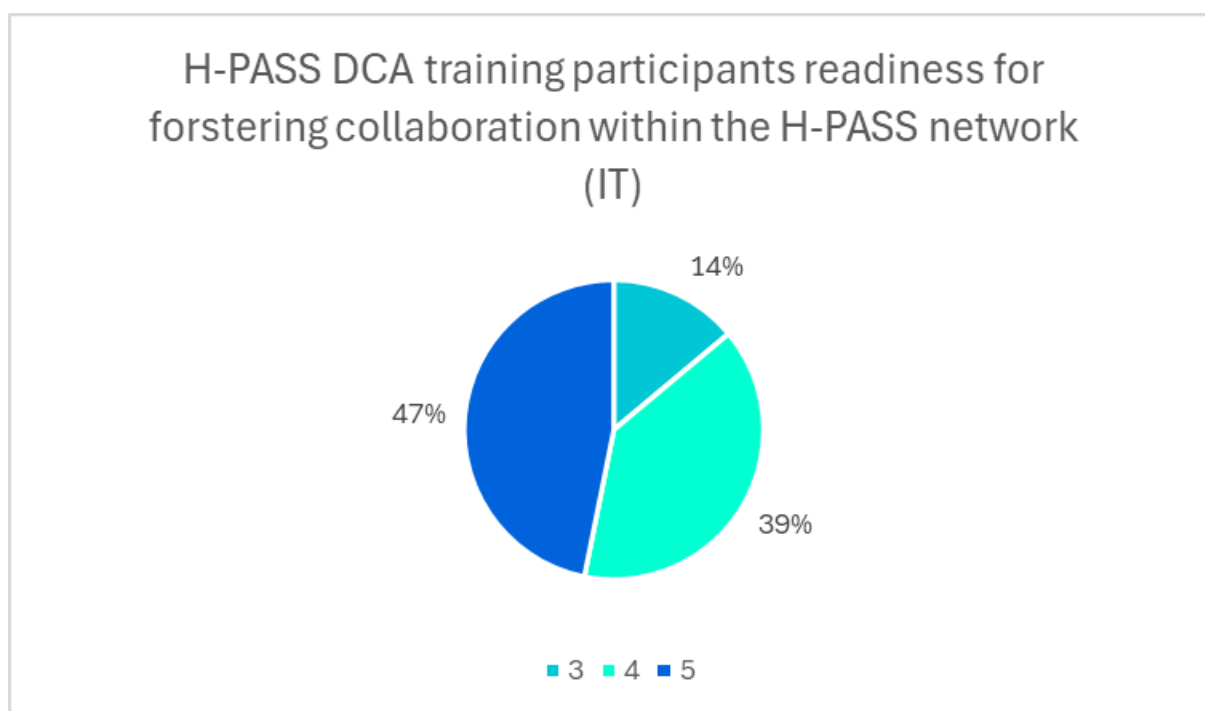


Figure IT-23. Self-reported readiness of H-PASS Digital Change Agent training participants in Italy to foster collaboration within the H-PASS network (n = 79)

Post-training self-evaluation results from the Italian Digital Change Agent (DCA) training indicate clear perceived improvements across the assessed competence areas (Figure IT-24.). 88% of participants reported increased or maintained higher scores in their understanding of the DCA role, while 87% reported improvement in change management skills and 85% in their ability to apply educational and communication methods to engage colleagues. The Italian results show a consistently high proportion of participants reporting improved or sustained self-assessments across all three areas, aligning with the strong positive trends observed at consortium level.

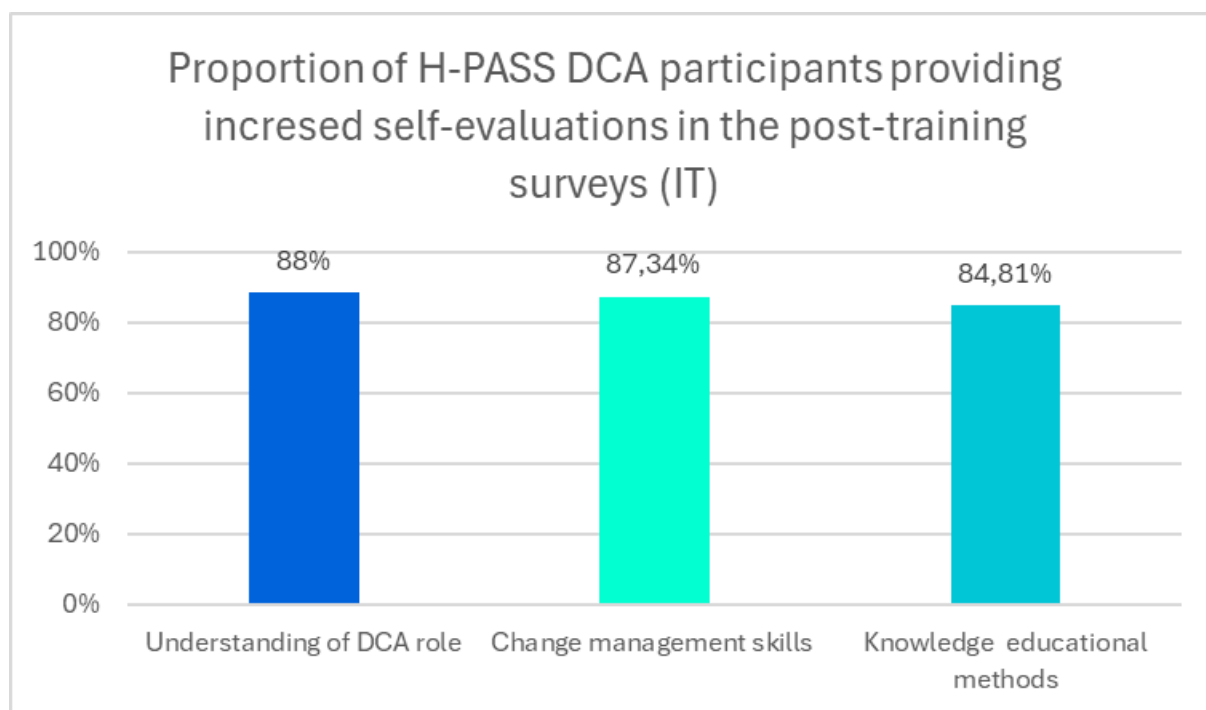


Figure IT-24. Proportion of Italian DCA participants reporting improved or maintained self-evaluations after the training (n = 77–79)

The follow-up survey of Italian DCA alumni provides insight into how participants applied the training outcomes in their professional environments (Figure IT-25.). A total of 21 alumni completed the follow-up survey with complete data, among whom 17 participants reported that the DCA training strengthened their leadership skills in facilitating digital transformation within their work environment. In addition, 10 respondents indicated that they had already taken concrete actions in their professional settings to support digital innovation or improve teamwork and collaboration. These results are close to the consortium-level results, only about 10 percentage points lower. Considering the sample size, this difference isn't considered significant.

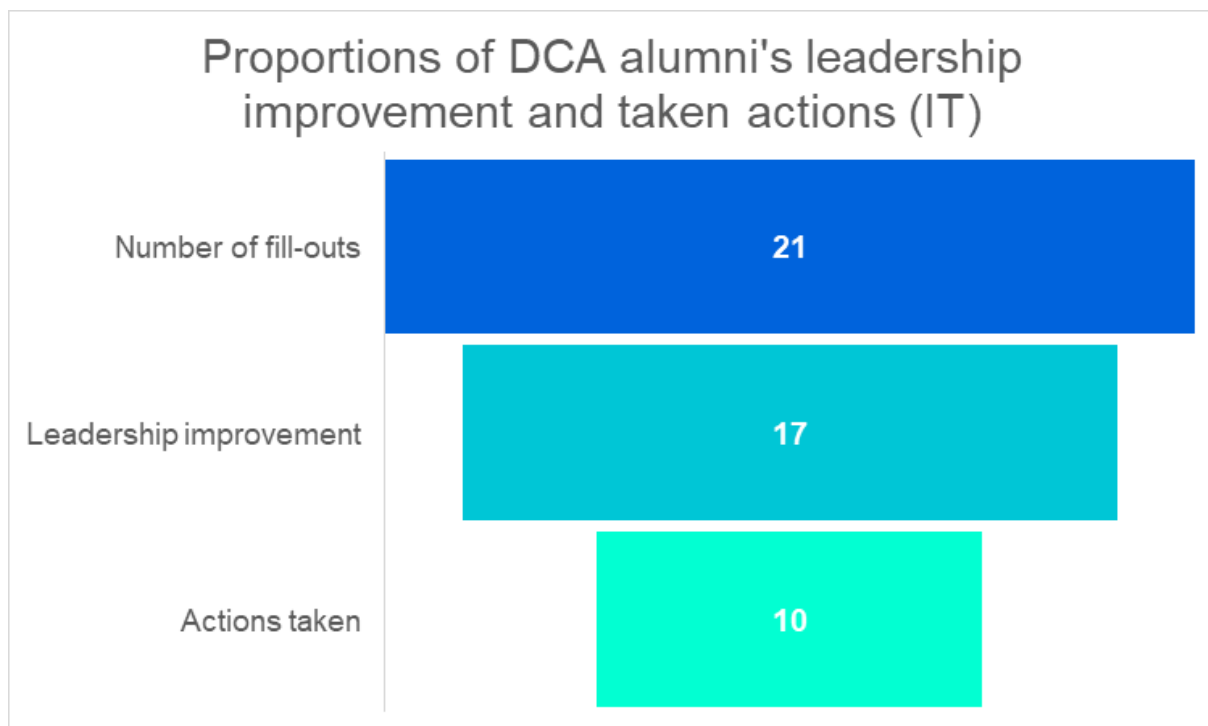


Figure IT-25. Leadership improvement and actions taken by H-PASS Digital Change Agent alumni in Italy based on the follow-up survey (n = 21)

4.4.9. Participant testimonials

Responses from the Closing Survey:

In general, the comments have been extremely positive, and below are some examples:

"The most useful skills acquired during this training are multiple and of utmost importance. The ones I consider most useful are: communication; approach to cultures; willingness to change and the related competence to manage the discomfort of those who do not feel able to accept it. This is the foundation of everything because it represents the 'conditio sine qua non' to undertake change and embrace new technologies"

"In addition to the knowledge I acquired in a short period of time, I have broadened my horizons, been encouraged to imagine new scenarios, changed my attitude towards the workgroup, and developed a passion for digital tools and new technologies. I feel honoured to have been able to participate in H-PASS"

"I believe the course was very well organized, with very interesting and practically useful topics. As a single suggestion, I would say, if possible, to improve the technological quality (audio, video)"

A minimal percentage expressed a neutral or, rarely, negative comment. Below are some examples:

“Adapt the sessions to the needs (work contexts) and skill levels of the participants”

“Devote more time to the use of artificial intelligence”

Answers from the DCA Post-training survey:

In general, the comments have been extremely positive, and below are some examples:

“The DCA course allowed me to better understand and improve teamwork, change management in healthcare, and provided me with the necessary tools to become a digital change agent”

There were only two neutral comments. As an example, the following comment is reported:

“In the current work situation, this training has not had an impact”

Answers from the DCA Follow-up survey:

In general, the comments have been extremely positive, and below are some examples:

“We have implemented a new IT management platform”

“Sharing the information learned during the course with the members of the work group”

Below is a negative comment identified in the follow-up questionnaire.

“Following the DCA course, I tried to apply the knowledge gained in my work environment. I proposed eliminating paper agendas and the secretarial task of contacting patients after their first visit with the doctor in favor of an electronic medical record. All of this was unsuccessful.”

4.5. Lithuania

4.5.1. Indicator summary

Satisfaction rate (evaluated with 4 or 5): 97,2% (n=72)

Satisfaction rate (evaluated with 5): 62,5% (n=72)

Breakdown	Number of health professionals completing the H-PASS training
In total	75/83
Medical doctors	0
Nurses	78
Allied health professionals	5
Other	0
Pharmacists	0
CME credential attainment	83
TtT participants	29
TtT participants / Trainer pool	4
TtT participants / DCA training course	25

Table LT-1. H-PASS output indicators

Breakdown	Number of health professionals completing the H-PASS training
18–24	39
25–34	35
35–44	3
45–54	4
55–64	2
65 or older	0
No data on age	0
Female	81
Male	2

Table LT-2. H-PASS participants by age groups and by gender

Breakdown	Target/Result
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/100%
Improvement in transversal skills among training participants (based on pre- and post-training surveys)	75%/100%
Improved capabilities for teamwork for teamwork in digital settings (based on post-training surveys)	75%/98,50%

Increased use of digital tools in clinical work (based on post-training survey)	75%/87,50%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/73,60%
Utilization of acquired digital and transversal skills in practice (based on post-training survey)	50%/85%
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/93,75%
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/93,75%
Utilization of acquired digital and transversal skills in practice (based on post-training survey) <i>Improved capabilities for leadership in digital settings among participants of train-the-trainer courses</i>	50%/100%

Table LT-3. H-PASS outcome indicators

4.5.2. Demographics of the H-PASS training courses

The demographic profile of participants in the Lithuanian H-PASS pilot training shows several notable differences compared with the consortium-level distribution. The age structure (Figure LT-1.) is strongly concentrated in younger age groups: 18–24-year-olds represent the largest group (40%), closely followed by 25–34 (39%), while 35–44 accounts for 10%, 45–54 for 7%, and 55–64 for 4%. Compared with the consortium-level pattern, the Lithuanian cohort appears considerably younger on average, with a particularly large proportion of participants in the two youngest age groups.

The gender distribution (Figure LT-2.) shows an extremely strong female majority (98% female, 2% male). While women represented the majority of participants at the consortium level as well, the Lithuanian sample is even more strongly dominated by female participants, which is consistent with the high share of nursing professionals in the cohort.

In terms of educational background (Figure LT-3.), most participants held higher education qualifications, with 78% reporting a Bachelor's degree and 18% a Master's degree, while 3% indicated a high school or equivalent qualification and 1% reported a doctorate/PhD. Compared with the consortium-level results, the Lithuanian sample shows a particularly strong concentration at the Bachelor's level, with relatively fewer postgraduate qualifications.

Regarding professional roles (Figure LT-4.), nurses constituted nearly the entire participant group (99%), while 1% were technicians. Compared with the consortium-level pattern, where a wider mix of professional groups such as physicians, administrative staff, and allied health professionals were represented, the Lithuanian cohort is far more homogeneous and strongly centred on nursing professionals.

The distribution of work experience (Figure LT-5.) further reflects the relatively early career stage of many participants. The largest group reported 1–5 years of professional experience

(38%), followed by less than one year (25%), 6–10 years (15%), 11–20 years (11%), and more than 20 years (11%). Compared with the consortium-level results, the Lithuanian cohort appears less dominated by highly experienced professionals, with a stronger representation of participants at the beginning of their professional careers.

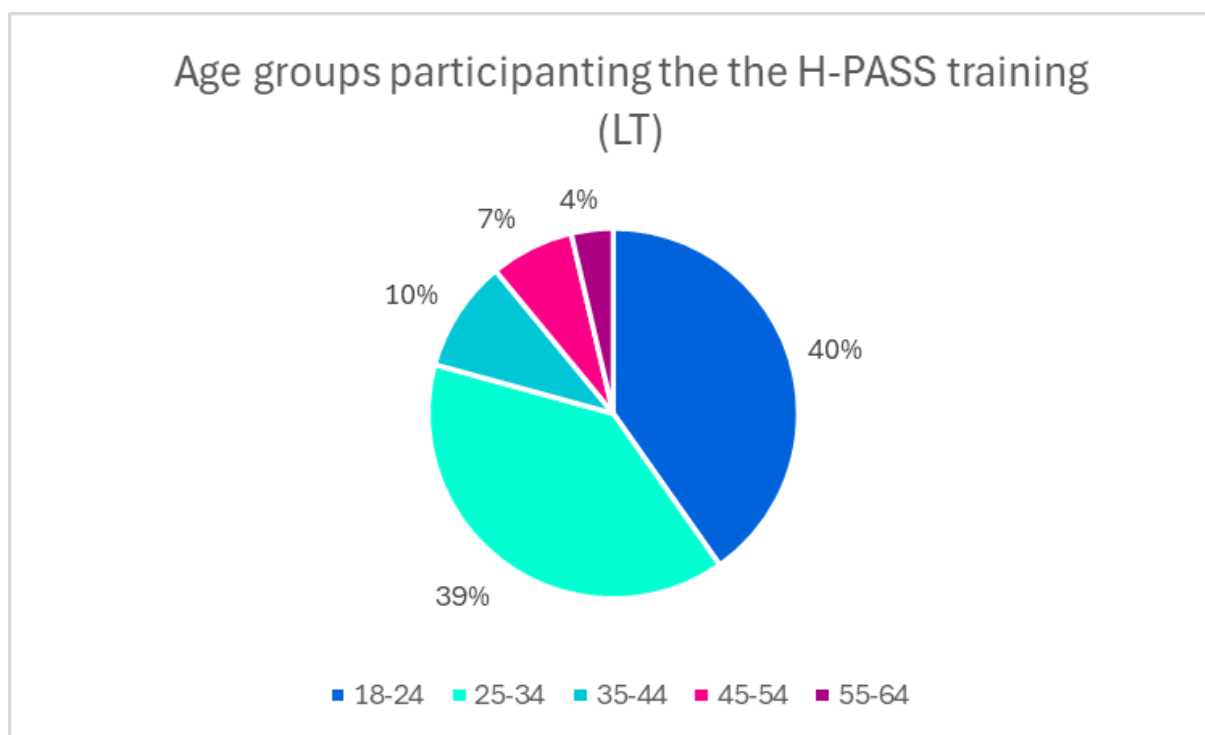


Figure LT-1. Age distribution of H-PASS training participants in Lithuania (n = 82)

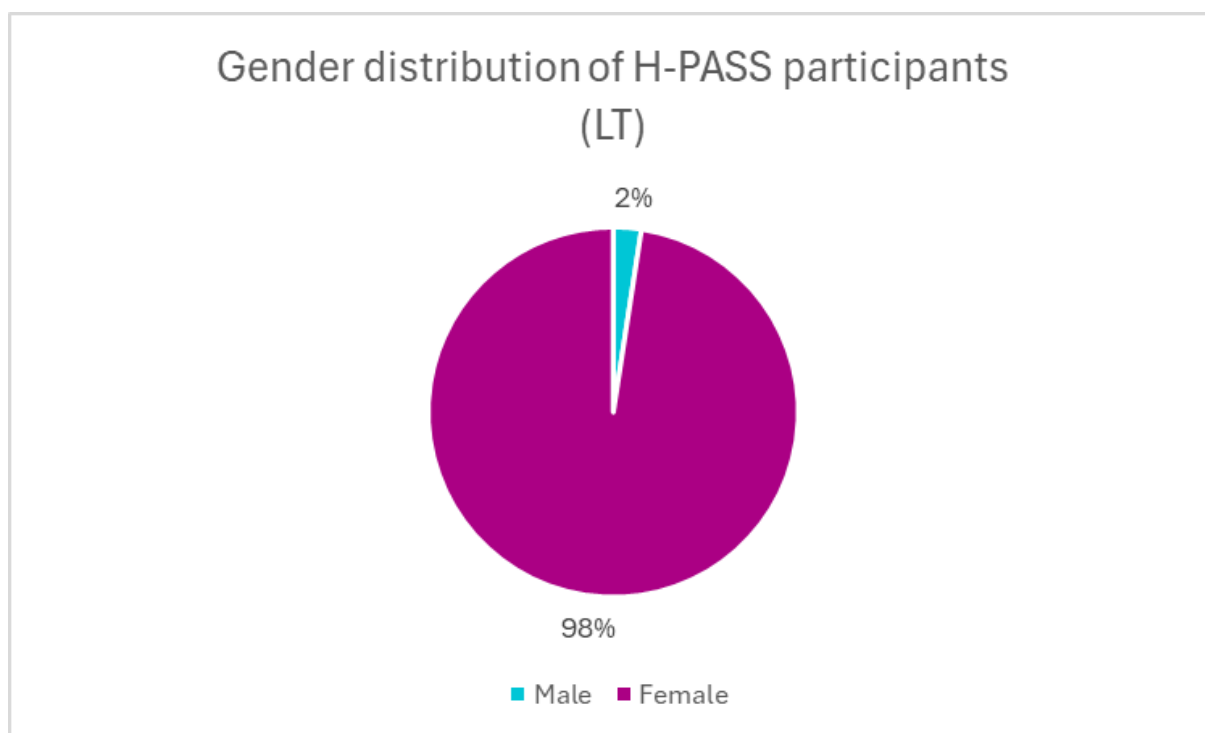


Figure LT-2. Gender distribution of H-PASS training participants in Lithuania (n = 82)

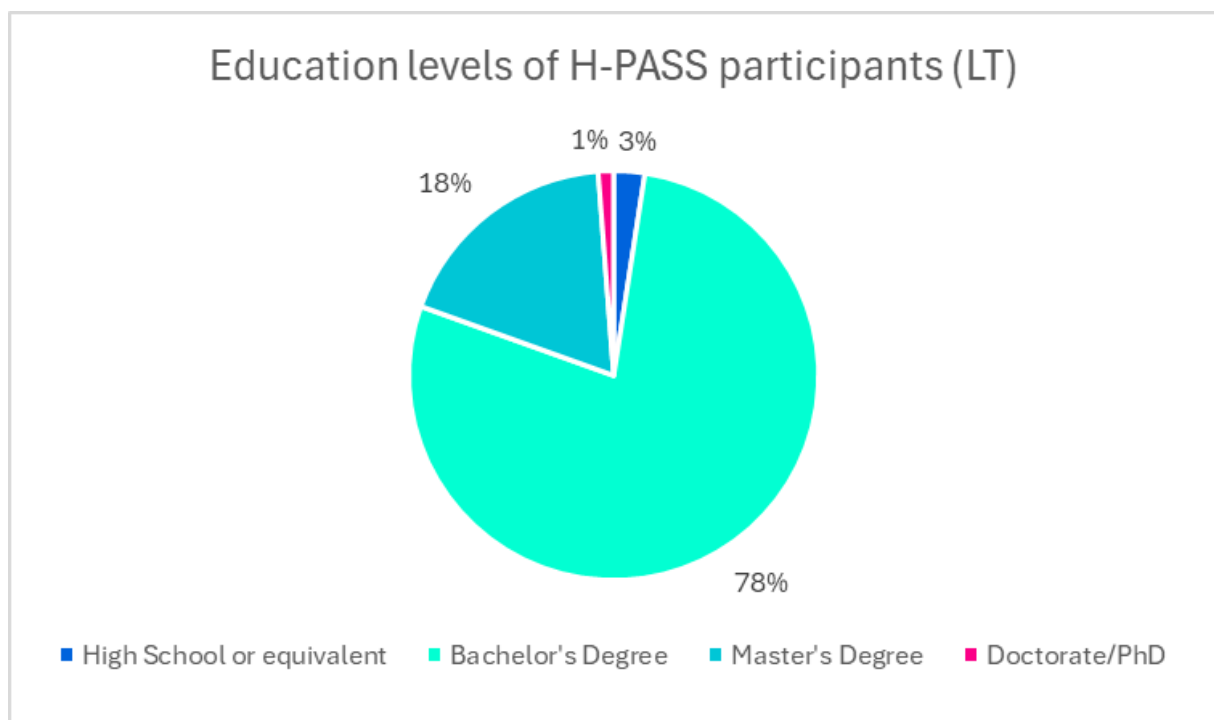


Figure LT-3. Education levels of H-PASS training participants in Lithuania (n = 82)

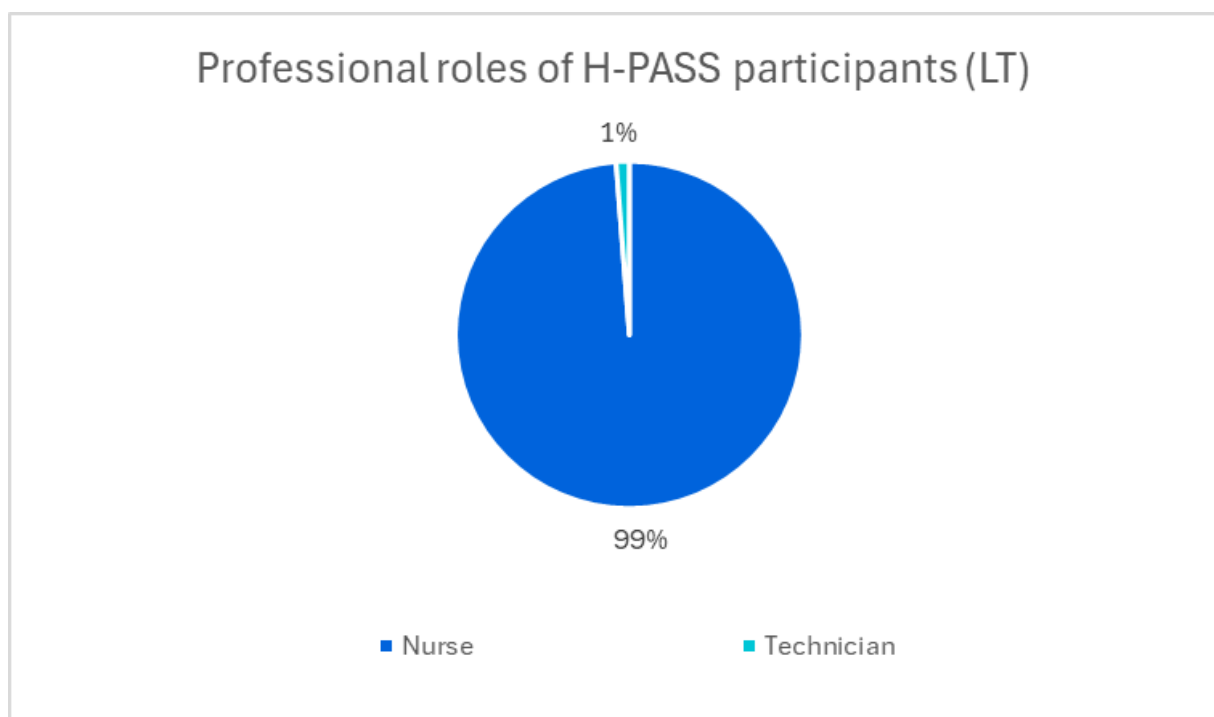


Figure LT-4. Professional roles of H-PASS training participants in Lithuania (n = 82)

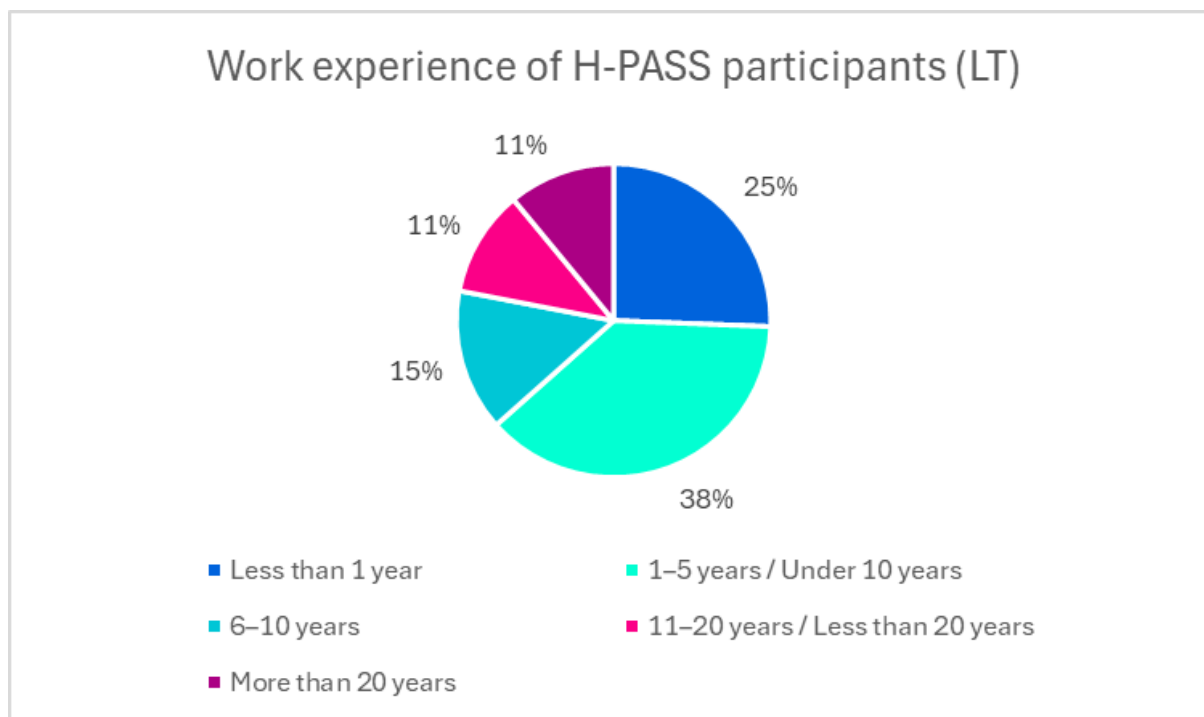


Figure LT-5. Work experience of H-PASS training participants in Lithuania (n = 82)

The workplace characteristics of Lithuanian H-PASS participants (Figure LT-6.) broadly follow the consortium-level tendency of strong representation from the public healthcare sector. The vast majority of respondents (95%) reported working in public institutions, while 5% indicated employment in private institutions.

Regarding employment status (Figure LT-7.), most Lithuanian participants were employed full-time (80%), while 16% reported part-time employment and 4% selected other employment arrangements. This distribution is generally consistent with the consortium-level results, where full-time employment also represented the dominant employment status among participants.

In terms of work location (Figure LT-8.), all respondents (100%) reported working in urban areas. Compared with the consortium-level distribution, where suburban and rural healthcare settings were also represented, the Lithuanian cohort appears entirely concentrated in urban healthcare institutions, suggesting that the training primarily reached professionals working in urban healthcare environments.

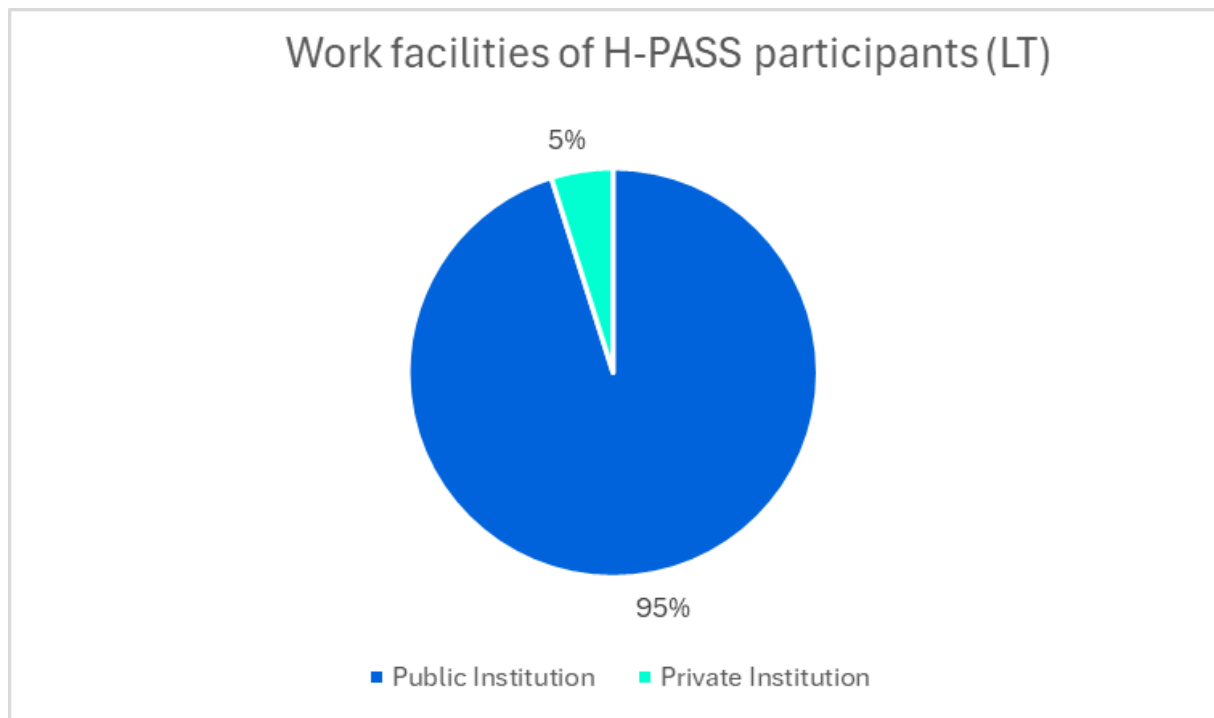


Figure LT-6. Work facilities of H-PASS training participants in Lithuania (n = 82)

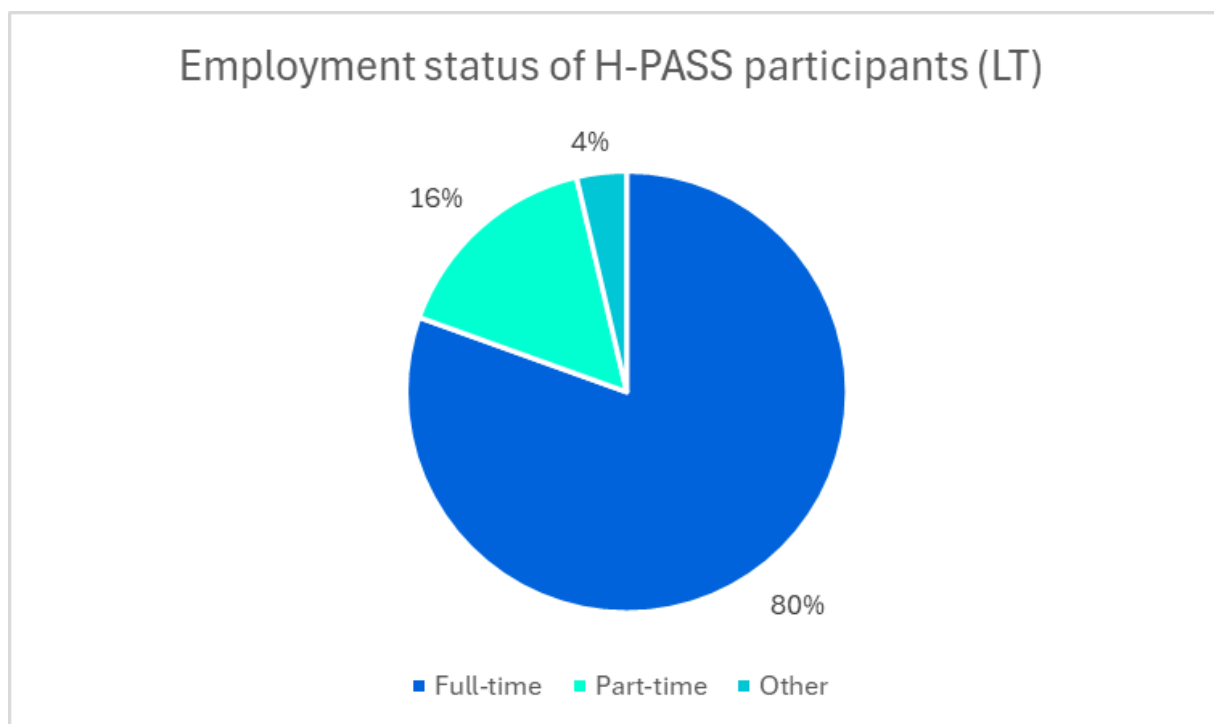


Figure LT-7. Employment status of H-PASS training participants in Lithuania (n = 82)

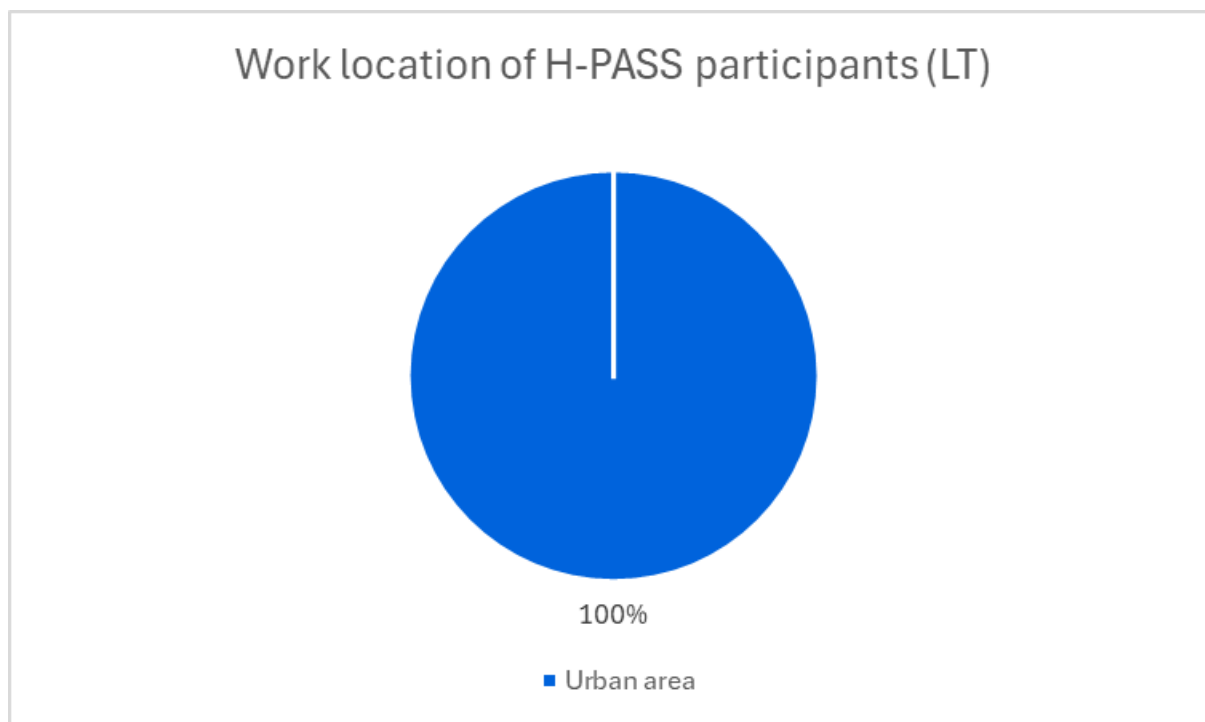


Figure LT-8. Work location of H-PASS training participants in Lithuania (n = 82)

4.5.3. Satisfaction with the H-PASS training

Lithuanian participants reported very high levels of satisfaction with the H-PASS training programme (Figure LT-9.). The majority of respondents (62%) rated their overall satisfaction with the highest score (5), while 35% selected 4 and 3% rated the training 3. No respondents expressed dissatisfaction. These results indicate that the training was very positively received among Lithuanian participants, even higher than on the consortium-level.

Participants also evaluated the applicability of the training to their professional practice very positively (Figure LT-10.). More than half of the respondents (55%) indicated the highest level of agreement (5) that the training is applicable to their work, while 42% selected 4 and 3% rated applicability 3. Similar to the satisfaction results, no respondents reported low applicability scores.

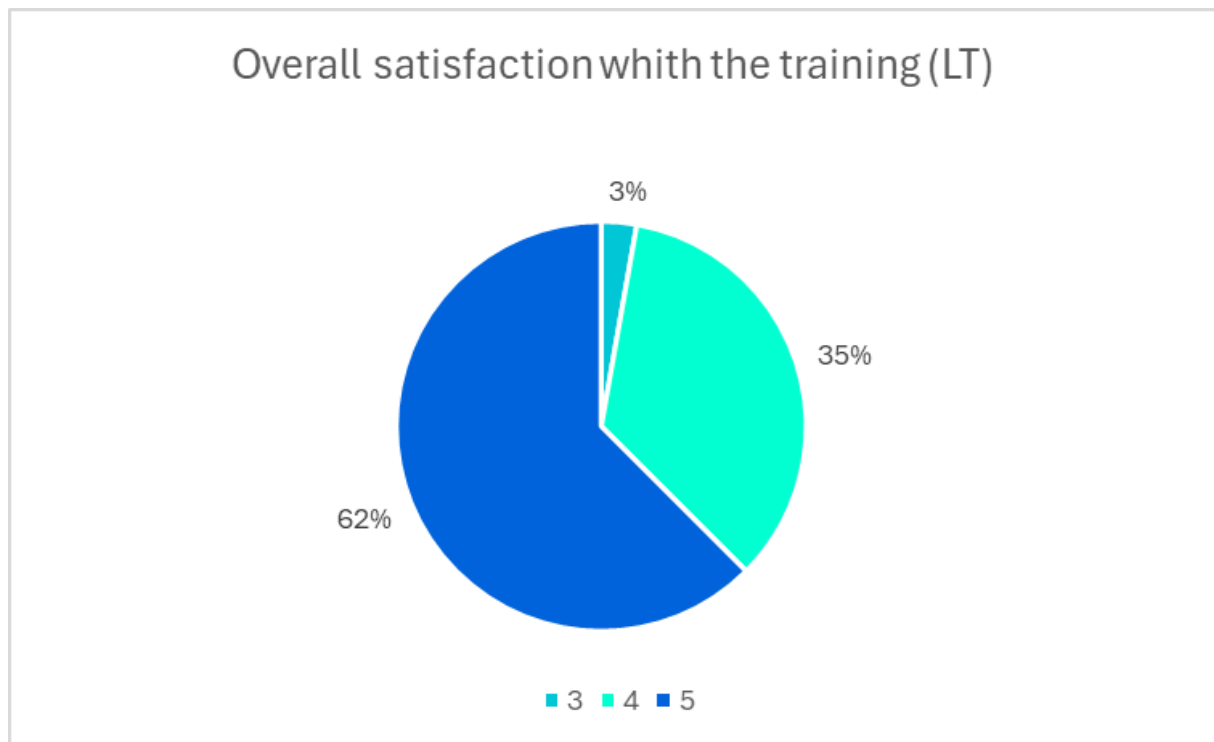


Figure LT-9. Overall satisfaction with the H-PASS training among participants in Lithuania (n = 72)

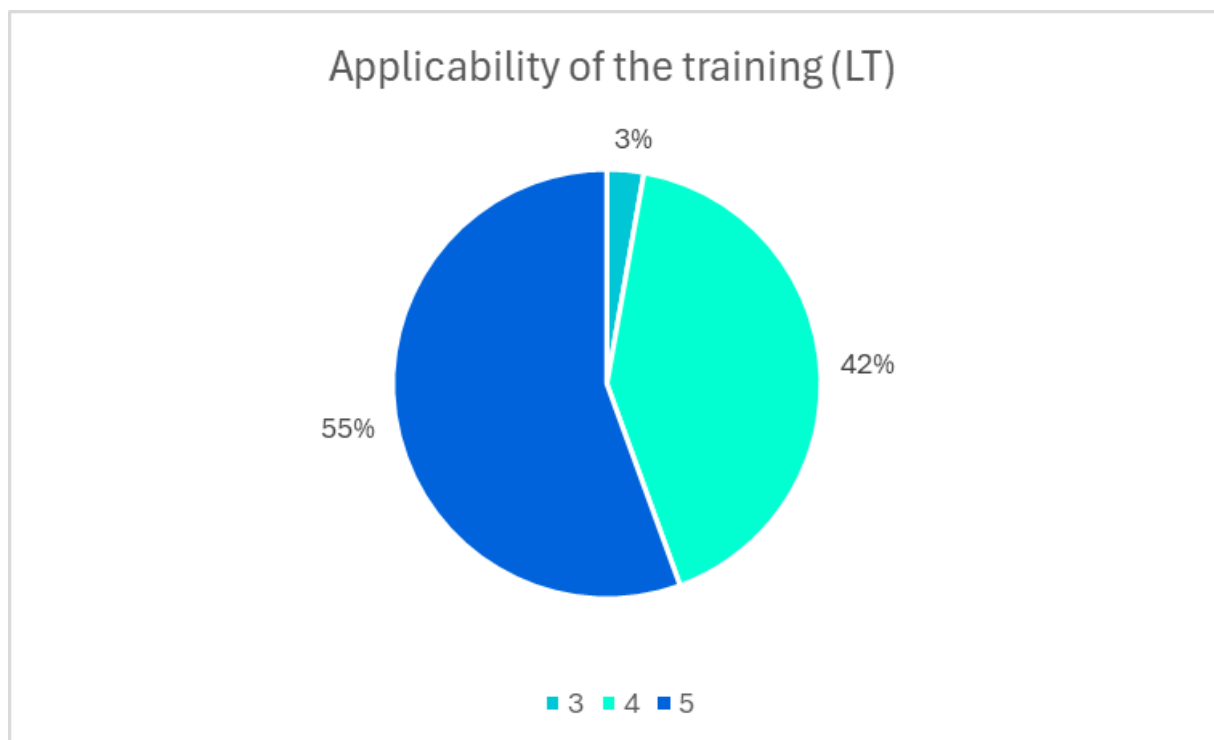


Figure LT-10. Perceived applicability of the H-PASS training to daily work among participants in Lithuania (n = 72)

4.5.4. Digital and transversal skill development

Participants in the Lithuanian H-PASS training reported clear improvements in their digital skills following the programme (Figure LT-11.). More than half of respondents (53%) indicated that their digital skills improved significantly, while 19% reported improvement to a great extent. Additionally, 18% perceived moderate improvement, and 10% reported slight improvement. No respondents indicated that the training had no effect on their digital skills.

When examining specific areas of digital competence based on the DigComp 2.2 framework, improvements were reported across all skill domains (Figure LT-12.). The most frequently improved area was digital safety, reported by 64 participants, followed by problem solving (45) and information and data literacy (44). Improvements were also reported in communication and collaboration (39) and digital content creation (35). These results indicate that the training particularly strengthened participants' awareness and capabilities related to safe and responsible use of digital technologies, while also enhancing their ability to apply digital tools for communication, information management, and problem solving in professional contexts.

The Lithuanian results demonstrate a broad and balanced improvement across multiple digital competence domains, where the primacy of the safety competence area could be accepted due to the additional cybersecurity training delivered in the local pilot.

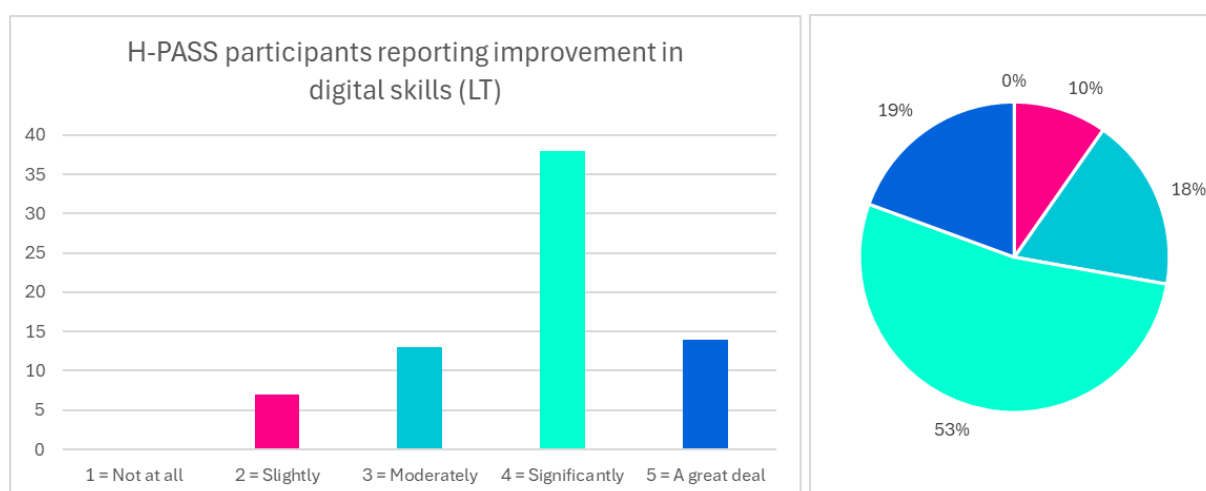


Figure LT-11. H-PASS participants reporting improvement in digital skills in Lithuania (n = 72)

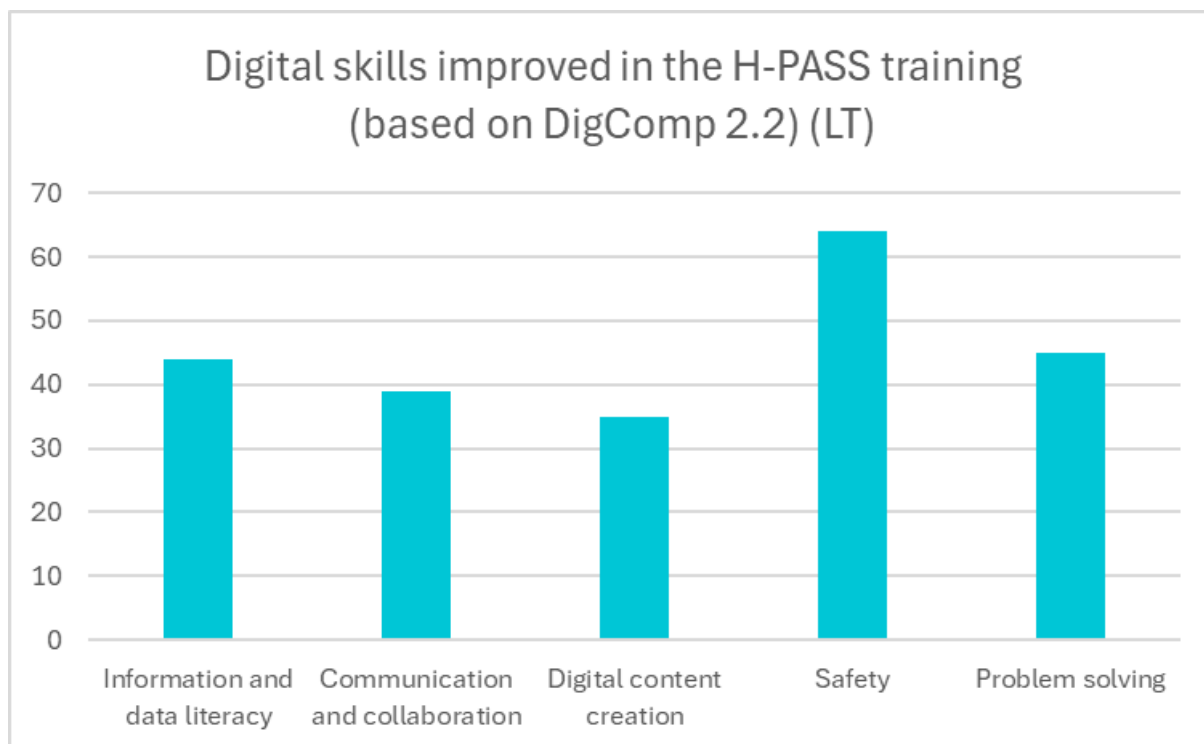


Figure LT-12. Digital skills improved in the H-PASS training based on DigComp 2.2 in Lithuania (n = 82)

Lithuanian participants also reported considerable improvement in transversal skills as a result of the H-PASS training (Figure LT-13.). The majority of respondents (53%) indicated that their transversal skills improved significantly, while 12% reported improvement to a great extent. Additionally, 25% perceived moderate improvement, and 10% reported slight improvement. No respondents indicated that the training had no impact on their transversal skills.

When analysing specific transversal competences based on the LifeComp framework, improvements were reported across all skill areas (Figure LT-14.). The most frequently improved competence was critical thinking (53 participants), followed by collaboration (48) and communication (47). Strong improvements were also observed in managing learning (47), self-regulation (38), and growth mindset (38). Other areas, such as flexibility (28), wellbeing (23), and empathy (19), were also reported as improved by a notable number of participants. These findings indicate that the training supported the development of key interpersonal and reflective competences, particularly those related to teamwork, communication, and critical thinking.

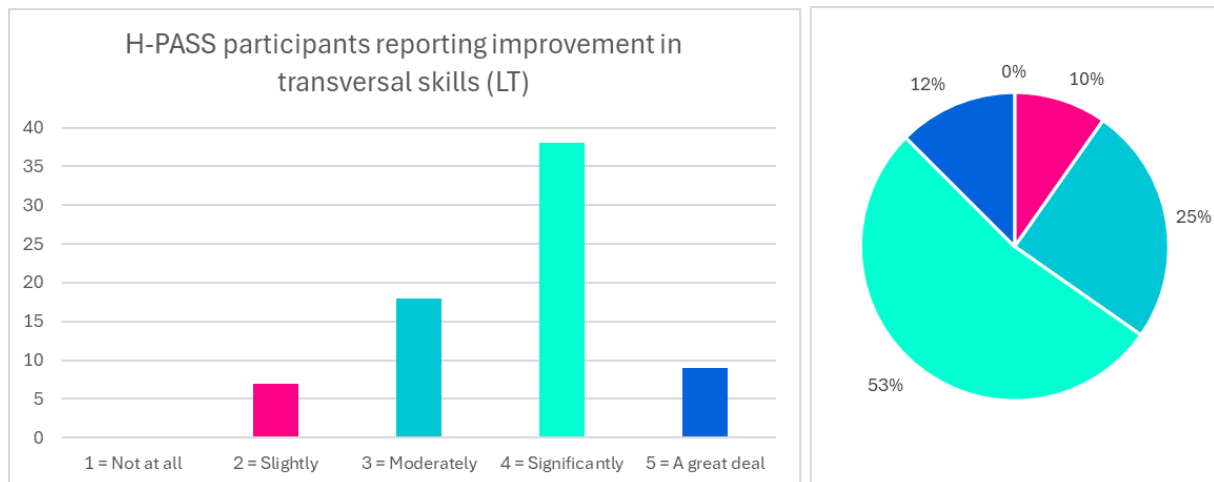


Figure LT-13. H-PASS participants reporting improvement in transversal skills in Lithuania (n = 72)

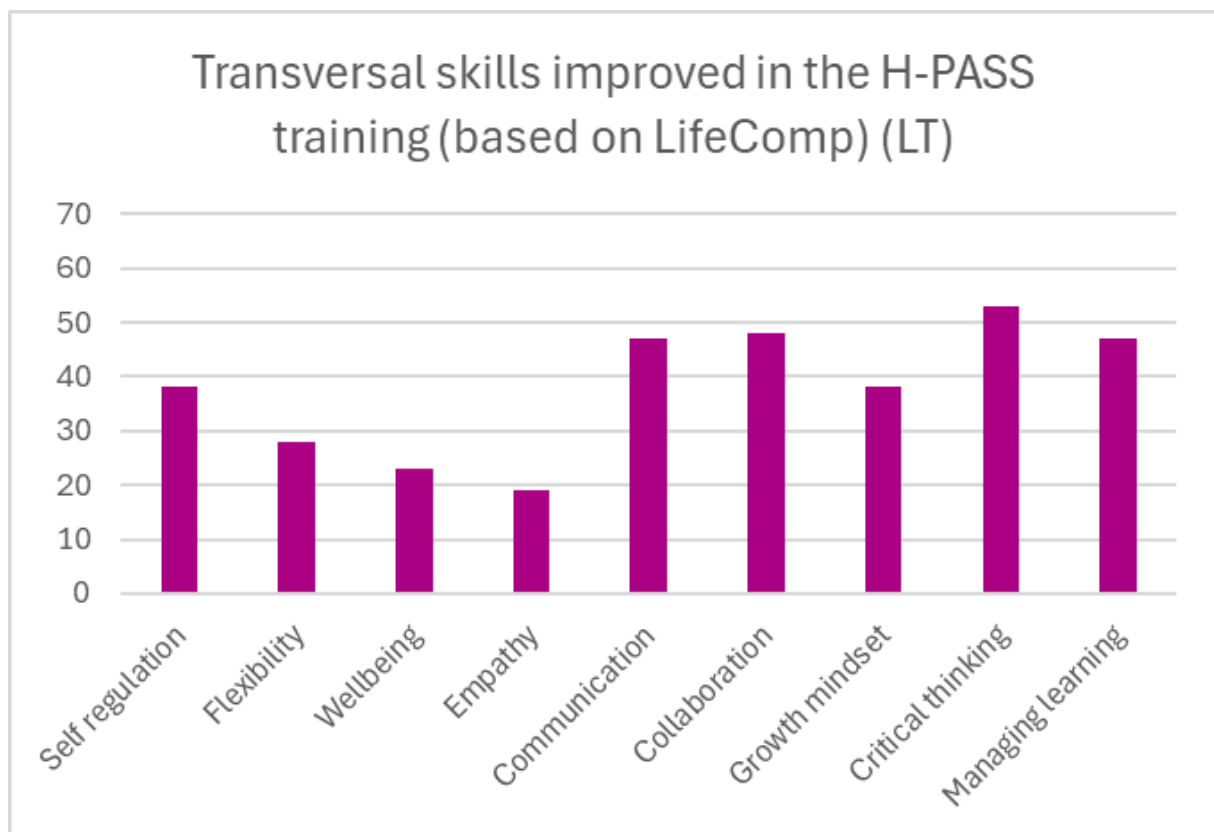


Figure LT-14. Transversal skills improved in the H-PASS training based on LifeComp in Lithuania (n = 82)

Lithuanian participants reported a substantial increase in confidence in digital teamwork following the H-PASS training (Figure LT-15.). The majority of respondents (57%) indicated a high level of improvement by selecting score 4, while 33% reported the highest level of

confidence (score 5). Smaller proportions of participants reported more moderate changes, with 7% selecting score 3, 1,4% selecting score 2, and 1,4% selecting score 1.

Overall, 90% of respondents rated their improvement at the two highest levels (4 or 5), suggesting that the training had a strong positive effect on participants' perceived ability to collaborate effectively in digital environments.

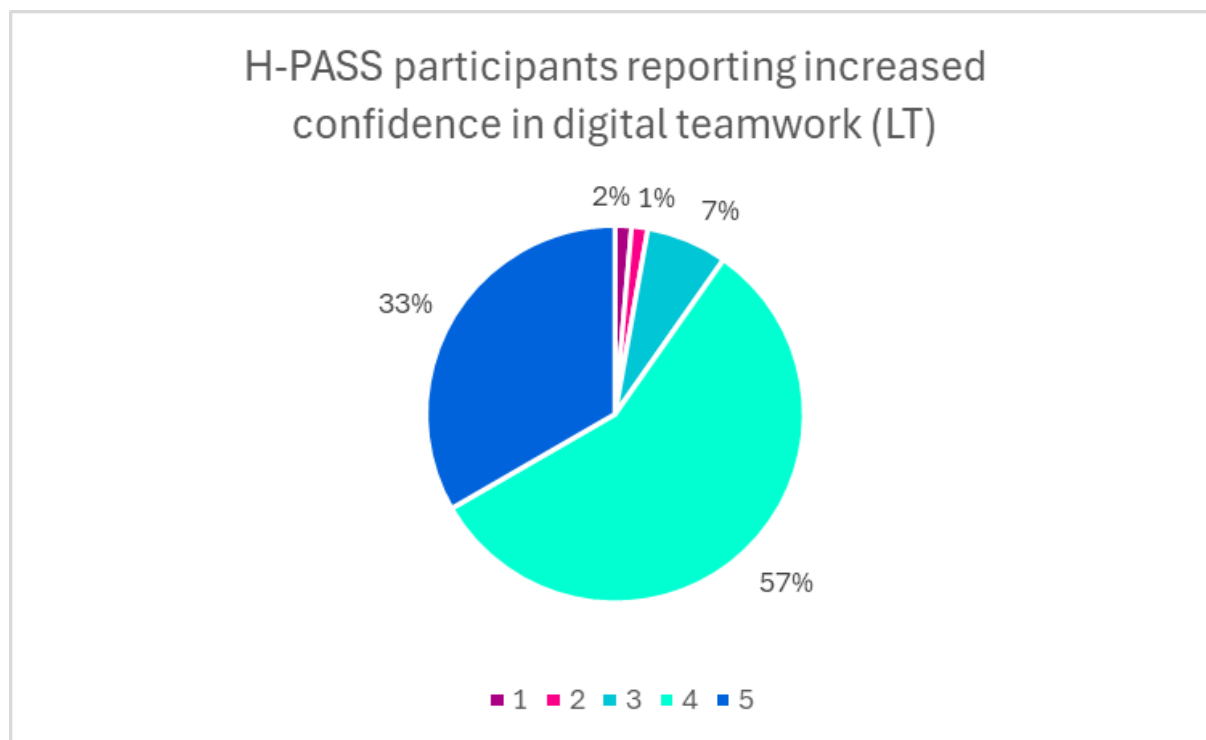


Figure LT-15. H-PASS participants reporting increased confidence in digital teamwork in Lithuania (n = 72)

4.5.5. Impact on digital tool usage

Lithuanian participants reported a notable increase in the use of digital tools in their professional activities following the H-PASS training (Figure LT-16.). Nearly half of the respondents (46%) indicated that they use digital tools slightly more frequently for professional tasks, while 42% reported using them significantly more. At the same time, 8% stated that their usage remained the same or decreased, and 4% considered the question not relevant to their work. Compared with the consortium-level tendency, Lithuanian participants appear to report a stronger increase in professional digital tool usage, indicating particularly successful uptake of digital practices in this cohort.

A similar trend can be observed regarding administrative tasks (Figure LT-17.). The largest share of respondents (40%) reported using digital tools slightly more frequently for administrative activities, while 34% indicated that they use them significantly more. Meanwhile, 11% reported no change or a decrease, and 15% indicated that the question was

not relevant to their work. These results again demonstrate that the training encouraged participants to integrate digital tools more actively into routine organisational processes.

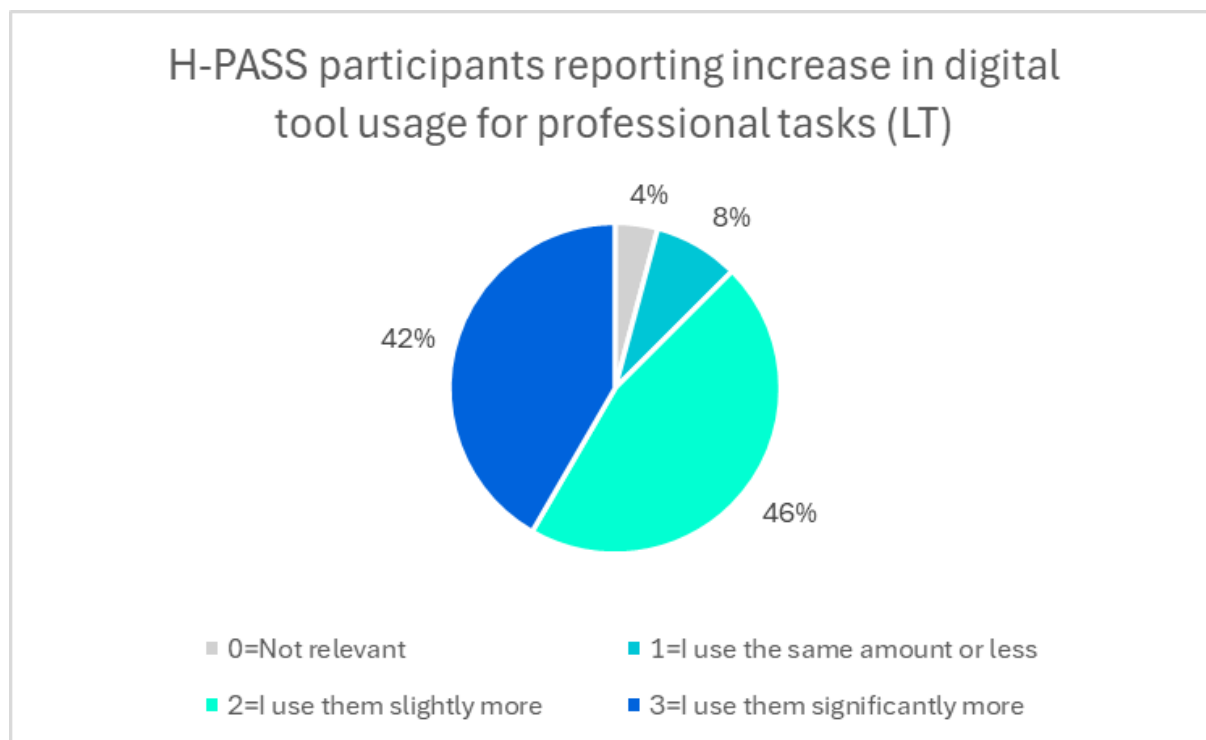


Figure LT-16. Increase in digital tool usage for professional tasks among Lithuanian H-PASS participants (n = 72)

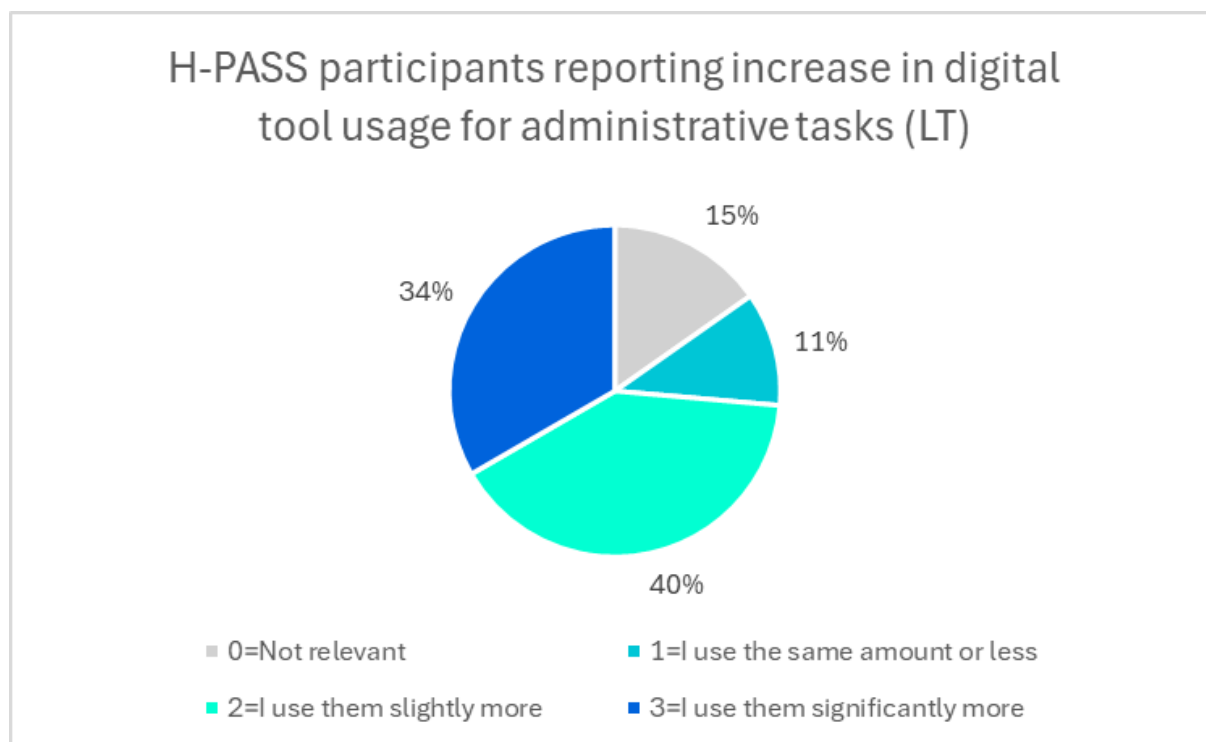


Figure LT-17. Increase in digital tool usage for administrative tasks among Lithuanian H-PASS participants (n = 72)

4.5.6. Training follow-up results

The follow-up survey provides insight into how Lithuanian participants perceived organisational changes after completing the H-PASS training. Among the respondents ($n = 20$), a large majority (85%) reported that they observed improvements in their organisations as a result of the training, while three participants (15%) indicated that they did not perceive any noticeable change (Figure LT-18.).

Participants were also asked to identify specific areas where organisational changes had been observed. The most frequently reported improvements were related to teamwork and workflow, each marked by 12 respondents (Figure LT-19.). Additionally, 10 participants reported improvements related to task-shifting, indicating better distribution or organisation of responsibilities within teams. Fewer respondents (4) reported noticeable changes in workload management. Participants marked 2,24 areas on average.

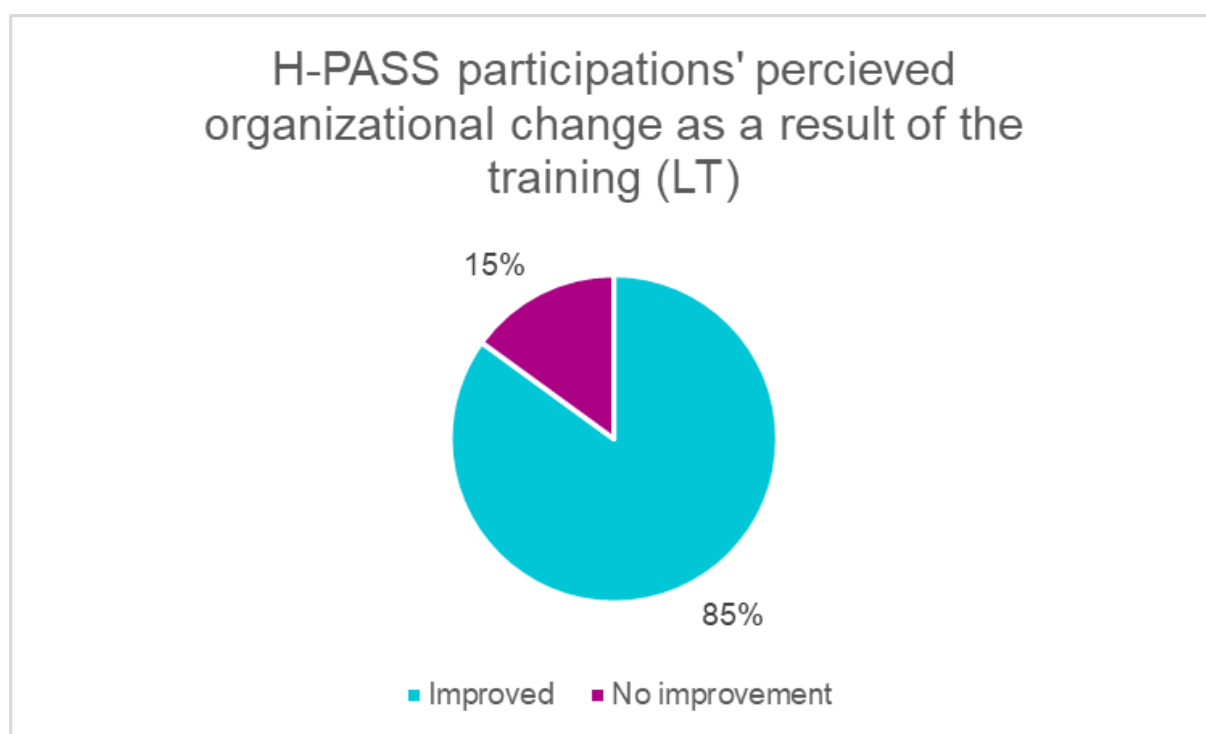


Figure LT-18. Perceived organisational change following the H-PASS training in Lithuania ($n = 20$)

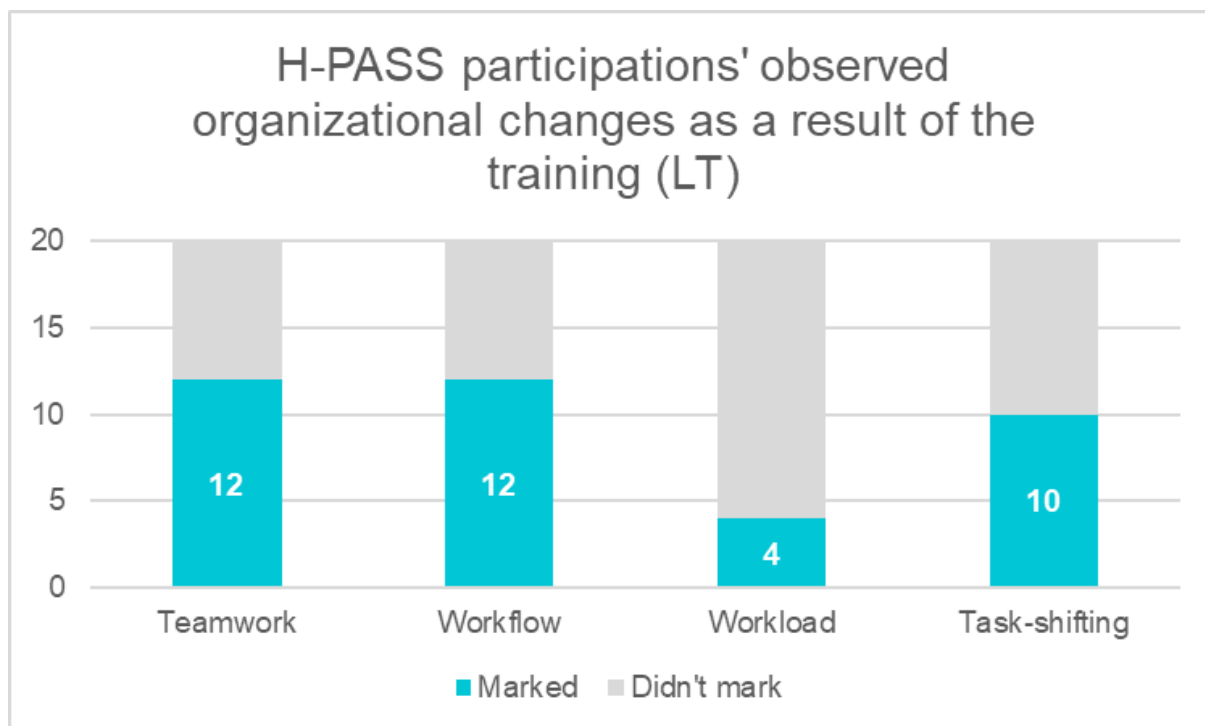


Figure LT-19. Observed organisational changes resulting from the H-PASS training in Lithuania (n = 20)

4.5.7. Module evaluation overview

The evaluation of the H-PASS training modules in Lithuania indicates very high overall satisfaction across all assessed aspects. Participants evaluated the modules based on four key criteria: organisation (ME1), technical aspects (ME2), relevance and usefulness (ME3), and alignment with development goals (ME4). The results (Figure LT-20.) show consistently strong scores across all areas, with average ratings ranging between 4.60 and 4.65 on the five-point scale. Among these aspects, organisation and relevance/usefulness received the highest evaluations, suggesting that participants perceived the training as well-structured and directly applicable to their professional development.

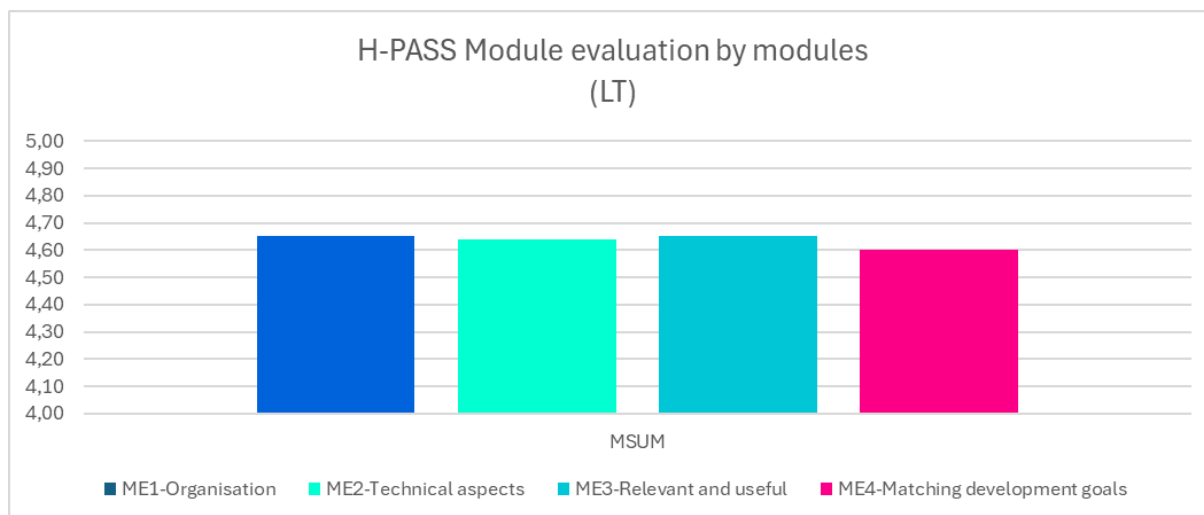


Figure LT-20. H-PASS module evaluation by aspects in Lithuania (n = 77)

Looking at the evaluation of individual training exercises (Table LT-4.), the highest-rated activities were “Reflection: digital technology use in own practice” (4.79) and “Leading digital change” (4.79), both from Module 1, followed closely by “Teamwork in Healthcare” (4.77) from Module 2.

At the lower end of the ranking, the exercises “Cyber security and digital wellbeing” (4.48) and “Digital wellbeing checklist” (4.45) from Module 4 received the lowest scores among the listed activities, although these evaluations remain relatively high on the five-point scale. The lowest-rated exercise overall was “Working with Data” (4.26) from Module 4. Despite being the lowest in the ranking, this score still reflects generally positive evaluations, indicating that participants maintained a favourable perception of all exercises included in the Lithuanian training.

The Lithuanian exercise evaluation results demonstrate consistently strong participant satisfaction across the programme, with particular appreciation for exercises that encouraged reflection, leadership in digital transformation, and teamwork in healthcare contexts.

TOP1	M1B2	Reflection: digital technology use in own practice	4,79
TOP2	M1B4	Leading digital change	4,79
TOP3	M2B3	Teamwork in Healthcare	4,77
BOTTOM3	M4B2	Cyber security and digital wellbeing	4,48
BOTTOM2	M4B3	Digital wellbeing checklist	4,45
BOTTOM1	M4B5	Working with Data	4,26

Table LT-4. Highest- and lowest-rated H-PASS training exercises in Lithuania

4.5.8. Evaluation results of the DCA training

Lithuanian participants of the DCA training reported very high levels of satisfaction with the programme (Figure LT-21.). The majority of respondents (61%) rated their overall satisfaction with the highest score (5), while 28% selected 4 and 11% rated the training 3. No respondents reported dissatisfaction. These results indicate that the DCA training was very positively received among Lithuanian participants.

Participants also reported a high level of readiness to foster collaboration within the H-PASS network (Figure LT-22.). An equal share of respondents (44%) selected score 5 and score 4, indicating strong agreement that they feel prepared to support collaboration within the network. Smaller proportions selected score 3 (6%) and score 2 (6%), suggesting moderate or limited agreement with the statement.

The results are broadly consistent with the consortium-level evaluation, confirming that the training effectively strengthened participants' readiness to act as Digital Change Agents within their professional environments.

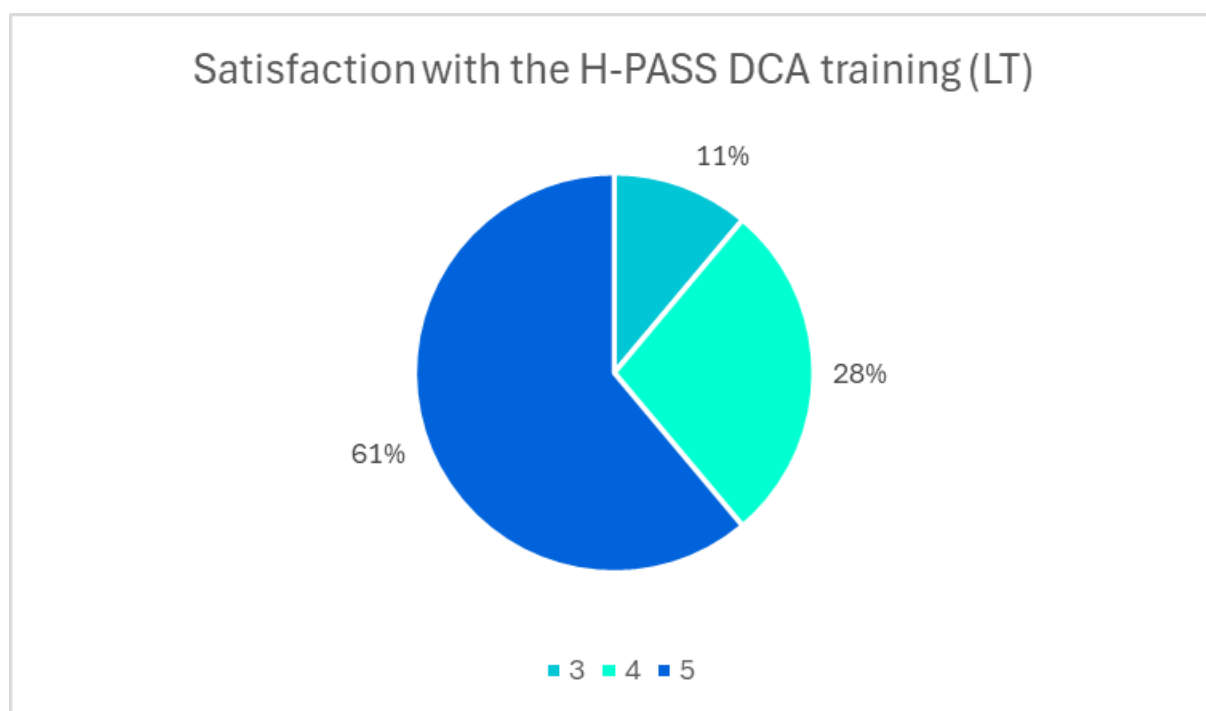


Figure LT-21. Satisfaction with the H-PASS DCA training in Lithuania (n = 18)

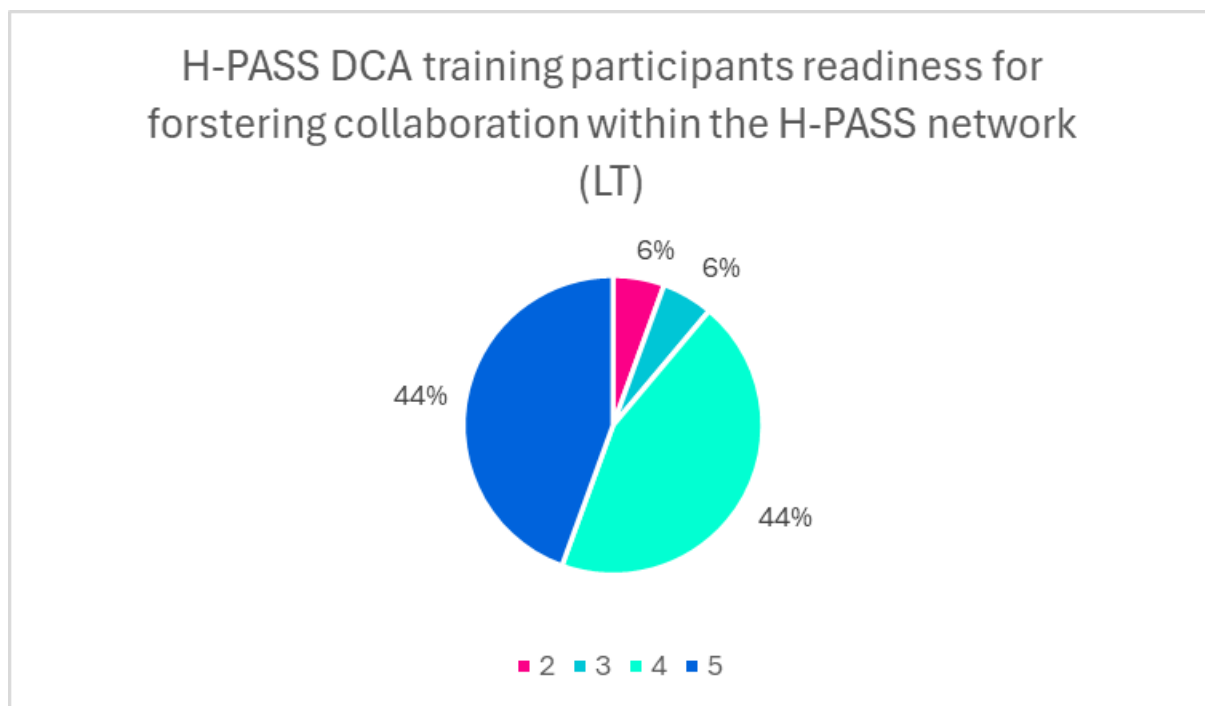


Figure LT-22. DCA participants' readiness to foster collaboration within the H-PASS network in Lithuania (n = 18)

The result of the pre-post self-evaluation provides insight into how Lithuanian DCA participants perceived changes in their competences after completing the programme (Figure LT-23.). Among the respondents (n = 9), a majority (63%) reported an increased understanding of the DCA role, indicating that the training helped participants clarify their responsibilities and potential impact as Digital Change Agents within their organisations.

More participants reported improvement in relation to change management skills and knowledge of educational methods, where 94% of respondents indicated improvement in both areas. These results suggest that the training was particularly effective in strengthening participants' capacity to facilitate digital transformation processes and support learning within healthcare organisations.

Although the sample size is small, the findings align with the consortium-level pattern, where DCA participants also reported significant improvements in their leadership and facilitation competences following the training.

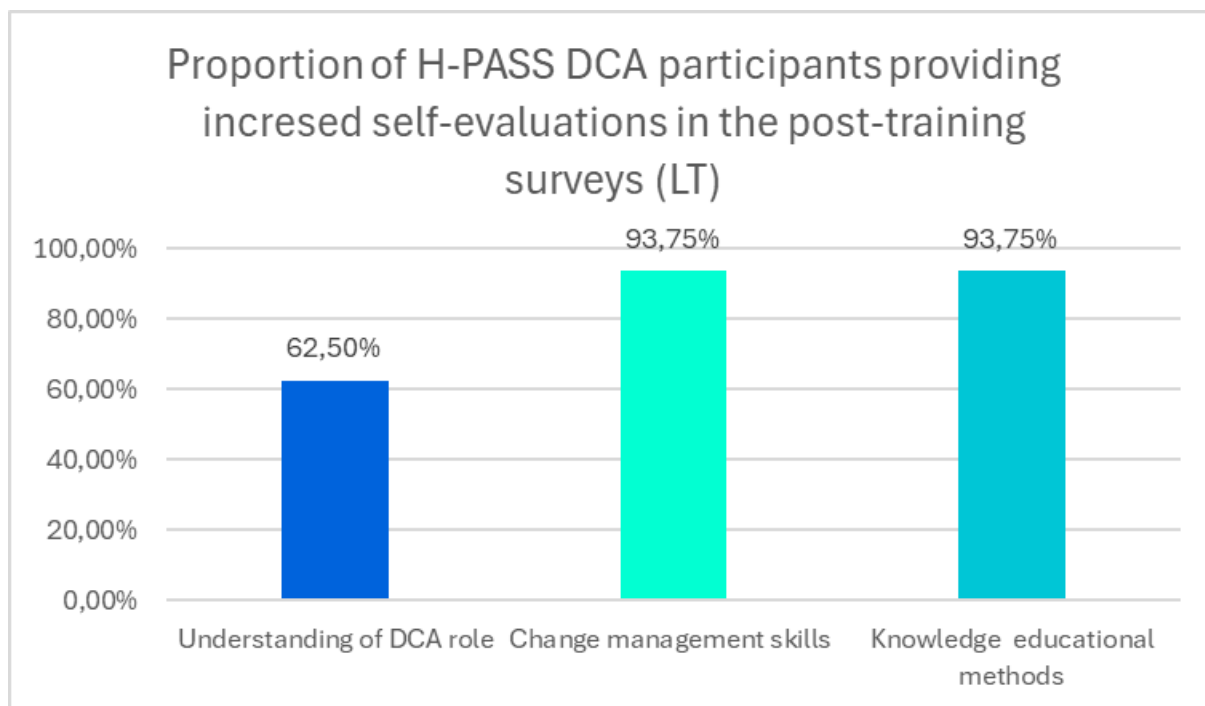


Figure LT-23. Proportion of Lithuanian DCA participants reporting increased self-evaluated competences after the training (n = 9)

The follow-up survey of Lithuanian DCA alumni provides insight into how participants applied the training outcomes in their professional environments. A total of 7 alumni completed the follow-up survey with complete data, and all respondents (7 participants) reported that the DCA training strengthened their leadership skills in facilitating digital transformation within their work environment (Figure LT-24.).

In addition, 6 respondents indicated that they had already taken concrete actions in their professional settings to support digital innovation or improve teamwork and collaboration. These findings suggest that the DCA training not only enhanced participants' leadership capacities but also encouraged the practical application of these skills in real organisational contexts.

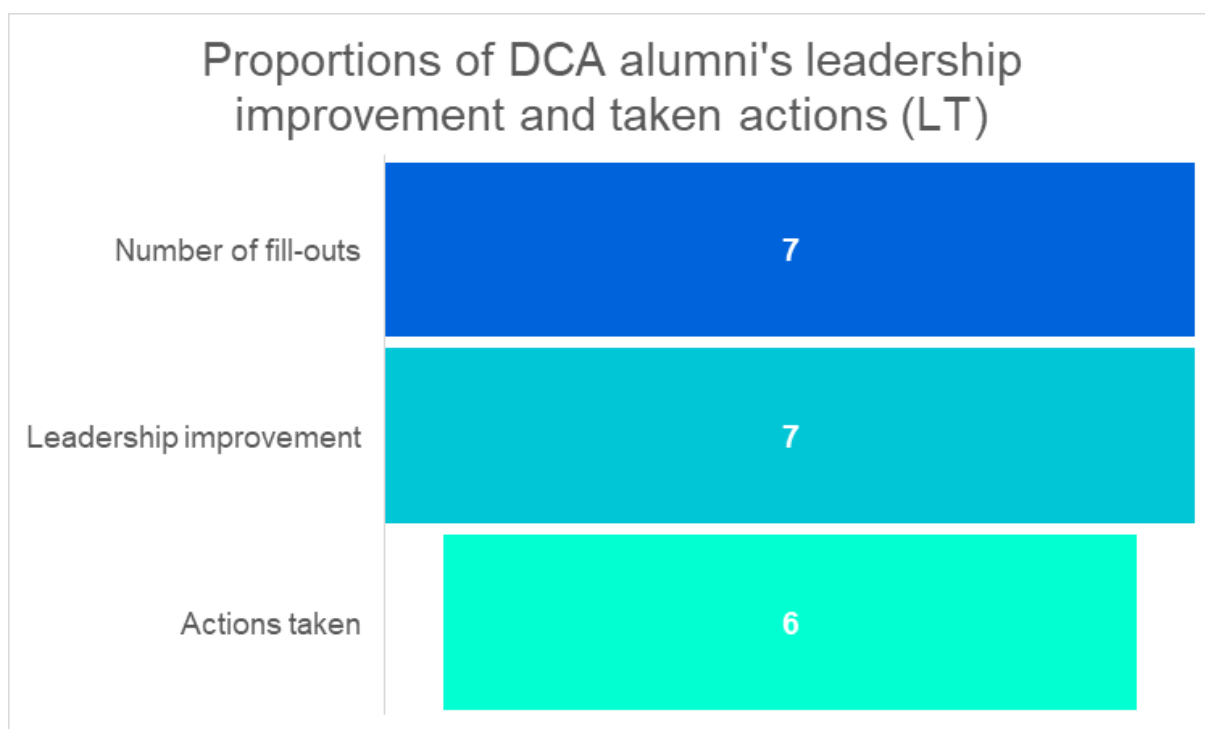


Figure LT-24. Leadership improvement and actions taken among Lithuanian DCA alumni (n = 7)

4.5.9. Participant testimonials

Responses from the Closing Survey:

"I am now better able to organize the distribution of tasks within the team."

"A clearer distribution of tasks among all staff members."

"After the H-PASS training, I am able to work more smoothly within the team, have a better understanding of workplace processes, and have started to distribute tasks among colleagues instead of trying to do everything myself."

"I have noticed that my teamwork skills have improved."

"In practice, I have noticed that the patient's situation and further actions are discussed more clearly within the team, making it easier to agree on responsibilities. This helps to organize work more effectively, especially during periods of higher patient flow."

"The training helped me better understand the importance of clear communication and task distribution within the team. This helps to organize work more clearly, transfer information more accurately to colleagues, and collaborate more effectively in daily practice."

Answers from the DCA Post-training survey:

Please complete the sentence: The most applicable knowledge and skills I gained during the H-PASS training are:

"Innovation and attractiveness in service delivery. The impact of cybersecurity and the importance of teamwork."

"I learned to better recognize patients' needs and to resolve conflicts calmly."

"More purposeful teamwork, a clearer understanding of roles, and skills in providing constructive feedback."

"More effective communication in clinical situations and decision-making."

"I have strengthened my digital competencies."

"I gained a better understanding of the principles of collaboration, the importance of teamwork, and practical tools for effective communication in the field of healthcare."

"Collaboration skills have been strengthened, and new knowledge has been gained in the areas of leadership and innovation."

"The ability to plan communication activities, formulate messages clearly, and practical skills in using digital tools and technologies required in modern healthcare practice."

Please complete the sentence: The H-PASS training impacted my work in the following way:

"Competencies have been expanded and leadership skills are being further developed."

"I feel more confident and better prepared to solve emerging problems."

"The H-PASS training improved the quality of my work, strengthened my communication skills, and helped me ensure patient safety more effectively."

"I can apply clear action algorithms; thanks to them, my work has become more precise and safer."

"My digital competencies have increased, which I hope will help me to apply all the knowledge gained in my work environment."

"I have become more engaged in team processes, more confident in initiating collaboration, and clearer in communicating information to colleagues."

"It gave me more confidence, strengthened my ability to use digital technologies at work, and improved my communication skills."

Answers from the DCA Follow-up survey:

"Teamwork has become smoother. There are fewer conflicts due to misunderstandings."

"More innovations have started to be applied in work practice."

“After the DCA training, I am beginning to bring innovations and new approaches into my workplace. I encourage my colleagues to dedicate more time to innovative tools and I am able to generate new ideas from an innovation.”

“From the perspective of teamwork, reflections, suggestions, and conflict resolution have become important, which we address within the team, drawing on the H-PASS training.”

“After the training, I pay more attention to ensuring that important information about patient care is communicated clearly and on time using the available electronic systems. This helps the team orient themselves in the situation more.”

4.6. Romania

4.6.1. Indicator summary

Satisfaction rate (evaluated with 4 or 5): 100% (n=86)

Satisfaction rate (evaluated with 5): 41,9% (n=86)

Breakdown	Number of health professionals completing the H-PASS training
In total	75/84
Medical doctors	0
Nurses	0
Allied health professionals	0
Other	0
Pharmacists	84
CME credential attainment	83
TtT participants	31
TtT participants / Trainer pool	12
TtT participants / DCA training course	19

Table RO-1. H-PASS output indicators

Breakdown	Number of health professionals completing the H-PASS training
18–24	1
25–34	26
35–44	26
45–54	28
55–64	3
65 or older	0
No data on age	0
Female	75
Male	9

Table RO-2. H-PASS participants by age groups and by gender

Breakdown	Target/Result
Improvement in digital skills among training participants (based on pre- and post-training surveys)	75%/100%
Improvement in transversal skills among training participants (based on pre- and post-training surveys)	75%/100%
Improved capabilities for teamwork for teamwork in digital settings (based on post-training surveys)	75%/100%

Increased use of digital tools in clinical work (based on post-training survey)	75%/100%
Increased use of digital tools in administrative work: (based on post-training survey)	75%/100%
Utilization of acquired digital and transversal skills in practice (based on post-training survey)	50%/95,92%
Improved change management skills among the participants of the train-the-trainer training (based on pre- and post-training surveys)	75%/83,33%
Increase in knowledge educational methods among participants of train-the-trainer courses (based on pre- and post-training surveys)	75%/94,44%
Utilization of acquired digital and transversal skills in practice (based on post-training survey) <i>Improved capabilities for leadership in digital settings among participants of train-the-trainer courses</i>	50%/100%

Table RO-3. H-PASS outcome indicators

4.6.2. Demographics of the H-PASS training course

The demographic profile of participants in the Romanian H-PASS pilot training shows a somewhat younger and more profession-specific cohort compared with the consortium-level distribution, as the Romanian training has been specifically targeted at pharmacy professionals.

The age distribution (Figure RO-1.) is concentrated in the mid-career groups. The largest share of participants belonged to the 45–54 age group (32%), followed by 25–34 (30%) and 35–44 (30%). A smaller proportion of participants were aged 55–64 (7%), while 1% belonged to the youngest group (18–24). Compared with the consortium-level pattern, the Romanian cohort appears more evenly distributed across the 25–54 age range, indicating strong representation of early- and mid-career professionals.

The gender distribution (Figure RO-2.) shows a clear female majority (90%), with 10% male participants.

In terms of educational background (Figure RO-3.), the Romanian cohort is characterised by a very high share of participants with Bachelor's degrees (87%), while 11% reported holding a doctoral/PhD degree and 2% reported a Master's degree. Compared with the consortium-level results, the Romanian sample shows a particularly strong concentration at the Bachelor's level, suggesting a relatively homogeneous educational profile among participants.

Regarding professional roles (Figure RO-4.), the cohort is highly specialised: 100% of participants identified as pharmacists. This represents a notable difference from the consortium-level distribution, where participants typically represented a broader mix of healthcare professions.

Finally, the distribution of work experience indicates a relatively experienced participant group (Figure RO-5.). The largest share (42%) reported 11–20 years of professional experience, followed by 33% with under 10 years and 25% with more than 20 years of experience. Compared with the consortium-level results, the Romanian cohort shows a balanced representation of both mid-career and highly experienced professionals, with fewer very early-career participants.

The Romanian participant profile reflects a highly specialised training cohort composed primarily of experienced female pharmacists, with a strong presence of professionals in the mid-career stages of their professional development.

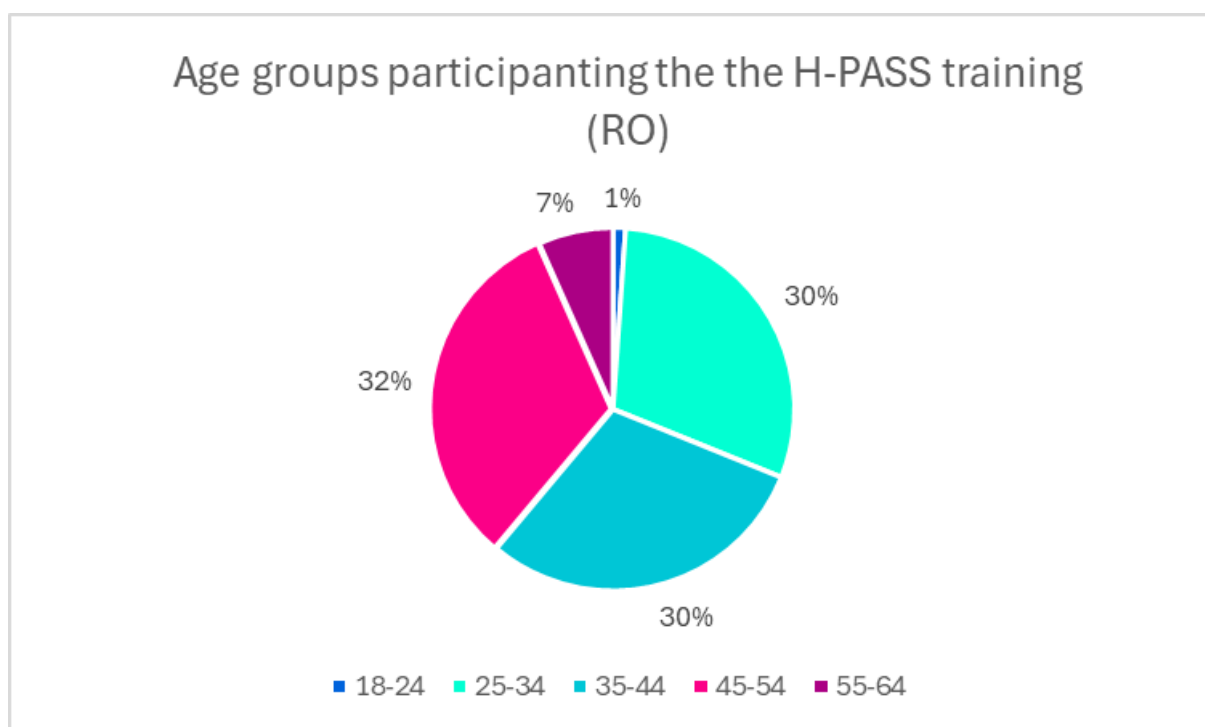


Figure RO-1. Age distribution of H-PASS training participants in Romania (n = 90)

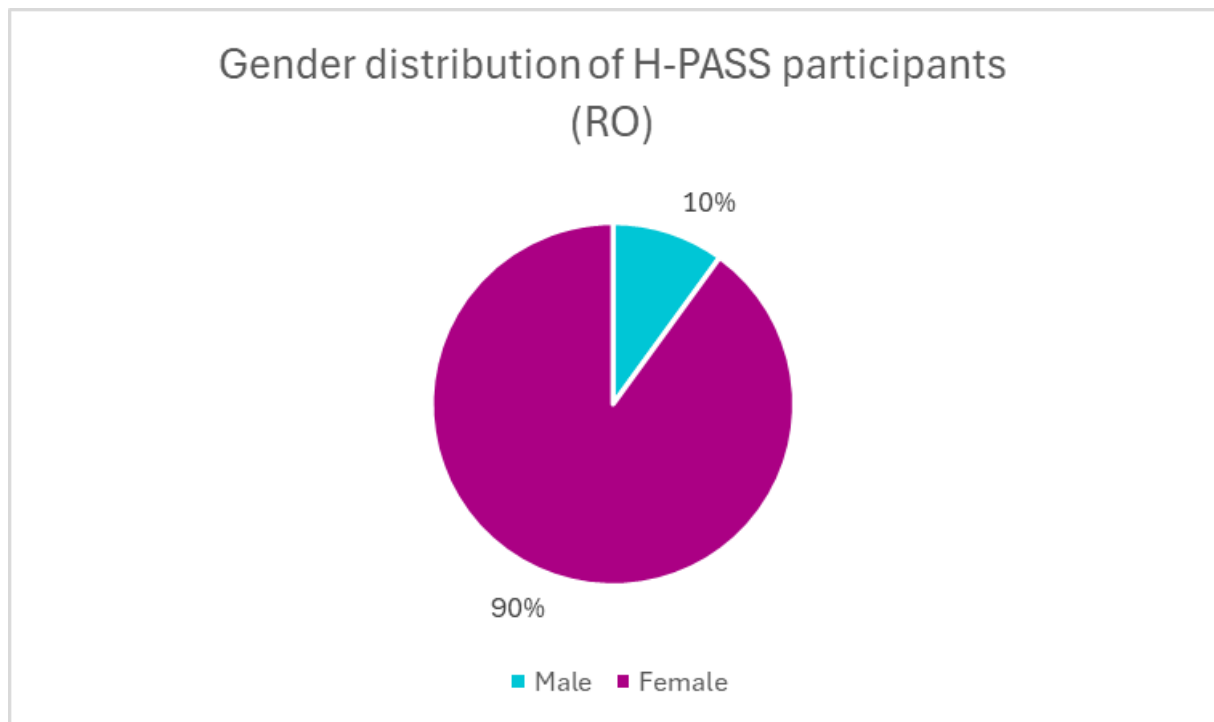


Figure RO-2. Gender distribution of H-PASS training participants in Romania ($n = 90$)

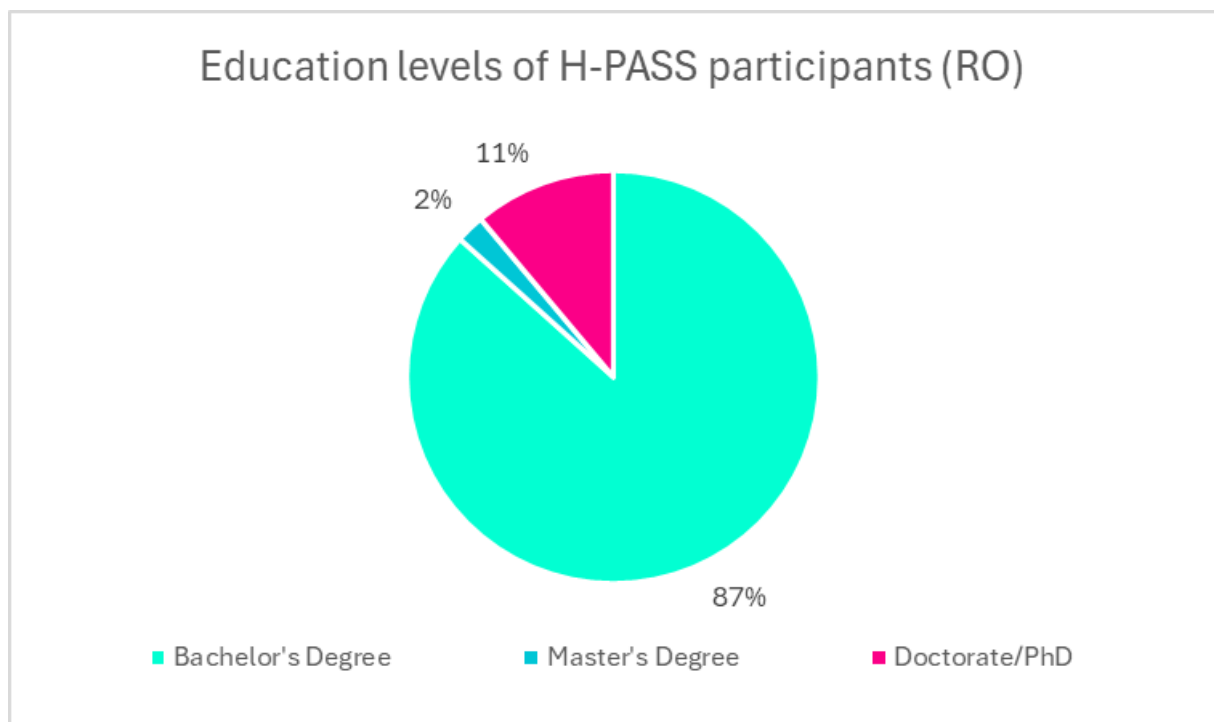


Figure RO-3. Education levels of H-PASS training participants in Romania ($n = 90$)

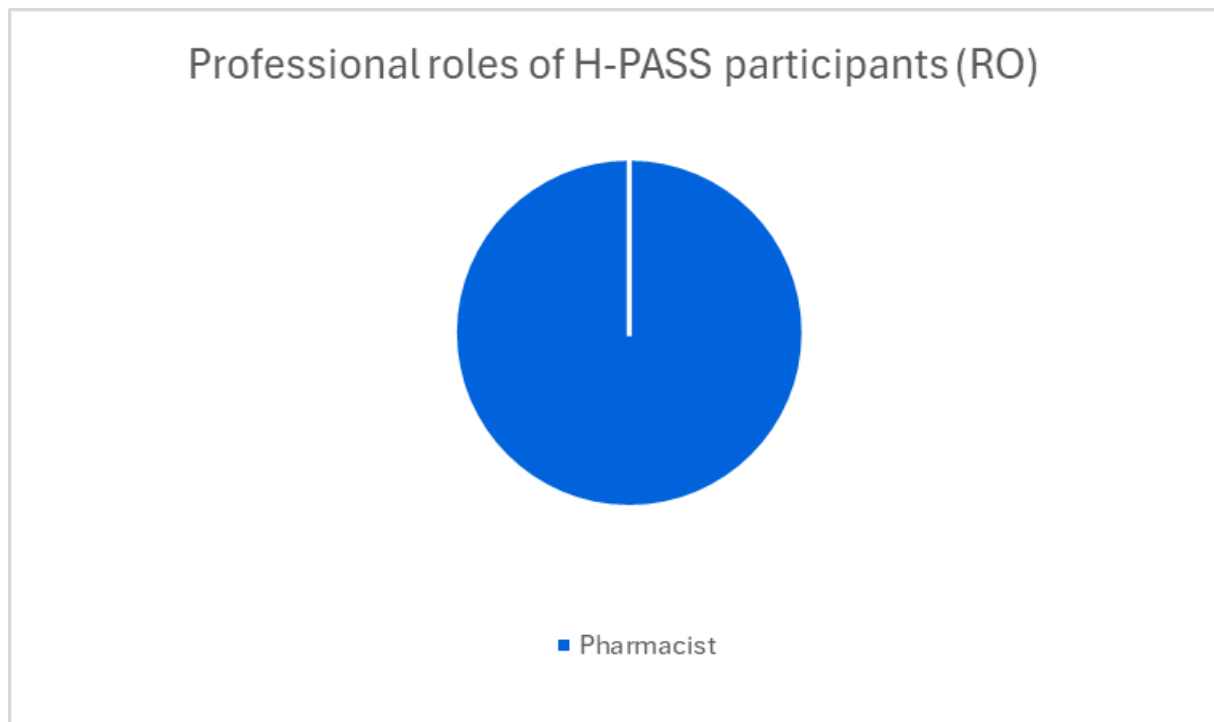


Figure RO-4. Professional roles of H-PASS training participants in Romania (n = 90)

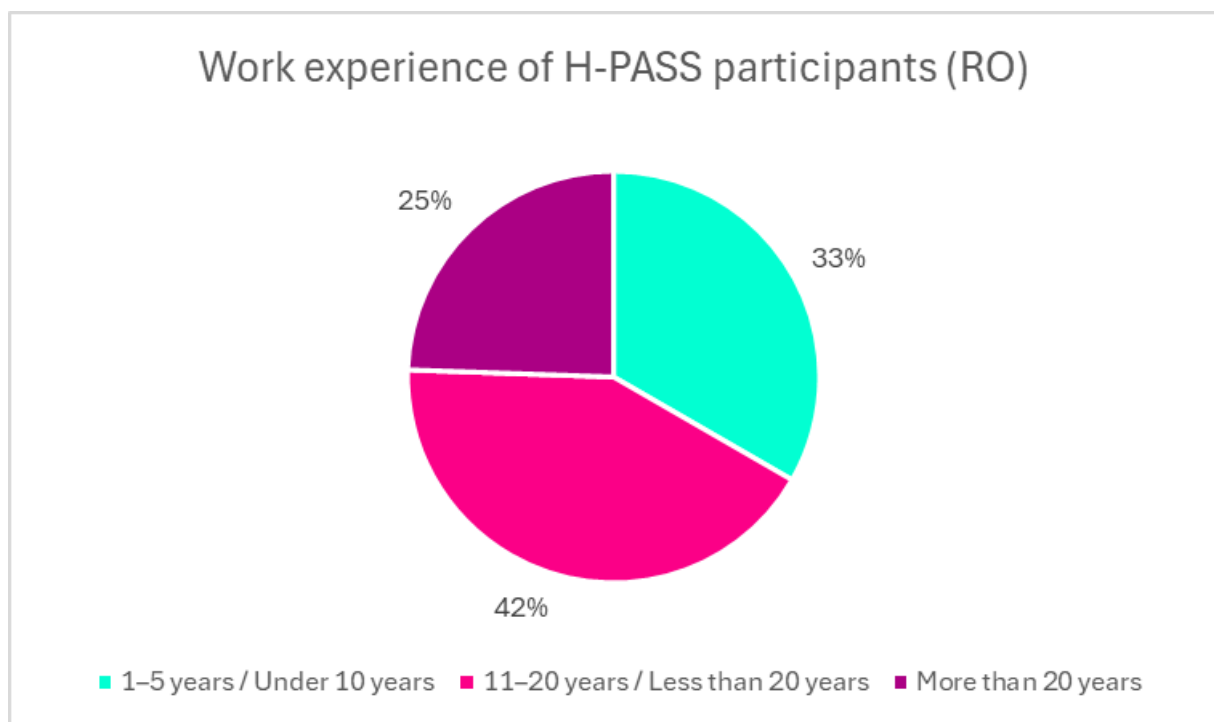


Figure RO-5. Work experience of H-PASS training participants in Romania (n = 90)

The workplace characteristics of Romanian H-PASS participants indicate a strong presence of professionals working in private healthcare settings due to the nature of pharmacies, which differs from the consortium-level trend where public institutions were typically more

dominant. The majority of respondents (74%) reported working in private institutions, while 26% indicated employment in public healthcare institutions, most likely as hospital pharmacists (Figure RO-6.).

Regarding employment status (Figure RO-7.), most participants were employed full-time (90%), while 9% reported being currently unemployed and 1% indicated part-time employment. This distribution is broadly consistent with the consortium-level pattern.

In terms of work location (Figure RO-8.), the majority of respondents (86%) reported working in urban areas, while 14% indicated working in rural areas. Compared with the consortium-level distribution, the Romanian cohort shows a similarly strong concentration of participants in urban healthcare settings.

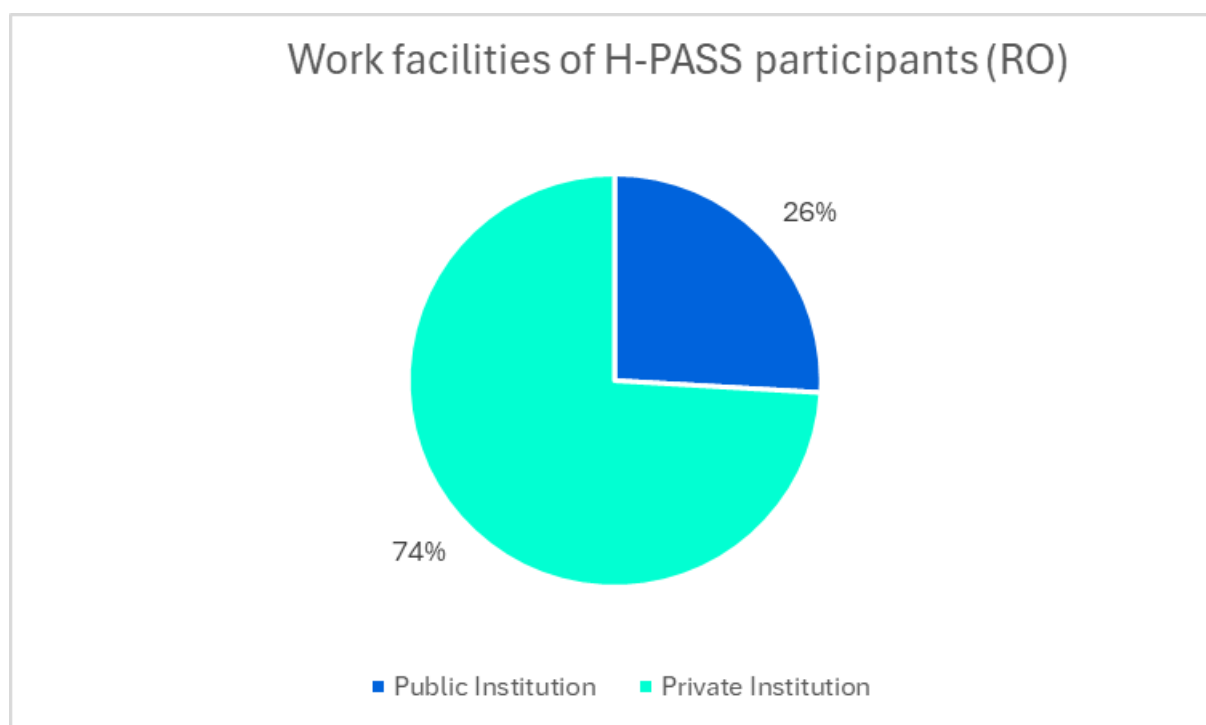


Figure RO-6. Work facilities of H-PASS training participants in Romania (n = 81)

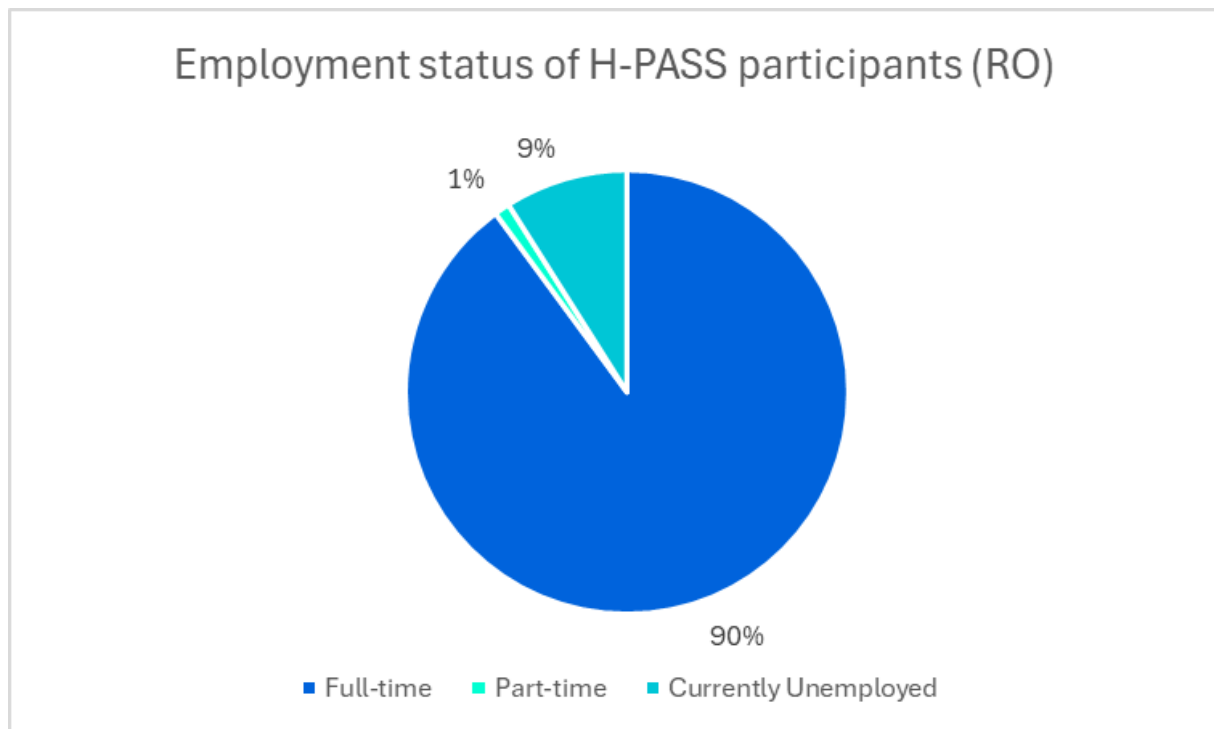


Figure RO-7. Employment status of H-PASS training participants in Romania ($n = 89$)

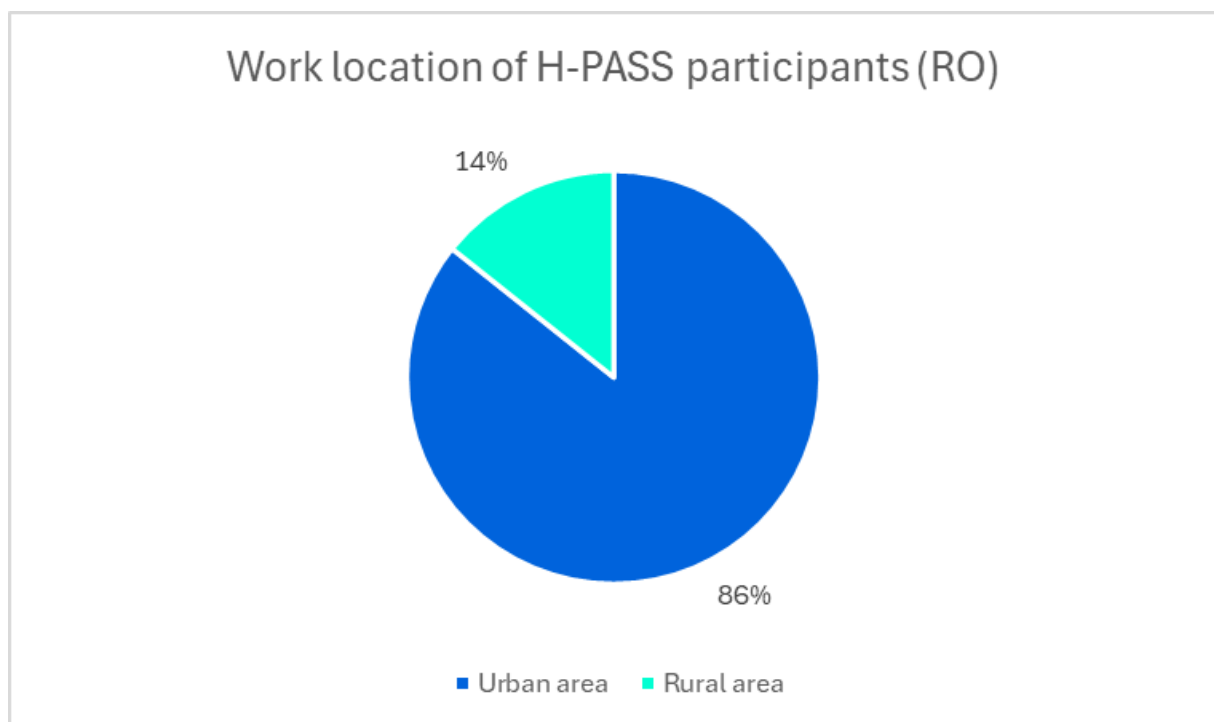


Figure RO-8. Work location of H-PASS training participants in Romania ($n = 84$)

4.6.3. Satisfaction with the H-PASS training

Romanian participants reported very high levels of satisfaction with the H-PASS training programme (Figure RO-9.). The majority of respondents (58%) rated their overall satisfaction with the highest score (5), while 42% selected 4. No respondents reported lower scores. These results indicate that the training was very positively received among Romanian participants, reflecting a level of satisfaction that is even higher than on the consortium-level.

Participants also reported very high perceived applicability of the training to their professional practice (Figure RO-10.). Slightly more than half of respondents (52%) selected score 4, while 48% rated applicability with the highest score (5). The absence of lower ratings suggests that participants considered the training highly relevant and useful for their professional activities.

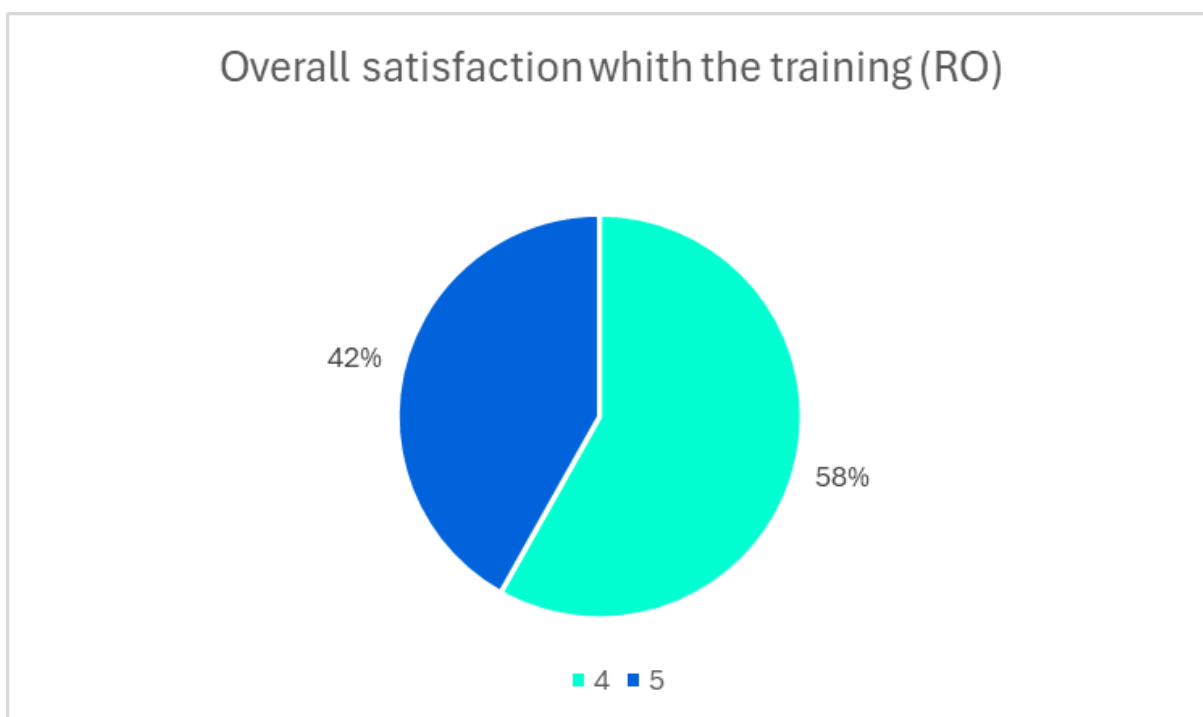


Figure RO-9. Overall satisfaction with the H-PASS training in Romania (n = 86)

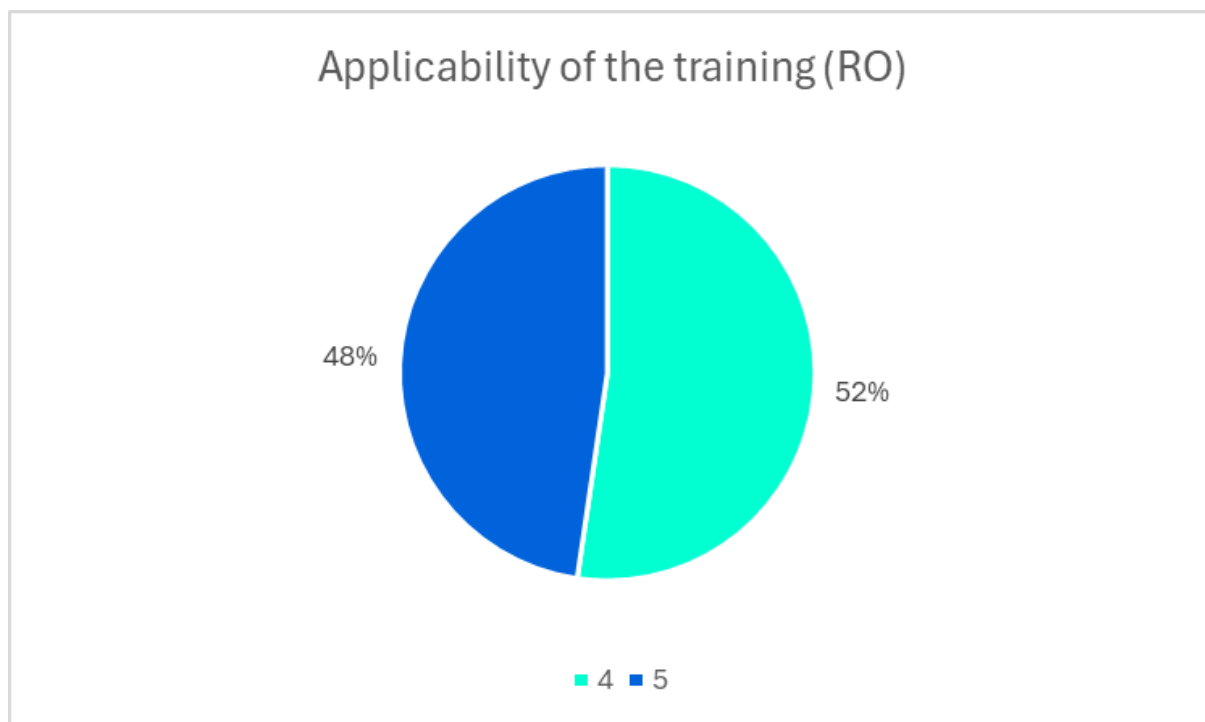


Figure RO-10. Perceived applicability of the H-PASS training in Romania (n = 86)

4.6.4. Digital and transversal skill development

Romanian participants reported substantial improvements in their digital skills following the H-PASS training (Figure RO-11.). The largest share of respondents (41%) indicated that their digital skills improved moderately, while 34% reported significant improvement and 25% stated that their skills improved to a great extent. No respondents selected the lower categories (“slightly” or “not at all”), indicating that all participants perceived at least moderate improvement in their digital competences. This distribution suggests that the training had a strong positive effect on participants’ perceived digital capability.

When examining specific digital competences based on the DigComp 2.2 framework, improvements were reported across all assessed areas (Figure RO-12.). The most frequently reported improvements were in communication and collaboration (25 participants) and digital safety (24). Improvements were also noted in digital content creation (20) and information and data literacy (19). The least frequently reported improvement was in problem solving (12), though it still represents a notable proportion of participants.

The Romanian results indicate that the H-PASS training contributed to broad development across multiple digital competence domains, particularly those related to communication, collaboration, and safe digital practices.

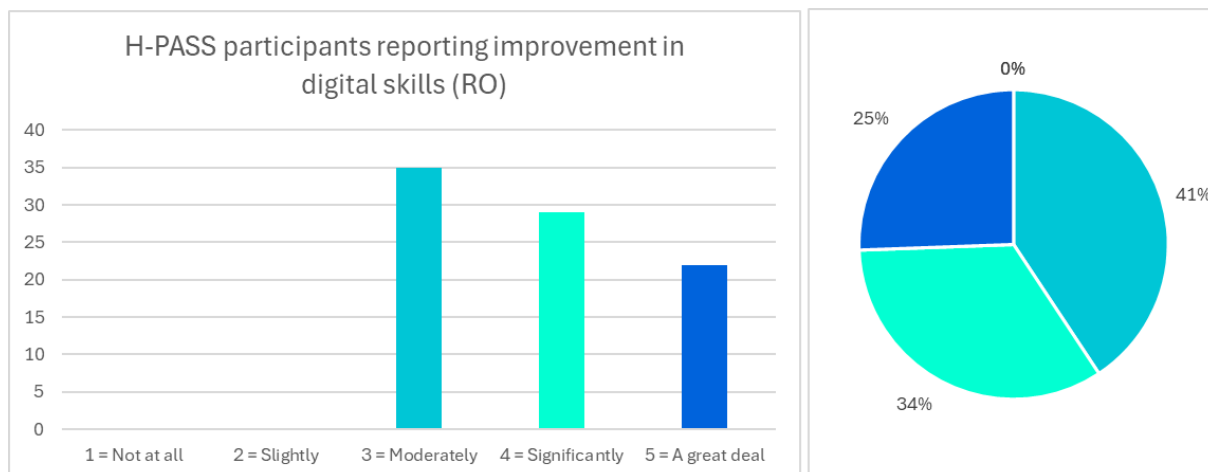


Figure RO-11. H-PASS participants reporting improvement in digital skills in Romania (n = 86)

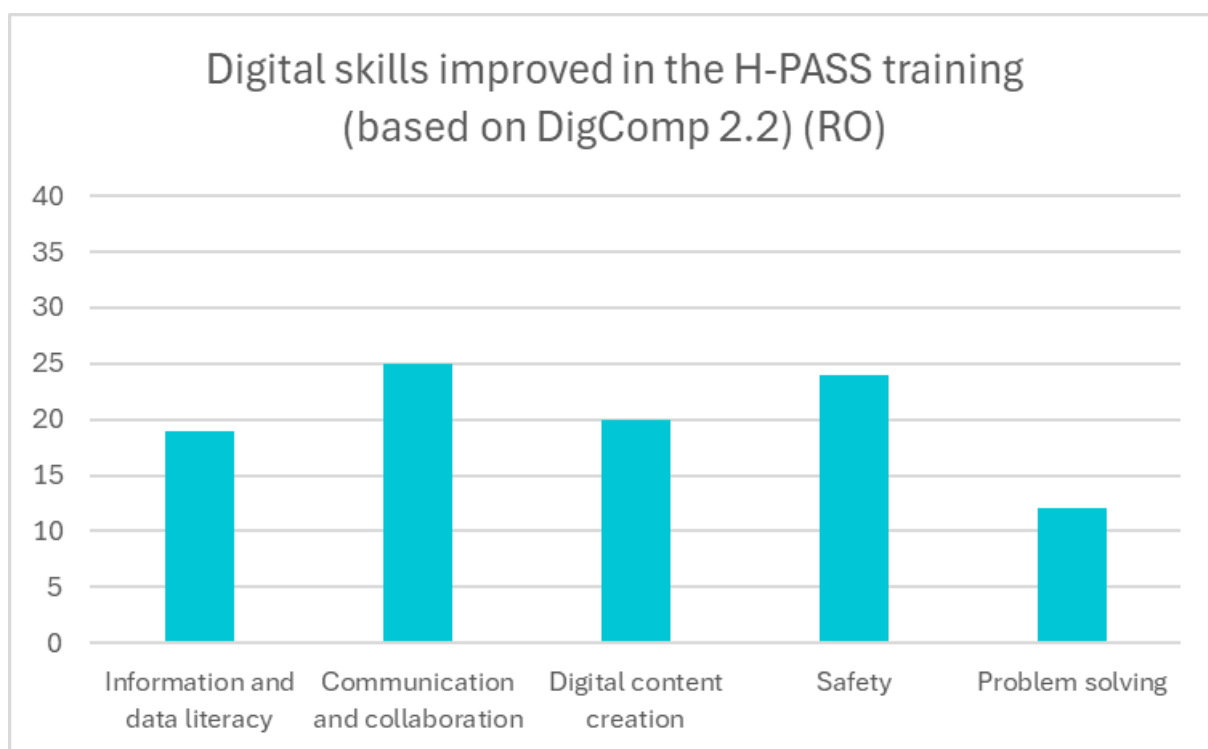


Figure RO-12. Digital skills improved in the H-PASS training based on DigComp 2.2 in Romania (n = 90)

Romanian participants reported very strong improvements in transversal skills as a result of the H-PASS training as well (Figure RO-13.). The majority of respondents (56%) indicated that their transversal skills improved to a great extent, while 44% reported significant improvement. No participants selected the lower categories (“moderately”, “slightly”, or “not at all”), indicating that all respondents perceived a substantial positive impact of the training on their transversal competences. Compared with the consortium-level results, this

distribution suggests an especially strong perceived improvement among Romanian participants, with all respondents reporting high levels of skill development.

When examining specific transversal competences based on the LifeComp framework, improvements were reported across all assessed areas (Figure RO-14.). The most frequently reported improvements were in self-regulation (38 participants) and empathy (37), followed closely by flexibility (35) and growth mindset (34). Strong improvements were also observed in wellbeing (33) and critical thinking (31). Smaller, though still notable, improvements were reported in communication (23), managing learning (15), and collaboration (14).

The Romanian results indicate that the H-PASS training contributed to broad development of interpersonal and reflective competences, particularly those related to emotional awareness, adaptability, and self-management.

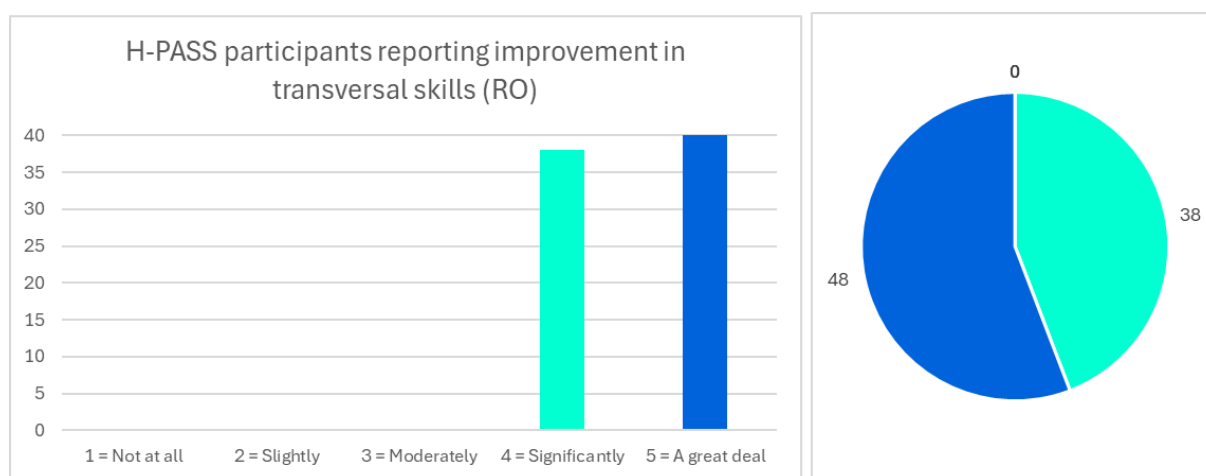


Figure RO-13. H-PASS participants reporting improvement in transversal skills in Romania (n = 86)

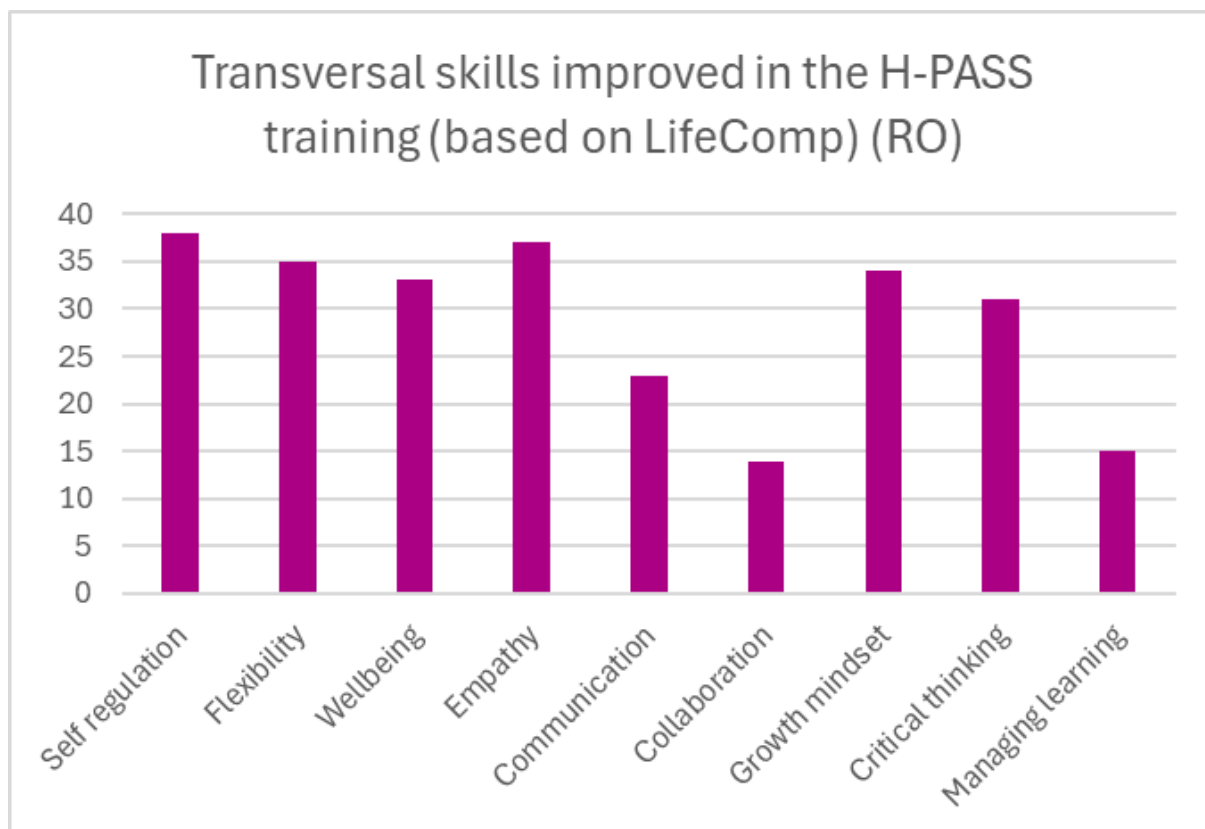


Figure RO-14. Transversal skills improved in the H-PASS training based on LifeComp in Romania (n = 90)

Romanian participants reported very strong increases in confidence related to digital teamwork following the H-PASS training (Figure RO-15.). A majority of respondents (55%) selected the highest rating (5 – a great deal), while the remaining 45% reported significant improvement (4). No participants selected the lower categories, indicating that all respondents experienced a clear increase in confidence when collaborating in digital environments.

Compared with the consortium-level results, the Romanian distribution shows an exceptionally strong outcome, with all participants reporting high levels of improvement and none indicating only moderate or limited change. This suggests that the training had a particularly strong impact on participants' perceived readiness to collaborate digitally within healthcare teams.

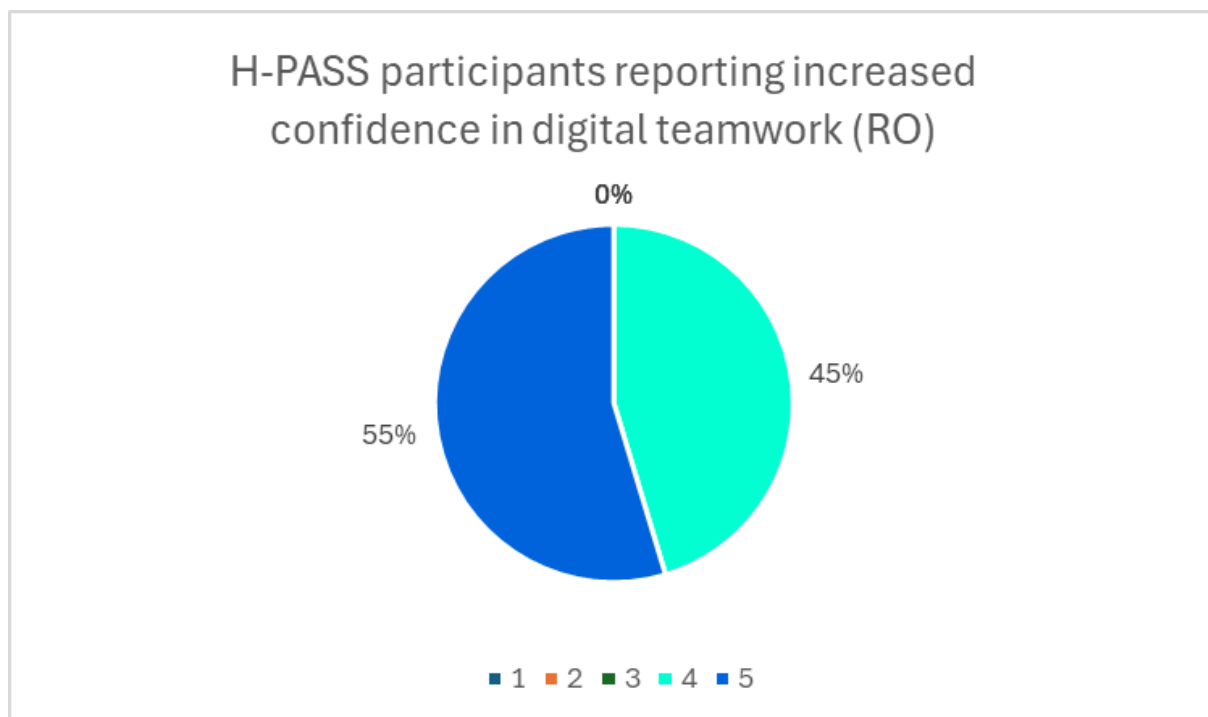


Figure RO-15. H-PASS participants reporting increased confidence in digital teamwork in Romania (n = 86)

4.6.5. Impact on digital tool usage

Romanian participants reported a clear increase in the use of digital tools for professional tasks following the H-PASS training (Figure RO-16.). More than half of respondents (55%) indicated that they use digital tools significantly more, while 45% reported using them slightly more in their professional activities. No respondents indicated that their usage remained the same or decreased.

A similar pattern can be observed for administrative tasks, where participants also reported increased use of digital tools (Figure RO-17.). Slightly more than half of respondents (52%) stated that they now use digital tools slightly more for administrative purposes, while 48% reported using them significantly more. Again, none of the respondents indicated unchanged or reduced usage.

Overall, these results demonstrate that the H-PASS training contributed not only to perceived competence development, but also to concrete behavioural changes in the workplace, with participants actively integrating digital tools more frequently into both professional and administrative workflows. Compared with the consortium-level findings, the Romanian results indicate a particularly strong shift toward increased digital tool usage, with all respondents reporting higher levels of use.

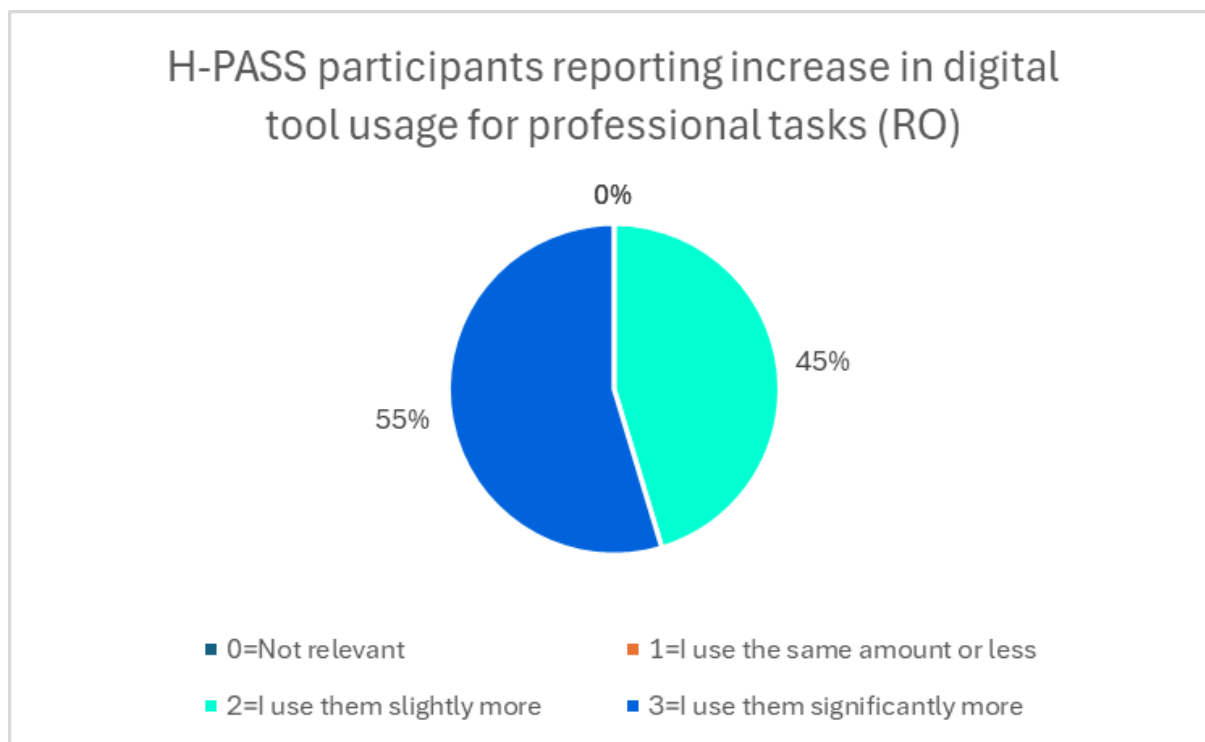


Figure RO-16. H-PASS participants reporting increase in digital tool usage for professional tasks in Romania (n = 86)

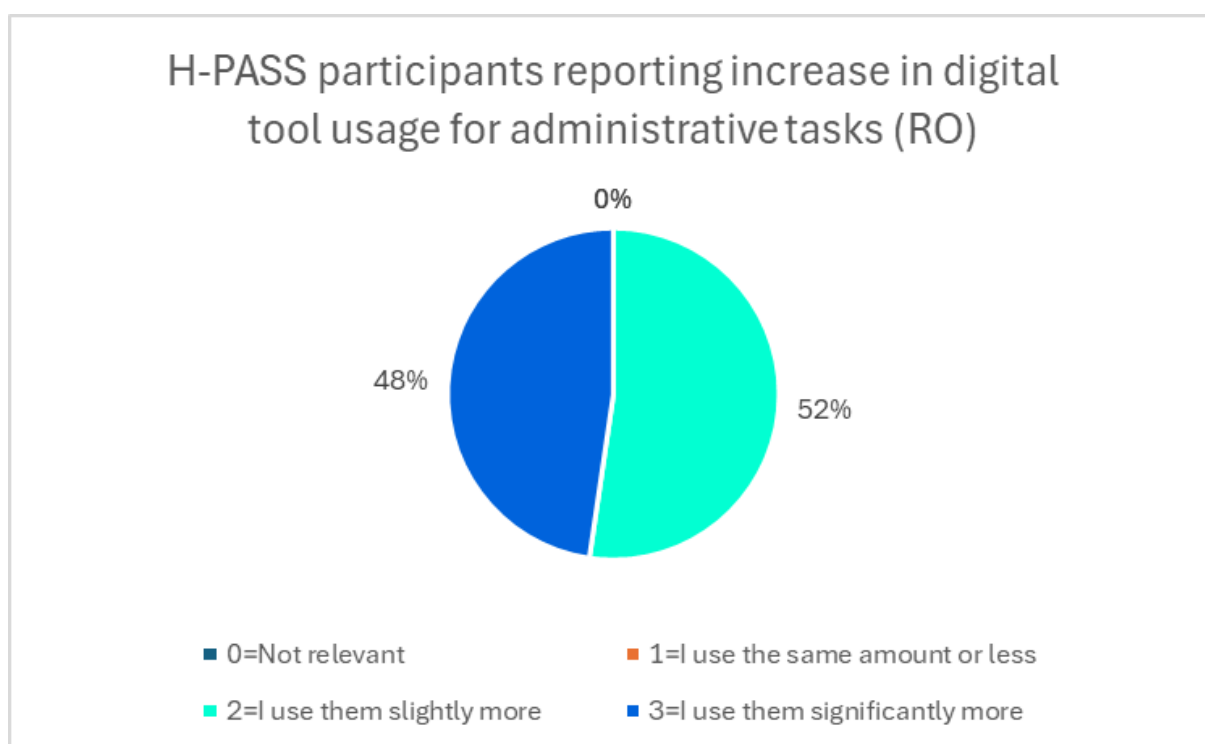


Figure RO-17. H-PASS participants reporting increase in digital tool usage for administrative tasks in Romania (n = 86)

4.6.6. Training follow-up results

The follow-up survey among Romanian participants indicates that the H-PASS training contributed to perceived organisational improvements in most workplaces (Figure RO-18.). An overwhelming majority of respondents (96%) reported that they had observed improvements in their organisation as a result of the training, while only 4% indicated that no noticeable improvement had occurred. This result suggests that the programme's impact extended beyond individual skill development to broader organisational practices and working processes.

Participants also identified specific areas of organisational change resulting from the training (Figure RO-19.). The most frequently reported improvement was in teamwork, marked by 33 respondents, indicating that enhanced collaboration and communication within teams was a key outcome. Improvements were also observed in workload management (26 respondents) and task-shifting (25 respondents), suggesting that the training may have supported more efficient distribution of responsibilities and better use of digital tools in daily workflows. In addition, 24 respondents reported improvements in workflow, reflecting perceived enhancements in organisational processes and coordination. Respondents marked 2,3 areas on average.

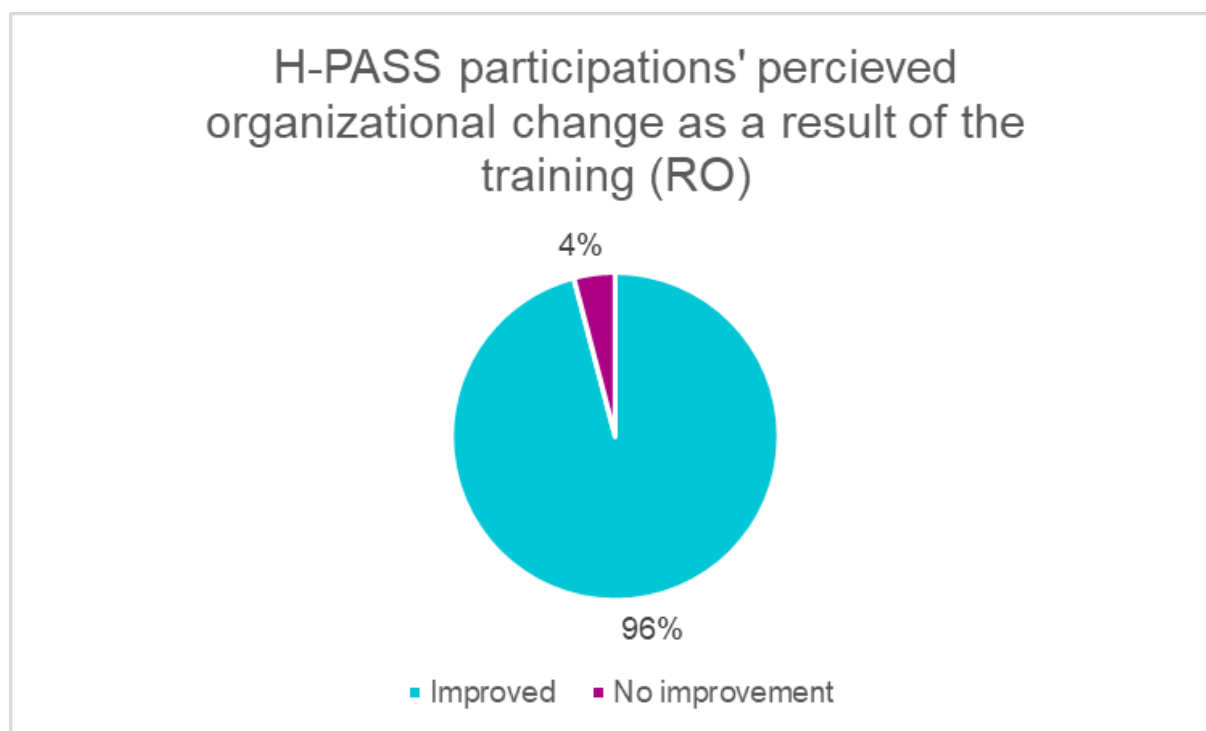


Figure RO-18. H-PASS participants' perceived organisational change as a result of the training in Romania (n = 49)

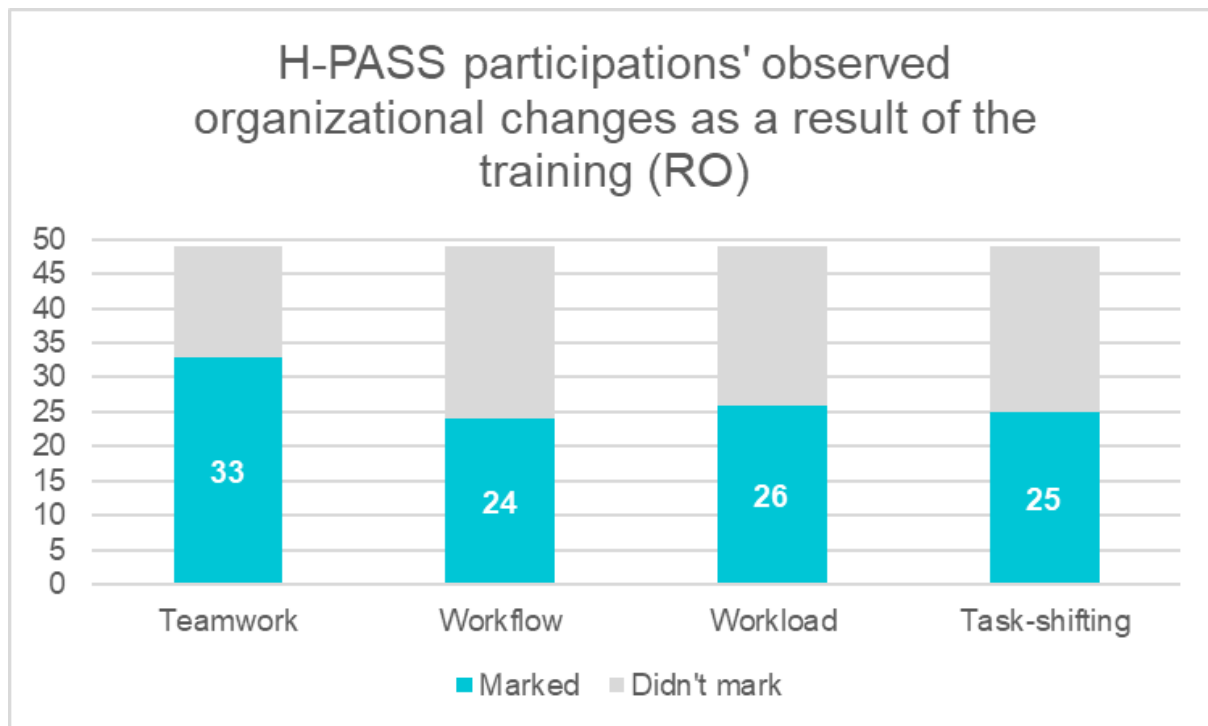


Figure RO-19. Observed organisational changes following the H-PASS training in Romania (n = 49)

4.6.7. Module evaluation overview

Participants in the Romanian H-PASS pilot training provided very positive evaluations of the delivered modules, with overall scores consistently above the mid-point of the scale. The evaluation considered five aspects of the learning experience: organisation of the module (ME1), technical aspects (ME2), relevance and usefulness (ME3), alignment with development goals (ME4), and learning experience (ME5).

When comparing the three delivered modules (M1, M2 and M4), Module 4 received the highest evaluations across all aspects (Figure RO-21.). Scores for M4 ranged from 4.44 to 4.58, indicating a very high level of satisfaction among participants. In particular, participants rated the module highly in terms of relevance and usefulness (around 4.58) and organisation (around 4.54). The technical aspects and learning experience of the module were also strongly evaluated, both exceeding 4.4 on average. These results suggest that the later stage of the training programme was perceived as especially valuable and well-delivered.

Modules M1 and M2 received more moderate but still positive evaluations, with average scores generally ranging between 3.18 and 3.68 depending on the aspect assessed (Figure RO-20.). For both modules, the highest scores were observed for alignment with participants' development goals (ME4), indicating that the content was perceived as relevant to participants' professional needs. Lower scores were observed for technical aspects (ME2) and learning experience (ME5), though these remained above the neutral midpoint.

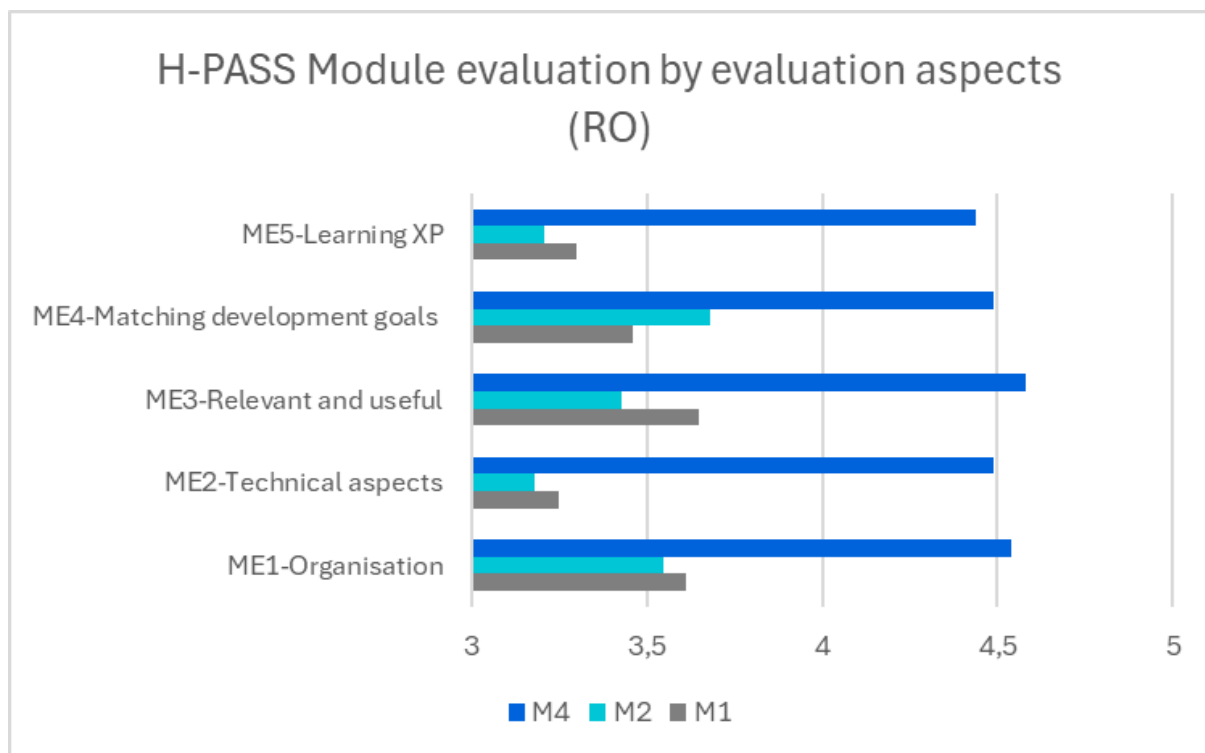


Figure RO-20. H-PASS module evaluation by evaluation aspects in Romania (n = 84)

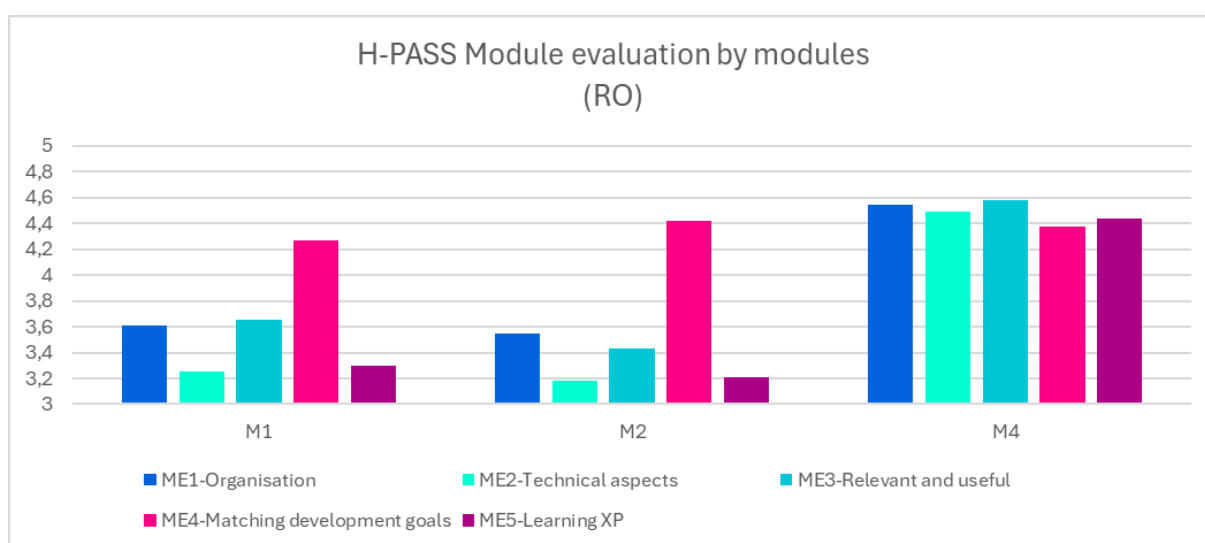


Figure RO-21. H-PASS module evaluation by modules in Romania (n = 84)

A closer examination of the evaluations at the level of individual learning activities shows that participants rated several sessions particularly highly, with scores consistently above 4.5 on average (Table RO-4.). The highest-rated activity was “Introduction to Digital Technology in Healthcare” (M1B1) with an average score of 4.56. An equally high score (4.56) was received by “Digital health and smart device-based patient follow up: A case study” (M4B7), indicating strong appreciation for practical and technology-oriented content. The third highest-rated

activity was “The effects of different cultures in Healthcare” (M2B5) with an average score of 4.54, highlighting the perceived importance of intercultural awareness in healthcare collaboration.

Although all evaluated activities received very positive scores overall, a few sessions received comparatively lower evaluations. These include “Cultural sensibility survey” (M2B6) with a score of 4.40, “Data in the Healthcare system” (M4B1) with 4.39, and “Communication in Healthcare” (M2B1) with 4.36. Despite being listed among the lower-rated activities, their scores remain well above four, indicating that participants still considered these learning components valuable and relevant.

The module-level analysis confirms that the Romanian H-PASS training programme delivered consistently high-quality learning activities, with particularly strong appreciation for sessions focusing on digital technologies and practical healthcare applications.

TOP1	M1B1	Introduction to Digital Technology in Healthcare	4,56
TOP2	M4B7	Digital health and smart device-based patient follow up: A case study	4,56
TOP3	M2B5	The effects of different cultures in Healthcare	4,54
BOTTOM3	M2B6	Cultural sensibility survey	4,4
BOTTOM2	M4B1	Data in the Healthcare system	4,39
BOTTOM1	M2B1	Communication in Healthcare	4,36

Table RO-4. *Highest and lowest performing training items in the Romanian pilot (n = 85)*

Module 1 – Main complaints and taken steps

Some participants reported lower engagement and challenges related to the learning experience, which may partly be explained by time constraints and fatigue, as many attendees joined the sessions either before or after work. While certain communication-related sessions received more moderate ratings, feedback also indicated that participants later recognized their practical value, particularly in improving patient interaction.

Additionally, participants highlighted that the introductory nature of the module led to varying levels of prior knowledge, making it difficult to maintain a consistent pace suitable for all learners. Some participants felt that the content was either too basic or, conversely, too condensed for complete beginners. Technical issues such as unfamiliarity with digital platforms also contributed to reduced engagement during early sessions. These insights have

been taken into account and will inform the design of future training activities, with increased emphasis on flexibility, engagement, and practical application.

Actions to be taken:

- Introduction of short digital onboarding sessions prior to the start of the module, aimed at familiarizing participants with the platforms used;
- Adaptation of content through differentiated learning paths (basic vs. advanced), including optional materials for deeper learning;
- Restructuring sessions into shorter units (microlearning) to reduce participant fatigue;
- Increasing interactivity through case studies, live polls, and practical examples from pharmacy practice;
- Integration of concrete pharmacist–patient interaction scenarios to highlight immediate applicability.

Module 2 – Main complaints and taken steps

Module 2 received generally positive but comparatively lower scores in areas such as technical aspects and learning experience. Sessions like “Communication in Healthcare” and “Cultural sensibility” were perceived as less engaging at the time, potentially influenced by participants’ workload and scheduling constraints. However, follow-up feedback highlighted that communication skills were among the most applied outcomes in practice. This suggests a delayed appreciation of the content, which will be considered in future programme development by strengthening interactivity and clearly linking theory to practice.

Furthermore, participants indicated that some theoretical components were perceived as abstract or insufficiently connected to real-life pharmacy scenarios, which initially reduced their perceived relevance. The timing of sessions, often overlapping with demanding work schedules, also contributed to reduced attention and participation.

Actions to be taken:

- Transformation of theoretical content into practical scenarios (role-play, pharmacist–patient simulations);
- Use of concrete examples from daily pharmacy practice to increase immediate relevance;
- Reorganization of delivery format to allow greater flexibility, including asynchronous learning options;
- Introduction of facilitated interactive sessions (e.g., breakout rooms and guided discussions);
- Clearer communication of how developed competencies directly impact the quality of pharmaceutical services;
- Collection of real-time feedback during the module to enable timely adjustments.

Module 4 – Main complaints and taken steps

Although Module 4 achieved the highest overall ratings, a few sessions were evaluated slightly lower, indicating room for minor improvements in clarity or content delivery. Nevertheless, participants expressed strong appreciation for the practical and technology-oriented aspects of the module. The feedback confirms the effectiveness of this approach and supports the continued integration of applied digital health topics in future trainings.

Some participants noted that certain topics, particularly those related to healthcare data and digital systems, were relatively complex and required additional explanation or more guided practice. A small number of attendees also mentioned that the pace of advanced topics was occasionally too fast, especially for those with limited prior exposure to digital health tools.

Actions to be taken:

- Inclusion of step-by-step guides and live demonstrations for digital tools and technologies;
- Provision of additional supporting materials (e.g., video tutorials and post-training resources);
- Introduction of recap and Q&A sessions to reinforce understanding;
- Adjustment of delivery pace by incorporating reflection time and practical exercises;
- Development of extended case studies based on real healthcare system scenarios;
- Continued emphasis on practical applications and emerging technologies, which were highly valued by participants.

4.6.8. Evaluation results of the DCA training

Participants in the Romanian DCA training reported very high satisfaction with the programme (Figure RO-22.). The majority of respondents (83%) rated their overall satisfaction with the highest score (5), while the remaining 17% selected score 4. No participants reported lower levels of satisfaction. Compared with the consortium-level results, the Romanian evaluation shows an equally strong or slightly stronger tendency toward the highest satisfaction rating.

Participants also reported a very high level of readiness to foster collaboration within the H-PASS network following the training (Figure RO-23.). A large majority (89%) selected the highest score (5) when assessing their preparedness to support collaboration, while 11% rated it 4. No respondents selected lower agreement levels.

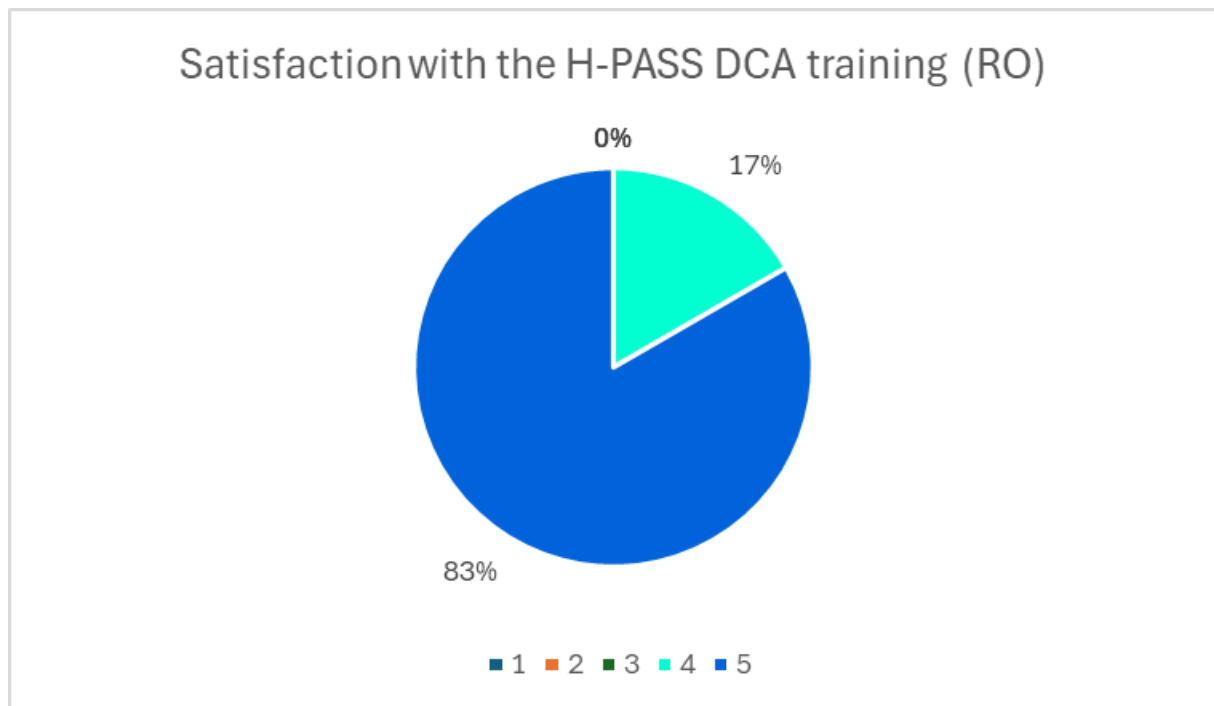


Figure RO-22. Satisfaction with the H-PASS DCA training in Romania (n = 18)

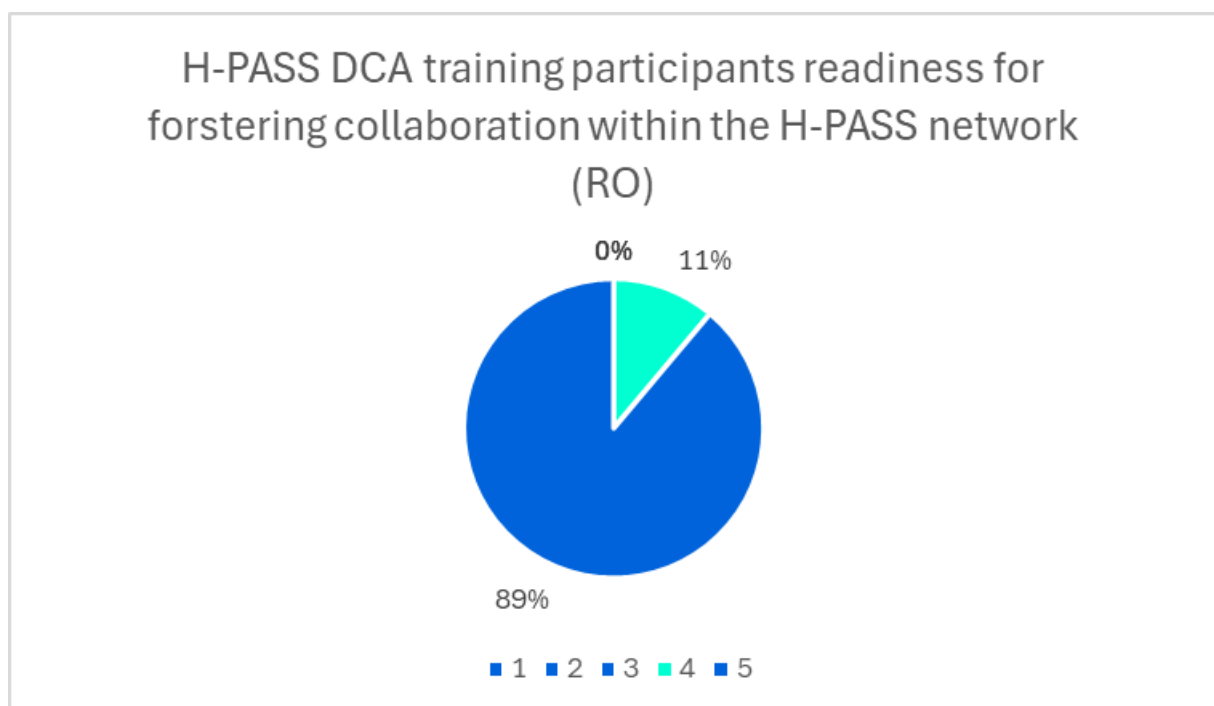


Figure RO-23. H-PASS DCA training participants' readiness to foster collaboration within the H-PASS network in Romania (n = 18)

The pre-post training evaluation of Romanian DCA participants shows very strong improvements across all assessed areas (Figure RO-24.). All respondents (100%) improved

understanding of the DCA role after completing the training. This result indicates that the programme was highly effective in clarifying the responsibilities and potential impact of digital change agents within healthcare organisations.

Participants also showed substantial improvement in their change management skills, with 83% indicating increased competence in this area. This suggests that the training successfully strengthened participants' ability to support and facilitate organisational transformation processes related to digital innovation.

In addition, 94% of respondents demonstrated improved knowledge of educational methods, reflecting the programme's emphasis on enabling DCAs to disseminate knowledge and support learning among colleagues. Strengthening these engagement competences is particularly important, as DCAs are expected to act as multipliers who help build digital capacity within their organisations.

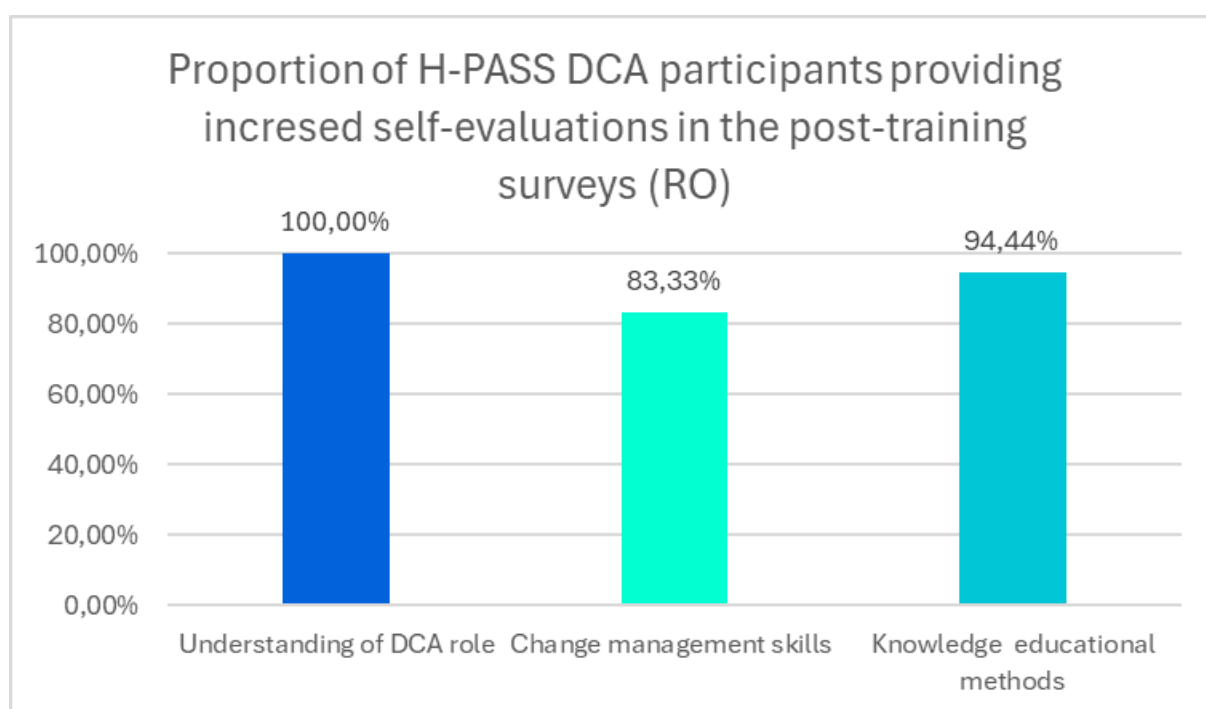


Figure RO-24. Proportion of H-PASS DCA participants reporting increased self-evaluations in the post-training surveys in Romania (n = 18)

The follow-up survey among Romanian DCA alumni provides insight into how participants applied the outcomes of the training in their professional environments. A total of 12 alumni completed the follow-up survey with complete data, and all respondents reported that the DCA training had strengthened their leadership skills in facilitating digital transformation within their work environment (Figure RO-25.). This indicates a very strong perceived impact of the training on participants' ability to act as leaders and promoters of digital change within their organisations.

In addition, 10 respondents reported that they had already taken concrete actions in their professional settings to support digital innovation or improve teamwork and collaboration.

These actions demonstrate that the training translated not only into perceived leadership improvement but also into practical implementation of digital transformation initiatives in participants' workplaces.

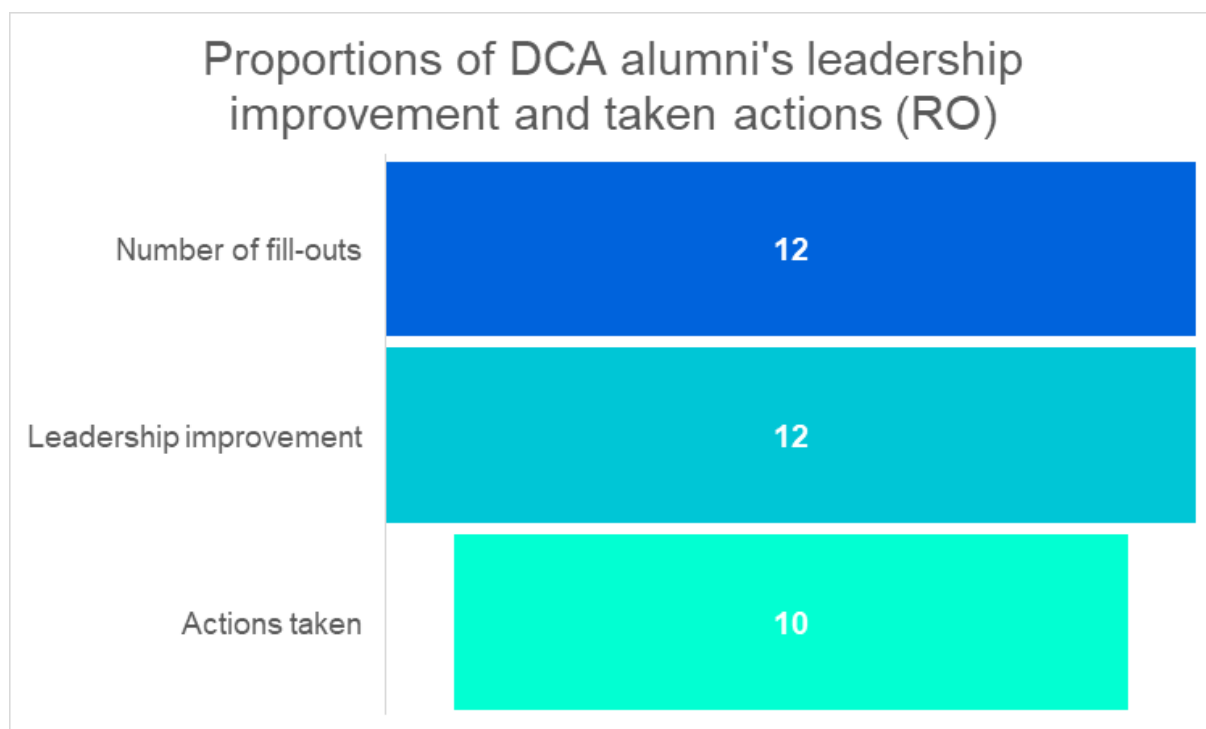


Figure RO-25. Proportions of DCA alumni reporting leadership improvement and actions taken in Romania ($n = 12$)

4.6.9. Participant testimonials

Responses from the Closing Survey:

„The training proved to be highly valuable and enriching. It significantly expanded my vocabulary, particularly with terms and concepts related to digital healthcare. I was introduced to many new ideas and practical insights that deepened my understanding of this evolving field. Overall, the experience was both informative and inspiring, and it will certainly support my future work in this area.”

“It was interesting. Shorter sessions could keep everyone more focused.”

Answers from the DCA Post-training survey:

„It has modernized pharmaceutical practice and significantly enhanced communication with patients, contributing to a more efficient, clear, and patient-centered approach to care.”

"Since participating in this course, I have become more attentive to the way I communicate with patients and better able to adapt my approach to each individual, taking into account different personality types. I have also learned how to effectively integrate technology into my daily work, helping to streamline tasks, improve efficiency, and make better use of the time allocated."

Answers from the DCA Follow-up survey:

„After the DCA training, I made a conscious effort to apply what I had learned in practice, particularly by exploring how AI can be used to support our work as pharmacists. I also focused on becoming more comfortable with these new digital methods and opportunities, recognizing their potential to benefit both our professional activities and, most importantly, the well-being of our patients."

"I build a work environment where any mistake in using new technologies is seen as a learning opportunity, not a source of stress."

"I constantly remind the team that technology does not replace our empathy; it frees up our time so we can be more present and attentive to the patient's needs. "

Annex

Annex 1 - H-PASS Assessment and Evaluation Framework Surveys

Welcome survey

Dear Respondent,

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

Section 2: Personal information

D1 - What is your age?

☐ 18-24

☐ 25-34

☐ 35-44

☐ 45-54

☐ 55-64

☐ 65+

D2 - What is your gender?

☐ Male

☐ Female

☐ Other/not willing to disclose

D3 - What is your highest level of education completed?

☐ High School or equivalent

☐ Bachelor's Degree

☐ Master's Degree

☐ Doctorate/PhD

☐ Other (please specify): _____

D4 - What is your current role in healthcare?

☐ Nurse

☐ Physician

☐ Technician

☐ Administrative Staff (management staff as well)

☐ Pharmacist

☐ Other (please specify): _____

D5 - How many years of experience do you have in the healthcare field?

☐ Less than 1 year

☐ 1-5 years

☐ 6-10 years

☐ 11-20 years

☐ More than 20 years

D6 - What type of healthcare facility do you work in?

☐ Public Institution

☐ Private Institution

☐ Clinic

☐ Research/Academic Institution

☐ Other (please specify): _____

D7 - What is your current employment status?

- ☐ Full-time
- ☐ Part-time
- ☐ Contract
- ☐ Other (please specify): _____

D8 - Where is your workplace located?

- ☐ Urban area
- ☐ Suburban area
- ☐ Rural area

Section 2: Self-assessment - Where am I now?

Please look at the following statements and provide an evaluation that feels realistic to you. Your self-assessment is anonymous as well, it doesn't affect your completion of this course in any way. We will use this information to assess how the training has contributed to the development of the participants.

m1i2 - I regularly look for digital solutions for my everyday challenges.

1 =Don't agree, 5 = Completely agree

m1i3 - I am open to experimenting with new digital tools in my work environment.

1 =Don't agree, 5 = Completely agree

m1i5 - I feel confident in planning and delivering change processes effectively in my work.

1 =Don't agree, 5 = Completely agree

m1i6 - I am open to modify my own practices when implementing new technologies or processes.

1 =Don't agree, 5 = Completely agree

m2i2 - I feel confident communicating with different partners in the healthcare setting both face-to-face and online.

1 =Don't agree, 5 = Completely agree

m2i3 - For me it's important to adjust my communication style to my communication partner's needs.

1 =Don't agree, 5 = Completely agree

m2i5 - I feel competent working in teams in both face-to-face and online settings.

1 =Don't agree, 5 = Completely agree

m2i6 - I promote collaboration of partners of different backgrounds in healthcare teams.

1 =Don't agree, 5 = Completely agree

m2i8 - I always succeed to resolve conflicts within my team to maintain a positive work environment.

1 =Don't agree, 5 = Completely agree

m2i9 - I am proactive in conflict resolution in my work setting.

1 =Don't agree, 5 = Completely agree

m2i11 - I feel competent in adjusting healthcare processes or care plans to respect the cultural preferences of patients or colleagues.

1 =Don't agree, 5 = Completely agree

m2i12 - I am open to change my behaviour to respect cultural differences.

1 =Don't agree, 5 = Completely agree

m3i2 - I understand health systems and strategies and their effects on my personal work.

1 =Don't agree, 5 = Completely agree

m3i3 - When making decisions I consider the wider healthcare system and its context.

1 =Don't agree, 5 = Completely agree

m3i5 - I feel competent in improving healthcare activities and processes, including using digital solutions.

1 =Don't agree, 5 = Completely agree

m3i6 - I regularly question routines and systems that are not working effectively.

1 =Don't agree, 5 = Completely agree

m3i8 - I feel confident managing projects from planning to implementation.

1 =Don't agree, 5 = Completely agree

m3i9 - I consider the circumstances and how different factors and people are connected when solving problems.

1 =Don't agree, 5 = Completely agree

m4i2 - I feel confident in using online and digital sources to search, filter, and manage healthcare data.

1 =Don't agree, 5 = Completely agree

m4i3 - I am conscious about choosing the sources of data and information I use.

1 =Don't agree, 5 = Completely agree

m4i5 - I feel competent in protecting personal and sensitive data as well as my digital wellbeing in my daily work.

1 =Don't agree, 5 = Completely agree

m4i6 - I am actively watching out for online threats in my daily work.

1 =Don't agree, 5 = Completely agree

m4i8 - I feel competent in using digital tools to manage and present healthcare data to support decisions.

1 = Don't agree, 5 = Completely agree

m4i9 - I am consciously assessing data for possible biases and inaccuracies in my daily work.

1 = Don't agree, 5 = Completely agree

Module 1-4 evaluation surveys

Dear Respondent,

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

MX_E1- How satisfied were you with the overall organization (e.g., scheduling, amount of learning materials, etc.) of the training module?

1 = Very dissatisfied; 5 = Very satisfied

MX_E2- How would you rate the technical aspects of the training module (e.g., online tools, technical support)?

1 = Very dissatisfied; 5 = Very satisfied

How useful did you find the following elements of the module:

[listing all the elements in your module including sync training events; coded with the exercise code defined in the draft training plan]

1 = Very dissatisfied; 5 = Very satisfied; 0=Can't assess

MX_E3- How relevant and useful did you find the training module's content?

1 =Not at all; 5 =Completely

MX_E4- How well did the training module align with your personal development needs?

1 =Not at all; 5 =Completely

MX_E5-How would you rate the overall learning experience of the module?

1 =Poor; 5 =Excellent

MX_6- Comments and suggestions

open text

Closing survey

Dear Respondent,

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

Section 2: Self-assessment - Where am I now?

Please look at the following statements and provide an evaluation that feels realistic to you. Your self-assessment is anonymous as well, it doesn't affect your completion of this course in any way. We will use this information to assess how the training has contributed to the development of the participants.

m1i2 - I regularly look for digital solutions for my everyday challenges.

1 =Don't agree, 5 = Completely agree

m1i3 - I am open to experimenting with new digital tools in my work environment.

1 =Don't agree, 5 = Completely agree

m1i5 - I feel confident in planning and delivering change processes effectively in my work.

1 =Don't agree, 5 = Completely agree

m1i6 - I am open to modify my own practices when implementing new technologies or processes.

1 =Don't agree, 5 = Completely agree

m2i2 - I feel confident communicating with different partners in the healthcare setting both face-to-face and online.

1 =Don't agree, 5 = Completely agree

m2i3 - For me it's important to adjust my communication style to my communication partner's needs.

1 =Don't agree, 5 = Completely agree

m2i5 - I feel competent working in teams in both face-to-face and online settings.

1 =Don't agree, 5 = Completely agree

m2i6 - I promote collaboration of partners of different backgrounds in healthcare teams.

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m2i8 - I always succeed to resolve conflicts within my team to maintain a positive work environment.

1 =Don't agree, 5 = Completely agree

m2i9 - I am proactive in conflict resolution in my work setting.

1 =Don't agree, 5 = Completely agree

m2i11 - I feel competent in adjusting healthcare processes or care plans to respect the cultural preferences of patients or colleagues.

1 =Don't agree, 5 = Completely agree

m2i12 - I am open to change my behaviour to respect cultural differences.

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m3i2 - I understand health systems and strategies and their effects on my personal work.

1 =Don't agree, 5 = Completely agree

m3i3 - When making decisions I consider the wider healthcare system and its context.

1 =Don't agree, 5 = Completely agree

m3i5 - I feel competent in improving healthcare activities and processes, including using digital solutions.

1 =Don't agree, 5 = Completely agree

m3i6 - I regularly question routines and systems that are not working effectively.

1 =Don't agree, 5 = Completely agree

m3i8 - I feel confident managing projects from planning to implementation.

1 =Don't agree, 5 = Completely agree

m3i9 - I consider the circumstances and how different factors and people are connected when solving problems.

1 =Don't agree, 5 = Completely agree

m4i2 - I feel confident in using online and digital sources to search, filter, and manage healthcare data.

1 =Don't agree, 5 = Completely agree

m4i3 - I am conscious about choosing the sources of data and information I use.

1 =Don't agree, 5 = Completely agree

m4i5 - I feel competent in protecting personal and sensitive data as well as my digital wellbeing in my daily work.

1 =Don't agree, 5 = Completely agree

m4i6 - I am actively watching out for online threats in my daily work.

1 =Don't agree, 5 = Completely agree

m4i8 - I feel competent in using digital tools to manage and present healthcare data to support decisions.

1 =Don't agree, 5 = Completely agree

m4i9 - I am consciously assessing data for possible biases and inaccuracies in my daily work.

1 =Don't agree, 5 = Completely agree

Section 2: Course evaluation

E1 - How satisfied were you with the H-PASS training overall?

1 =Very dissatisfied; 5= Very satisfied

E2 - How well do you feel the content covered in the training is applicable to your daily work?

1 =Not applicable at all; 5 = Highly applicable

E3 - How much do you feel you have improved your digital skills in this training?

1 = Not at all

2 = Slightly

3 = Moderately

4 = Significantly

5 = A great deal

E4 - Which of your digital skills do you think you have improved as a result of this training?

Information and data literacy

Communication and collaboration

Digital content creation

Safety

Problem solving

Other

E5 - How much do you feel you have improved your transversal skills (e.g. critical and innovative thinking, interpersonal skills, intrapersonal skills, global citizenship, media and Information literacy) in this training?

1 = Not at all

2 = Slightly

3 = Moderately

4 = Significantly

5 = A great deal

E6 - Which of your transversal skills do you think you have improved as a result of this training?

Self-regulation

Flexibility

Wellbeing

Empathy

Communication

Collaboration

Growth mindset

Critical thinking

Managing learning

Other

E7 - Do you feel more confident in team work skills in digital settings after completing this training?

1 =No change; 5 =A great deal

E8 - Have you started to use digital tools more often in your clinical work as a result of this training?

- 1- I use the same amount or less
- 2- I use them slightly more
- 3- I use them significantly more
- 0- Not relevant

E9 -Have you started to use digital tools more often in your administrative work as a result of this training?

- 1- I use the same amount or less
- 2- I use them slightly more
- 3- I use them significantly more
- 0- Not relevant

E10 - Please provide any additional comments or suggestions for improving future training sessions:

Follow-up survey for the H-PASS training

Dear H-PASS Alumni,

As you completed the H-PASS training some time ago, we would like to ask you about the impact the training may have had on your work and work environment. We would greatly appreciate it if you could spend a couple of minutes sharing your experience with us.

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

As a result of my H-PASS training participation, I can observe change in my work organizations:

- ☐ Teamwork patterns
- ☐ Workflows and processes
- ☐ Workload among health professionals
- ☐ Task-shifting practices
- ☐ I can't observe any changes in the above fields

We would appreciate it if you could summarize the observed positive organizational changes in a couple of sentences you marked in the above question.

DCA Pre-Training Survey

Dear Respondent,

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

I understand the role of a Digital Change Agent in a healthcare professional or work environment.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

I am competent in managing change in my own professional or work environment.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

I can apply different educational and communication methods to engage my colleagues.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

DCA Post-Training Survey

Dear Respondent,

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

How satisfied were you with the Digital Change Agent training overall?

Very dissatisfied ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Very satisfied

I understand the role of a Digital Change Agent in a healthcare professional or work environment.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

I am competent in managing change in my own professional or work environment.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

I can apply different educational and communication methods to engage my colleagues.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

I am prepared to foster collaboration in building an H-PASS network of healthcare professionals.

Don't agree ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Completely agree

Please complete the sentence:

The most applicable knowledge and skills I gained during the H-PASS training are:

Please complete the sentence:

The H-PASS training impacted my work in the following way:

Follow-up survey for the DCA training

Dear Change Agent,

As you completed the DCA training some time ago, we would like to ask how it has supported you in creating the change you wanted to see in your organization. We would greatly appreciate it if you could spend a couple of minutes sharing your experience with us.

Thank you for helping us by completing the following questionnaire. In order to maintain your anonymity while allowing us to link the pre- and post-training data, please create a unique identifier as follows:

Write down the first letter of your mother's first name.

Write down the last two digits of your birth year.

Write down the first letter of your father's first name.

Write down how many siblings you have.

Example: If your mother's name is "Anna," you were born in 1990, your father's name is "Peter," and you have 2 siblings (not including yourself), your unique identifier would be: A90P2.

Your unique identifier:

I believe that the Digital Change Agent training has strengthened my leadership skills in facilitating digital transformation within my professional or work environment.

☐ Agree

☐ Disagree

I have taken actions in my professional or work environment to enable digital innovation or to improve teamwork and collaboration.

☐ Yes

☐ No

If you answered “Yes” previously, please briefly describe your actions and any results that are already noticeable:

Annex 2 - Differences in country-level data collection

Cyprus

In the case of Cyprus, Digital Change Agent (DCA) evaluation data associated with EUC participants could not be clearly identified. The DCA training was jointly organised by UOC and EUC, and pre- and post-evaluation surveys were distributed collectively to participants. Respondents were asked to indicate their training institution; however, no responses were marked as EUC. This may be due either to respondents not indicating their institutional affiliation or to EUC-delegated participants not completing the surveys. Due to the time-sensitive nature of pre- and post-evaluation processes, this issue could not be rectified retrospectively.

In the Cypriot Welcome Survey, certain demographic response categories were modified compared to the centrally recommended structure. In some cases, this resulted in minor inconsistencies. For example, the category “less than 20 years of work experience” overlapped with other categories representing shorter time ranges. During the data processing phase, this category was recoded as “11–20 years” in order to maintain consistency with the consortium-level dataset.

Greece

In the Greek DCA assessment, the questionnaire did not include two general evaluative questions used in other pilots (e.g. overall satisfaction with the Digital Change Agent training and perceived preparedness to foster collaboration within an H-PASS network). Instead, the survey focused on the pre- and post-self-evaluation statements. As a result, direct responses to these general evaluative questions are not available for the Greek pilot; however, partial insights can be derived from the DCA follow-up questionnaire.

In the Greek Welcome Survey, three statements (1/m2i11, 1/m3i8, and 1/m4i6) were not included, although they were later incorporated into the Closing Survey. This limits direct statement-by-statement comparisons between the surveys. To address this, the analysis compared the overall questionnaire score with the score obtained in the Closing Survey.

In the later pilot phases (V2 and V2B), this inconsistency was corrected and the full set of statements was included in the questionnaires.

Hungary

In the Hungarian module evaluation surveys, items related to synchronous training activities were not included. The local training delivery team chose to collect feedback on a module-by-module basis, while synchronous training sessions were organised after two modules had already been delivered.

Including synchronous training evaluation items earlier in the process would therefore have resulted in participants evaluating activities before they had taken place. For this reason,

synchronous training-related items are not represented in the Hungarian module-level data used in the consortium-level analysis.

Italy

In Italy, data collection had to be conducted through the locally used Learning Management System (Blackboard Ultra) instead of Google Surveys due to institutional regulations. As a result, the survey structure differed slightly from the consortium template. For example, demographic information was collected separately from other evaluation questionnaires.

During the first edition of the Italian training, the surveys did not include a unique personalised identifier, which meant that demographic, pre-evaluation, and post-evaluation datasets could not be linked at the individual level. Consequently, it was not possible to analyse changes in participants' self-evaluation over time or to examine relationships with demographic characteristics.

In the second edition of the training this issue was resolved through the introduction of a unique identifier, allowing a larger proportion of the participant data to be integrated into the consortium-level dataset.

With regard to module evaluation, the Italian pilot delivered Modules 1–3 only; therefore, no evaluation data is available for Module 4. This difference is also reflected in the self-evaluation pre- and post-assessment responses.

Additionally, the Italian questionnaires used the original Learning Outcome descriptions rather than the predefined survey statements derived from those outcomes, which introduces a minor methodological variation.

Lithuania

In Lithuania, the pre- and post-self-evaluation questionnaire included statements covering all modules. However, the Lithuanian pilot delivered Modules 1, 2, and 4, with an additional training component on cybersecurity. As a result, Module 3 learning outcomes were included in the self-evaluation questionnaire despite the module not being delivered within the pilot training.

Furthermore, in order to minimise survey fatigue among participants, the Lithuanian pilot issued a single overarching Module Evaluation survey covering all delivered modules rather than separate evaluations for each module. Consequently, module-specific evaluation data is not available.

Romania

In Romania, the pre- and post-self-evaluation questionnaire also included statements covering all modules, while the pilot training delivered Modules 1, 2, and 4. As in the Lithuanian case,

this creates a methodological question regarding the interpretation of learning outcomes related to Module 3.

In the Romanian Welcome Survey, some demographic response categories were modified compared to the centrally suggested structure. For example, instead of five categories for years of work experience, three categories were provided. During the data harmonisation process, these were reclassified into the original five categories using participants' age data where possible.

Annex 3 - Assessment and evaluation guide

Here you can find the list of questions to use in your own local assessment and evaluation surveys. You can add further questions freely in a separate section or at the end of the questions within one section. In the survey you can delete the codes from in front of the questions but make sure that they can be re-identified later and coded again for analysis.

You can start translating the google surveys shared with you, please make sure that the translation is as accurate as possible and that you don't edit the survey any other way (e.g. changing the sequence of the questions, changing the type of questions, etc.).

You can find your own samples of the Welcome and Closing survey and a Module evaluation survey in your country folder: [reduced]

You can organize the knowledge assessment of your pilot as you see fit (similar to the prototype's structure or issuing a final assessment instead) but make sure that you assess the knowledge you delivered. You will see the questions we used at the end of this document. The knowledge assessment surveys are not shared with you separately as they can be designed locally, however, if you need them, OKFÖ can provide you with copies.

In case of questions contact the Work Package leader.

Table of contents

Demographics (Section1 in Welcome survey)

Skills and attitudes based on the LeO table (Section2 in Welcome and Section1 in Closing survey)

Course evaluation (Section2 in Closing survey)

Module evaluation (at the end of every module)

Knowledge assessment (based on the English prototype) - optional

- M1B1 – Digital technology in healthcare.

- M1B4 – Leading digital change.

- M2B1 - Communication.

- M2B3 - Team.

- M2B4 - Conflict.

- M2B5 – Culture.

- M3B1 - Healthcare system awareness.

- M3B3 - Developing healthcare solutions.

- M3B4 – Managing healthcare developments.

- M4B1 - Data in the Healthcare system.

M4B2 - Safety.

M4B5 - Working with Data.

Demographics (Section1 in Welcome survey)

D1 - What is your age?

☐ 18-24

☐ 25-34

☐ 35-44

☐ 45-54

☐ 55-64

☐ 65+

D2 - What is your gender?

☐ Male

☐ Female

☐ Other/not willing to disclose

D3 - What is your highest level of education completed?

☐ High School or equivalent

☐ Bachelor's Degree

☐ Master's Degree

☐ Doctorate/PhD

☐ Other (please specify): _____

+ VET

D4 - What is your current role in healthcare?

☐ Nurse

☐ Physician

☐ Technician

☐ Administrative Staff (**management staff as well**)

☐ Pharmacist

☐ Other (please specify): _____

+ **Allied Health Professional** (nurses working as assistants, midwives, public care nurses, etc.)

+ **Other** (conductive education specialists, mental hygiene specialist, masseuse, biochemist, etc.)

D5 - How many years of experience do you have in the healthcare field?

- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11-20 years
- ☐ More than 20 years

D6 - What type of healthcare facility do you work in?

- ☐ Public Institution
- ☐ Private Institution
- ☐ Clinic
- ☐ Research/Academic Institution
- ☐ Other (please specify): _____

+ **Both Public and Private Institutions**

+ **Religious Institution**

+ **Currently Unemployed**

D7 - What is your current employment status?

- ☐ Full-time
- ☐ Part-time
- ☐ Contract
- ☐ Other (please specify): _____

+ **Currently Unemployed**

D8 - Where is your workplace located?

- ☐ Urban area
- ☐ Suburban area
- ☐ Rural area

Skills and attitudes based on the LeO table (Section2 in Welcome and Section1 in Closing survey)

Here you can omit the questions belonging to the Module that you are not adapting in your pilot (Module 3 or Module 4). Make sure that you assess what you deliver in your training.

No.	Item description	Type	Component	Module	Assessment question(s)
m1i 1	Knows trends in Healthcare in connection with digital health in a specific professional field	knowledge	Digital technologies in healthcare	Module 1	....
m1i 2	Can identify needs and plan adequate responses related to digital health tools, services, is able to implement digital solutions and tools in his/her work	skill	Digital technologies in healthcare	Module 1	I regularly look for digital solutions for my everyday challenges. 1 =Don't agree, 5 = Completely agree
m1i 3	Is ready to learn about and try new tools, applications	attitude	Digital technologies in healthcare	Module 1	I am open to experimenting with new digital tools in my work environment. 1 =Don't agree, 5 = Completely agree
m1i 4	Is familiar with leadership and management functions, basic concepts change management in connection with digitalization	knowledge	Leading digital change	Module 1	.....

m1i 5	Can identify the need for change and plan the change process, manage change and engage stakeholders to attain strategic goals.	skill	Leading digital change	Module 1	I feel confident in planning and delivering change processes effectively in my work. 1 = Don't agree, 5 = Completely agree
m1i 6	Is ready to change his/her own practices and be proactive in the change process.	attitude	Leading digital change	Module 1	I am open to modify my own practices when implementing new technologies or processes. 1 = Don't agree, 5 = Completely agree
m2i 1	Knows the basic concepts of communication (e.g., assertive communication, feedback) and is familiar with different digital communication tools and services.	knowledge	Communication	Module 2	....
m2i 2	Can communicate clearly and concisely with various stakeholders (internal and external) both in face-to-face and in online interactions.	skill	Communication	Module 2	I feel confident communicating with different partners in the healthcare setting both face-to-face and online. 1 = Don't agree, 5 = Completely agree

m2i 3	Open to adapt his/her communication style and strategies to stakeholder needs and backgrounds.	attitude	Communication	Module 2	For me it's important to adjust my communication style to my communication partner's needs. 1 = Don't agree, 5 = Completely agree
m2i 4	Knows the principles of teamwork in healthcare settings.	knowledge	Team	Module 2	....
m2i 5	Can effectively collaborate in teams both in face-to-face and in online interactions.	skill	Team	Module 2	I feel competent working in teams in both face-to-face and online settings. 1 = Don't agree 5 = Completely agree
m2i 6	Promotes collaboration among diverse healthcare professionals, technologists, researchers, and industry experts to exchange ideas and develop interdisciplinary solutions.	attitude	Team	Module 2	I promote collaboration of partners of different backgrounds in healthcare teams. 1 = Don't agree 5 = Completely agree
m2i 7	Knows different types of conflicts that can arise in healthcare settings (e.g., interpersonal, interprofessional, role, organizational)	knowledge	Conflict	Module 2	....

m2i 8	Can recognise and resolve conflicts within a healthcare team to maintain a positive and collaborative work environment and a high-level patient care	skill	Conflict	Module 2	I always succeed to resolve conflicts within my team to maintain a positive work environment. 1 = Don't agree 5 = Completely agree
m2i 9	Is open to constructive resolution of conflicts	attitude	Conflict	Module 2	I am proactive in conflict resolution in my work setting. 1 = Don't agree 5 = Completely agree
m2i 10	Knows the basic concepts of cultural backgrounds, traditions, and customs with focus on professional cultures and generational culture	knowledge	Culture	Module 2	....
m2i 11	Can adapt health processes and care plans to cultural preferences and beliefs	skill	Culture	Module 2	I feel competent in adjusting healthcare processes or care plans to respect the cultural preferences of patients or colleagues. 1 = Don't agree 5 = Completely agree

m2i 12	Demonstrates respect for cultural differences and avoiding cultural/generational stereotypes or biases in healthcare interactions	attitude	Culture	Module 2	I am open to change my behaviour to respect cultural differences. 1 = Don't agree 5 = Completely agree
m3i 1	Knows the structure and characteristics of the national healthcare system with its eHealthcare platforms and services	knowledge	H-system awareness	Module 3	....
m3i 2	Can interpret the role of systems and strategies, and their effects for their personal work	skill	H-system awareness	Module 3	I understand health systems and strategies and their effects on my personal work 1 = Don't agree 5 = Completely agree
m3i 3	Demonstrates a holistic view about the healthcare system	attitude	H-system awareness	Module 3	When making decisions I consider the wider healthcare system and its context. 1 = Don't agree 5 = Completely agree
m3i 4	Knows the basic concepts of process development and planning and (digital) tools to enhance efficiency/effectiveness.	knowledge	Developing H solutions	Module 3	....

m3i 5	Is able to analyse processes along efficiency and effectiveness, define suggestions for improvement, and consider the involvement of digital solutions.	skill	Developing H solutions	Module 3	I feel competent in improving healthcare activities and processes, including using digital solutions. 1 = Don't agree 5 = Completely agree
m3i 6	Questions inefficient/ineffective routines and systems.	attitude	Developing H solutions	Module 3	I regularly question routines and systems that are not working effectively. 1 = Don't agree 5 = Completely agree
m3i 7	Knows the basics concepts of project management and its digital or non-digital tools.	knowledge	Managing H developments	Module 3	...
m3i 8	Is able to plan and manage innovation projects.	skill	Managing H developments	Module 3	I feel confident managing projects from planning to implementation. 1 = Don't agree 5 = Completely agree
m3i 9	Has a systematic approach when working on improvements.	attitude	Managing H developments	Module 3	I consider the circumstances and how different factors and people are connected when solving problems. 1 = Don't agree 5 = Completely agree

m4i 1	Is familiar with the healthcare data landscape, the key terms related to healthcare data, and the most relevant healthcare data an information sources.	knowledge	Data in the Healthcare system	Module 4	...
m4i 2	Can browse, search and filter data, information, and digital content on the web and in health information systems.	skill	Data in the Healthcare system	Module 4	I feel confident in using online and digital sources to search, filter, and manage healthcare data. 1 = Don't agree 5 = Completely agree
m4i 3	Is conscious about choosing data/information sources.	attitude	Data in the Healthcare system	Module 4	I am conscious about choosing the sources of data and information I use. 1 = Don't agree 5 = Completely agree
m4i 4	Knows personal and organisational data protection regulations, measures and tools, as well as the guidelines of personal digital wellbeing.	knowledge	Safety	Module 4	....
m4i 5	Can protect personal and other sensitive data.	skill	Safety	Module 4	I feel competent in protecting personal and sensitive data as well as my digital

					wellbeing in my daily work. 1 = Don't agree 5 = Completely agree
m4i 6	Demonstrates an ethical mindset in handling healthcare data, and is conscious about online threats and personal digital wellbeing.	attitude	Safety	Module 4	I am actively watching out for online threats in my daily work. 1 = Don't agree 5 = Completely agree
m4i 7	Knows various sources of healthcare data, types and characteristics of data (incl. AI generated) and tools to present data insights.	knowledge	Working with Data	Module 4	....
m4i 8	Can manage, interpret, analyze and present healthcare data for (collaborative) decision-making with digital tools.	skill	Working with Data	Module 4	I feel competent in using digital tools to manage and present healthcare data to support decisions. 1 = Don't agree 5 = Completely agree
m4i 9	Demonstrates critical thinking connected to data (e.g, biases, source, potential impact).	attitude	Working with Data	Module 4	I am consciously assessing data for possible biases and inaccuracies in my daily work. 1 = Don't agree 5 = Completely agree

Course evaluation (Section2 in Closing survey)

E1 - How satisfied were you with the H-PASS training overall?

1 =Very dissatisfied; 5= Very satisfied

E2 - How well do you feel the content covered in the training is applicable to your daily work?

1 =Not applicable at all; 5 = Highly applicable

E3 - How much do you feel you have improved your digital skills in this training?

1 = Not at all

2 = Slightly

3 = Moderately

4 = Significantly

5 = A great deal

E4 - Which of your digital skills do you think you have improved as a result of this training?

Information and data literacy

Communication and collaboration

Digital content creation

Safety

Problem solving

Other

E5 - How much do you feel you have improved your transversal skills (e.g. critical and innovative thinking, interpersonal skills, intrapersonal skills, global citizenship, media and Information literacy) in this training?

1 = Not at all

2 = Slightly

3 = Moderately

4 = Significantly

5 = A great deal

E6 - Which of your transversal skills do you think you have improved as a result of this training?

Self-regulation

Flexibility

Wellbeing
Empathy
Communication
Collaboration
Growth mindset
Critical thinking
Managing learning
Other

E7 - Do you feel more confident in team work skills in digital settings after completing this training?

1 =No change; 5 =A great deal

E8 - Have you started to use digital tools more often in your clinical work as a result of this training?

- 1- I use the same amount or less
- 2- I use them slightly more
- 3- I use them significantly more
- 0- Not relevant

E9 -Have you started to use digital tools more often in your administrative work as a result of this training?

- 1- I use the same amount or less
- 2- I use them slightly more
- 3- I use them significantly more
- 0- Not relevant

E10 - Please provide any additional comments or suggestions for improving future training sessions:

Module evaluation (at the end of every module)

MX_E1- How satisfied were you with the overall organization (e.g., scheduling, amount of learning materials, etc.) of the training module?

1 = Very dissatisfied; 5 = Very satisfied

MX_E2- How would you rate the technical aspects of the training module (e.g., online tools, technical support)?

1 = Very dissatisfied; 5 = Very satisfied

[coded with the exercise code defined in the draft training plan] How useful did you find the following elements of the module:

listing all the elements in your module including sync training events

1 = Very dissatisfied; 5 = Very satisfied; 0=Can't assess

MX_E3- How relevant and useful did you find the training module's content?

1 =Not at all; 5 =Completely

MX_E4- How well did the training module align with your personal development needs?

1 =Not at all; 5 =Completely

MX_E5-How would you rate the overall learning experience of the module?

1 =Poor; 5 =Excellent

MX_6- Comments and suggestions

open text

Knowledge assessment (based on the English prototype) - optional

Questions marked with green performed good on the prototype, meaning that not more than ca. 50% of the participants knew the answer before completing the module. Questions with black might need modification not only translation.

M1B1 – Digital technology in healthcare

Which of the following is not an application of AI in healthcare?

1. Medical imaging
2. Drug discovery and development
3. Remote monitoring and predictive analytics
4. **Communication via smartphones**

Which of the following is not an application of IoT in healthcare?

1. Remote patient monitoring
2. Smart medical devices
3. **Receiving and sending e-mails**
4. Telemedicine and virtual care

How are robotics used in healthcare?

1. **Surgery**
2. Driving patients to the hospital
3. Cooking for patients
4. Arranging appointments with patients

M1B4 – Leading digital change

Change management involves

1. deciding when to change the medication of a patient
2. choosing when to transfer a patient to another hospital
3. deciding whether a patient should do a surgery
4. **preparing, supporting, and helping individuals, teams**

What is not a typical effect of digitalisation in the work environment?

1. **Less personnel needed**
2. Improved patient care
3. Increased efficiency
4. Enhanced data management

What is not a problem that could be solved by the implementation of digital transformation in a healthcare setting?

1. Issues with outdated, manual processes
2. Inefficiencies in patient data management
3. Delays in communication & coordination among staff
4. **Lack of medical equipment**

M2B1 - Communication

What is one of the key elements of effective communication within healthcare teams?

- A. Using detailed explanations in every interaction
- B. Ensuring clear, concise, and timely information sharing**
- C. Focusing mainly on written communication
- D. Sharing information only when prompted by others

What role does non-verbal communication play in healthcare?

It is less important than verbal communication.

It conveys a significant portion of the message, such as body language and facial expressions.

It rarely impacts patient interactions.

It complicates patient communication unnecessarily.

What is the most effective way to ensure patients understand their treatment?

- A. Use technical medical terms
- B. Speak quickly to cover all details
- C. Use simple language and provide explanations**
- D. Limit communication to written instructions

M2B3 - Team

What role does the group leader play in the forming phase

- A. The leader should delegate tasks and responsibilities.
- B. The leader should push the team members to the next phase, the "Storming phase".
- c. The group leader should not share too much information so as not to confuse the participants.
- d. The leader must make sure that group members understand why their presence and expertise is required.**

in teamwork ...

- 1. successful collaboration depends on clear roles and responsibilities**
2. the success of the collaboration depends on the charismatic leadership skills of leader
3. successful collaboration depends on the ability of individuals to team up from "day one"

4. it is impossible that the team will regress to an earlier stage and evolve again when the change is finally managed.

Belbin's nine roles can be divided ...

1. into three main categories and explains that the most successful teams are made up of a mix of these roles; thinking roles, technical roles, action roles
2. into three main categories and explains that the most successful teams are made up of a mix of these roles: social roles, technical roles, analytic roles
3. **into three main categories and explains that the most successful teams are made up of a mix of these roles: social roles, action roles, thinking roles**
4. none of the above

M2B4 - Conflict

What is the main characteristic of the competing conflict management style?

1. Seeking a compromise
2. **Asserting one's position to achieve a quick resolution**
3. Prioritizing long-term solutions
4. Avoiding direct confrontation

Which of these can be a source of structural conflict in a healthcare setting?

- a) **Unequal access to equipment**
- b) Disagreement over treatment ethics
- c) Miscommunication during a handoff
- d) Personality differences among staff

What is the focus of the compromising conflict management style?

1. **Finding a middle ground where each party makes concessions**
2. Ensuring a win-win outcome for all parties
3. Yielding to the more assertive party
4. Avoiding any major conflicts

M2B5 – Culture

How can healthcare providers demonstrate cultural competence?

1. By avoiding questions about a patient's culture.
- 2. By learning about and respecting patients' cultural beliefs and values.**
3. By making sure that all patients receive the same care.
4. By enabling and helping patients to conform to the provider's cultural norms.

Which of the following is the most effective way to measure cultural competence in healthcare delivery?

- 1. Assessing patient satisfaction with culturally appropriate care by interviews, surveys.**
2. Evaluating the provider's employees' knowledge of different cultures.
3. Tracking how quickly patients complete their appointments.
4. Focusing on the healthcare outcomes of non-majority patients.

What does "Implicit Bias" refer to?

1. Implicit bias is a conscious decision to favour one group over another based on stereotypes.
2. Implicit bias is the deliberate and intentional avoidance of making judgments about certain groups of people.
- 3. Implicit bias refers to unconscious attitudes or stereotypes that affect our understanding, actions, and decisions, often without our awareness.**
4. Implicit bias occurs when an individual consciously chooses to treat people equally, regardless of their background.

M3B1 - Healthcare system awareness

Which of the following is FALSE regarding Electronic Medical Records (EMR)?

- a) There is typically a degree of accessibility to patients through patient portals, in a bilaterally interactive manner.**
- b) EMR are the legal record of a Care Delivery Organization, such as a hospital.
- c) EMR are owned by the Care Delivery Organization.
- d) There are substantial differences between EMR and Electronic Health Records (EHR) and the terms should not be used interchangeably.

Efficiency of a Health System expresses:

- a) The performance of the services provided (e.g. number and outcome of therapeutic interventions) under ideal conditions**

- b) **The output produced (e.g. number and outcome of therapeutic interventions) by a given input (e.g. personnel number)**
- c) The performance of the services provided (e.g. number and outcome of therapeutic interventions) per unit of time, under real-world conditions
- d) All of the above

Which of the following is FALSE regarding healthcare fragmentation?

- a) **Over-specialization of medical personnel is not a contributing factor**
- b) Young patients with few comorbidities are not the most likely to be affected
- c) Increased life expectancy is a contributing factor
- d) Has been associated to more hospital admissions and worse patient outcomes

M3B3 - Developing healthcare solutions

Which is not a main characteristic of processes?

- 1. Time
- 2. **Scope**
- 3. Cost
- 4. Quality

Which is not process development framework?

- 1. Service design
- 2. Six sigma
- 3. Lean
- 4. **8S model**

Which statement is not true for critical organisational processes?

- 1. Involve the participation of many internal employees or departments
- 2. Regular or frequently repeated
- 3. **Can only be core processes of the operation**
- 4. Affect all or most customers

M3B4 – Managing healthcare developments

Which of these is not considered a key element in project management?

1. Budget
2. Time
3. **Creativity**
4. Scope

What is the main purpose of the RBS?

1. Identify and classify project costs
2. **Identify and organize risks into categories**
3. Plan the duration of the project
4. Assign tasks to the project team

Who are the stakeholders in a project

1. Only the project team members
2. Only the end customers
3. **All individuals who have an interest, influence, or impact on the project**
4. Only the patients

M4B1 - Data in the Healthcare system

Which of the following is FALSE regarding Big Data and AI in healthcare?

- a) **AI algorithm-derived clinical recommendations can be followed without verification by a healthcare provider**
- b) A defining characteristic of Big Data is that they cannot be handled efficiently by traditional data processing software and techniques
- c) Big Data can include patient-generated data
- d) Genetic biobanks and financial datasets are potential sources of Big Data

Which of the following health data categories cannot be affected by manual entry errors?

- a) **A dataset of heart rate measurements directly transmitted from a state-of-the-art smartwatch**
- b) A disease registry database
- c) ICD-10 codes on a clinic's admission records
- d) Electronic Medical Records

Which of the following is FALSE regarding Open Data in healthcare:

- a) An open license that allows for free access is in place
- b) Datasets are typically provided in a format that can be easily processed
- c) **Data are freely available to use and share, but never to modify**
- d) Timely release of data is usually crucial for its purpose to be fulfilled

M4B2 - Safety

Which of the following is true regarding cyber-attacks in healthcare?

- a) Smishing involves fraudulent e-mails aimed at deceiving individuals into downloading malware
- b) Performing recommended regular operating system updates ensures their optimal function, but does not mitigate threats from malwares
- c) Setting access passwords longer than 8 characters minimizes the risk of sensitive data breach, while obviating the need to use special characters
- d) **E-mail notifications prompting someone to change his/her password should raise the suspicion of a phishing attack**

Which of the following is FALSE regarding cyber-attacks in healthcare:

- a) The consequences can be serious, but healthcare facilities are not popular targets for attackers
- b) Economic benefit and assuming false identities are among key potential motives of attackers
- c) Patients' safety can be threatened indirectly through financial losses and compromised medical file integrity, but not directly by intervention on treatment
- d) **Options A and C are FALSE**

A healthcare professional is at a library has to urgently update a password-protected disease. Available WiFi is password-protected but the password is written on a wall panel.

Which statement is correct?

- a) **Using a VPN and performing the task is an acceptable option**
- b) The available network is still considerably safer than an open WiFi network.
- c) An attacker cannot have a strong motive for hacking the healthcare professional's credentials
- d) The task can be performed safely as long as the access password is very strong

M4B5 - Working with Data

Which of the following is FALSE regarding personal data protection in healthcare?

- a) Personal data that have been rendered anonymous in such a way that the individual is not or is no longer identifiable are no longer considered personal data.
- b) Informed consent is not always a prerequisite for data processing
- c) Design specifications and architecture of information systems and technologies are subject to GDPR
- d) **Pseudonymization is a more robust data de-identification method than encryption**

Which of the following is FALSE regarding informed consent for health data processing?

- a) **The data subject can be considered as having opted-in as long as he/she has not actively opted-out**
- b) Documentation is mandatory
- c) Data subjects should have adequate time to consider their choice, and have access to further details and consultation if appropriate
- d) The purpose of data processing must be clear to the data subject

A healthcare professional includes in an analysis patient data that supports his/her initial hypothesis while ignoring data that suggests the opposite. This is called...:

- a) Anchoring bias
- b) Selection bias
- c) **Confirmation bias**
- d) Framing effect

Annex 4 - H-PASS assessment and evaluation master template

This section presents the columns of the Excel template that was provided to partners to facilitate the summarisation and reporting of data to the work package leader.

Tab1 - Course data

Code; Country; D1-Age; D2-Gender; D3-Education; D4-Role; D5-XP (years); D6-Facility; D7-Emp status; D8-Location; 1/m1i2; 1/m1i3; 1/m1i5; 1/m1i6; 1/m2i2; 1/m2i3; 1/m2i5; 1/m2i6; 1/m2i8; 1/m2i9; 1/m2i11; 1/m2i12; 1/m3i2; 1/m3i3; 1/m3i5; 1/m3i6; 1/m3i8; 1/m3i9; 1/m4i2; 1/m4i3; 1/m4i5; 1/m4i6; 1/m4i8; 1/m4i9; 2/m1i2; 2/m1i3; 2/m1i5; 2/m1i6; 2/m2i2; 2/m2i3; 2/m2i5; 2/m2i6; 2/m2i8; 2/m2i9; 2/m2i11; 2/m2i12; 2/m3i2; 2/m3i3; 2/m3i5; 2/m3i6; 2/m3i8; 2/m3i9; 2/m4i2; 2/m4i3; 2/m4i5; 2/m4i6; 2/m4i8; 2/m4i9; E1 - Satisfied; E2 - Applicable; E3- Digital skill improved; E4- Information and data literacy; E4- Communication and collaboration; E4- Digital content creation; E4- Safety; E4- Problem solving; E5- Transversal skills improved; E6- Self-regulation; E6-Flexibility; E6-Wellbeing; E6-Empathy; E6-Communication; E6-Collaboration; E6-Growth mindset; E6-Critical thinking; E6-Managing learning; E7- Confident in digital team work; E8- Increased professional digital tool usage; E9- Increased administrative digital tool usage; E10- Free text feedback

Tab1 - Module data

Code; Country; Module; ME1-Organisation; ME2-Technical aspects; ME3-Relevant and useful; ME4-Matching development goals; ME5-Learning XP; ME6-Free text feedback; M1B1-Introduction to Digital Technology in Healthcare; M1B2-Reflection: digital technology use in own practice; M1B3-Generative AI use exercise (patient-/professional perspective); M1B4-Leading digital change; M1B5-Exploring reactions to change (New teleconsultation service 1.); M1B6-Case of an organisational change (New teleconsultation service 2.); M1B7-Digital ecosystems in healthcare; M2B1-Communication in Healthcare; M2B2a-Case discussions on communication in health care; M2B2b-Improving Patient Medication Adherence and Comprehensive Care; M2B3-Teamwork in Healthcare; M2B4-Conflict in healthcare teams; M2B5-The effects of different cultures in Healthcare; M2B6-Cultural sensibility survey; M2B7-Complex case study; M2B8-Reflection on digital communication and collaboration; M2B9-The Role and Impact of Community Facilitators and Digitalization in Improving Access to Healthcare Services for Vulnerable Migrant Populations; M2B10-Intergenerational Conflicts in Healthcare Setting; M3B1-Healthcare system awareness; M3B2-Forum debate; M3B3-Developing healthcare solutions; M3B4-Managing healthcare developments; M3B5-Let's develop healthcare solutions!; M3B6-Let's provide feedback; M3B7-Presenting the development projects; M4B1-Data in the Healthcare system; M4B2-Cyber security and digital wellbeing; M4B3-Digital wellbeing checklist; M4B4-AR-in-a-Box; M4B5-Working with Data; M4B6-Working with healthcare data: Which data type should we rely on?; M4B7-Digital health and smart device-based patient follow up: A case study Discussing digital wellbeing and cyber security; M4B9-Data Biases; Add local exercise here

Annex 5 - H-PASS data preparation guide

Data collection on the “Course data” label

- 1) Please do not modify the column names or structure! (you can delete the examples included in the template)
- 2) Copy your data (Welcome and Closing surveys) into the master database template to the “Course data” label
 - Make sure, that the question codes match
 - Make sure that you pair Welcome (1/...) and Closing (2/...) survey self-evaluation data based on participants’ codes (if for a participant code there is no Welcome or Closing data, can’t be matched, it is ok, you can just leave the connected data slots empty in that row)
 - If you added questions to your local survey, leave those questions out from the database
 - **Pay special attention to E3-E6, as well as E8-E9**, as these answers are recoded with numbers, not only copied.
- 3) Delete duplications
- 4) Translate the answers back to English; for that use the original answer options provided here and here and in the Assessment and Evaluation guide:
 - (We added further central answer categories **(in red)** for the coding process based on the experiences of initial data gathering), use them in the re-coding process

D1 - What is your age?

- ☐ 18-24
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65+

D2 - What is your gender?

- ☐ Male
- ☐ Female
- ☐ Other/not willing to disclose

D3 - What is your highest level of education completed?

- ☐ High School or equivalent
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate/PhD
- ☐ Other (please specify): _____

+ VET

D4 - What is your current role in healthcare?

- ☐ Nurse
- ☐ Physician
- ☐ Technician
- ☐ Administrative Staff (**management staff as well**)
- ☐ Pharmacist
- ☐ Other (please specify): _____

+ Allied Health Professional (nurses working as assistants, midwives, public care nurses, etc.)

+ Other (conductive education specialists, mental hygiene specialist, masseuse, biochemist, etc.)

D5 - How many years of experience do you have in the healthcare field?

- ☐ Less than 1 year
- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 11-20 years
- ☐ More than 20 years

D6 - What type of healthcare facility do you work in?

- ☐ Public Institution
- ☐ Private Institution
- ☐ Clinic
- ☐ Research/Academic Institution
- ☐ Other (please specify): _____

+ Both Public and Private Institutions

+ Religious Institution

+ Currently Unemployed

D7 - What is your current employment status?

☐ Full-time

☐ Part-time

☐ Contract

☐ Other (please specify): _____

+ Currently Unemployed

D8 - Where is your workplace located?

☐ Urban area

☐ Suburban area

☐ Rural area

E1 - How satisfied were you with the H-PASS training overall?

1 =Very dissatisfied; 5= Very satisfied

E2 - How well do you feel the content covered in the training is applicable to your daily work?

1 =Not applicable at all; 5 = Highly applicable

E3 - How much do you feel you have improved your digital skills in this training?

1 = Not at all

2 = Slightly

3 = Moderately

4 = Significantly

5 = A great deal

E4 - Which of your digital skills do you think you have improved as a result of this training?

Information and data literacy

Communication and collaboration

Digital content creation

Safety

Problem solving

Other

E5 - How much do you feel you have improved your transversal skills (e.g. critical and innovative thinking, interpersonal skills, intrapersonal skills, global citizenship, media and Information literacy) in this training?

1 = Not at all

2 = Slightly

3 = Moderately

4 = Significantly

5 = A great deal

E6 - Which of your transversal skills do you think you have improved as a result of this training?

Self-regulation

Flexibility

Wellbeing

Empathy

Communication

Collaboration

Growth mindset

Critical thinking

Managing learning

Other

E7 - Do you feel more confident in team work skills in digital settings after completing this training?

1 =No change; 5 =A great deal

E8 - Have you started to use digital tools more often in your clinical work as a result of this training?

1- I use the same amount or less

2- I use them slightly more

3- I use them significantly more

0- Not relevant

E9 -Have you started to use digital tools more often in your administrative work as a result of this training?

- 1- I use the same amount or less
- 2- I use them slightly more
- 3- I use them significantly more
- 0- Not relevant

- Translate free text feedback too!

5) If you modified any of the answer sets of the demographic (code D) or the evaluation (code E) questions, recode them to the original options and send us the coding history in a document (see the Hungarian example shared with you)

- for example participants added extra information under „other”, so for example you had two participants indicating they were head nurses and you recoded: „head nurse” à „nurse” (2),
- you don’t have to translate the original record, so in Hungarian this would be „főnővér” à „nurse” (2)

Data collection on the “Module data” label

6) Please don’t modify the column names or the structure of the database! You can only add the additional exercise evaluations in the last columns (marked with yellow). (you can delete the examples included in the template)

7) Copy your data (Module evaluation surveys) into the master database template to the “Module data” label

- Make sure all Module evaluation entry is connected to the correct training participant code
- Make sure, that data is copied to right the question and exercise codes (for the list of core exercises see the Training guide, section “Draft training plan” on page 14.), as the structure of the database is a little different from the questionnaire’s structure
- If you added questions to your local survey, leave those questions out, BUT
- If you added exercises to the original core exercises (that got evaluated in your surveys) add them to the end of the table in a new column

8) Delete duplications

9) Translate free text feedback too



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