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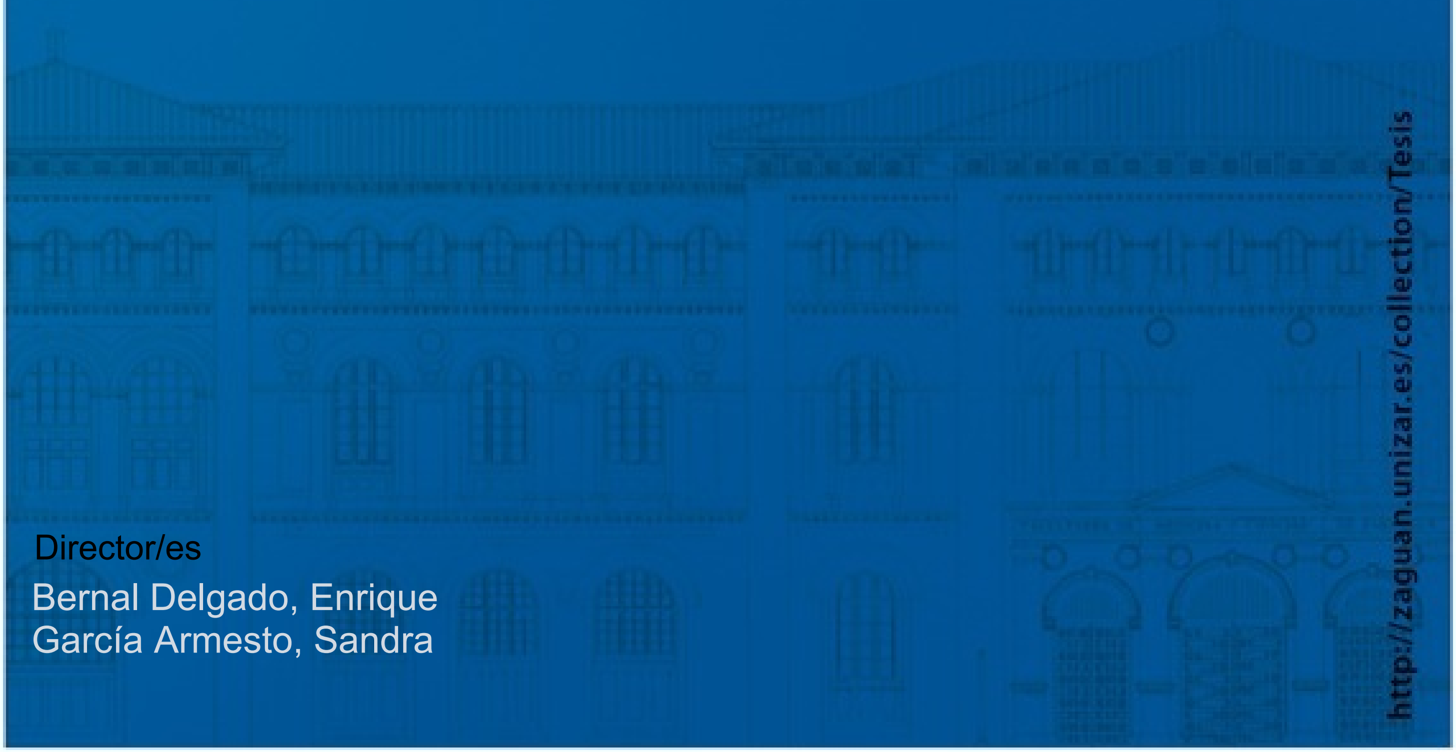
María José Vicente Edo

European consensus of criteria for the evaluation of good practices in chronic conditions



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EUROPEAN CONSENSUS OF CRITERIA FOR THE EVALUATION OF GOOD PRACTICES IN CHRONIC CONDITIONS

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EUROPEAN CONSENSUS OF CRITERIA FOR THE EVALUATION OF GOOD PRACTICES IN CHRONIC CONDITIONS

Doctoranda

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RESUMEN

Los sistemas sanitarios reconocen las enfermedades crónicas como uno de sus grandes desafíos de salud del siglo XXI para los sistemas sanitarios. A pesar de ser en gran medida prevenibles, las enfermedades crónicas son importante causa de mortalidad y morbilidad en Europa. En 2015, más de 1,2 millones de personas en los países de la UE murieron por enfermedades y lesiones que podrían haberse evitado a través de políticas de salud pública más fuertes o de una atención médica más efectiva y menos fragmentada.

La presente tesis doctoral reporta el desarrollo y resultados de una proceso de consenso internacional cuyo objetivo ha sido desarrollar criterios de evaluación para valorar el potencial de las prácticas clínicas e intervenciones y políticas sanitarias a la hora de disminuir la carga atribuible a las enfermedades crónicas en cuatro áreas de interés: promoción de la salud y prevención primaria de condiciones crónicas; intervenciones organizativas enfocadas al tratamiento de pacientes crónicos con condiciones clínicas múltiples; intervenciones sobre el empoderamiento del paciente; e, intervenciones y políticas orientadas a mejorar la diabetes (la diabetes se utiliza como condición paradigmática). Con objeto de acordar los criterios de evaluación y otorgarles relevancia distinta en función del dominio de interés, se desarrolló un consenso internacional mediante la técnica Delphi-modificada, en la que participaron 100 expertos de diferentes disciplinas procedentes de 23 países europeos.

El proceso de consenso produjo 145 criterios de evaluación (28 criterios en el Delphi de *Health promotion and primary prevention of chronic conditions*, 50 en el de *Organizational interventions aimed at dealing with complex chronic patients with multiple conditions*, 28 en el de P*atient empowerment interventions with chronic conditions* y 39 criterios en Delphi de *diabetes* as a case-study) orientados a valorar cada uno de los citados dominios y ponderarlos en función de cada área de interés. El conjunto de criterios acordados para el caso paradigmático de Diabetes apoya la hipótesis de que los criterios de valoración son transferibles y aplicables a la evaluación de prácticas, intervenciones y políticas desarrolladas sobre otras condiciones crónicas.

Consistentemente con lo observado en otras iniciativas europeas, en este consenso, los criterios relacionados con 'diseño de la práctica', 'evaluación', 'sostenibilidad' y 'escalabilidad' parecen ser componentes esenciales en el desarrollo e implementación de buenas prácticas en Europa.

Por último, como virtualidad destacable de este proceso de consenso, el componente internacional de las decisiones consensuadas, apoya la posibilidad de que las prácticas evaluadas con los criterios acordados puedan ser transferidas a cualquier contexto europeo.

1. INTRODUCTION

1.1 The challenge of chronicity

Many countries and institutions widely recognize major chronic disease as an important burden within the EU. It is one of the major health challenges of the 21st century and will entail some major actions to strengthen existing health systems. Despite being largely preventable, chronic conditions are the leading cause of mortality and morbidity in Europe and worldwide[1] and the associated economic and social burden remains high[2].

The burden associated with chronic conditions

In 2016, Non-communicable diseases (NCDs) were responsible for 71% (41 million) of the world's 57 million deaths, 15 million of these deaths being considered premature (30 to 70 years), showing that NCDs are not solely a problem for older populations.

The major NCDs responsible for these deaths included cardiovascular diseases (17.9 million deaths, accounting for 44% of all NCD deaths and 31% of all global deaths); cancers (9 million deaths, 9% of all NCD deaths and 16% of all global deaths); chronic respiratory diseases (3.8 million deaths, 9% of all NCD deaths and 7% of all global deaths); and diabetes (1.6 million deaths, 4% of all NCD deaths and 3% of all global deaths)[2] . In EU countries 85% of deaths are due to chronic diseases including cancer, cardiovascular disease, chronic respiratory disease, diabetes, and mental illness. For example, cancer from all causes is the predominant cause of death before the age of 65, whereas cardiovascular disease is the predominant cause of death after age 65[3]. In 2015, more than 1.2 million people in EU countries died from diseases and injuries that could have been avoided either through stronger public health policies or more effective and timely health care[1].

Some overarching trends deserve special mention. Until recently, life expectancy was rising rapidly and steadily across EU countries; however the steady increase has slowed considerably since 2011 in many EU countries due to a slower rate of reduction of cardiovascular deaths and an increase in the number of deaths among the elderly during winter months in recent years. Secondly, inequality in life expectancy continues; it is expected that people with a low level of education live six years less than those with a high level of education[1] .The EU's age pyramid has also undergone important changes in these years and demostrated the speed of demographic change. In 1996, there were 86.5 million children in the EU-27 compared with 71.3 million elderly persons. However, by 2016 there were 97.7 million people in the EU-28 aged 65 years and more, compared with 79.5 million children[4].

Health costs and chronicity

Patients with chronic conditions rely heavily on the health services and this situation carries significant human costs (e.g. the burden on patients, their families and careers) which affect workforce participation, and generate health inequalities and social exclusion[5]

The financial burden associated with chronic diseases is extremely high in the EU, and given that the average age of European populations is increasing, chronic diseases will continue to place an important pressure on national budgets. For example, the total costs arising from mental health problems are estimated at more than 4% of EU GDP – over € 600 billion in the 28 EU countries. The health expenditure allocated to treat diabetes and prevent complications are estimated at € 150 billion in 2017 in the European Union, with the average expenditure per diabetic adult estimated at € 4 600 a year[1]. In turn, the expenditure for EU health care systems (including primary care, outpatient care, accident and emergency, inpatient care and medications) to treat cardiovascular disease (CVD) and cancer was almost €111 billion in 2015, approximately €19 billion due to ischemic heart disease (IHD), €20 billion due to stroke[6] and €51 billion for cancer[7]. In addition, CVD non-healthcare costs were estimated at €54 billion in production losses, and at €45 billion in informal care[6]; lastly, cancer cost €50 billion in productivity losses and €20 billion in informal care[7].

These figures have shaped a complicated landscape, and the magnitude of that scenario is extremely worrying. Health systems are under great pressure to drive forward transformation in order to meet the growing needs of their populations within a sustainable framework. Many countries and organizations already recognize that in order to respond effectively to the needs of the populations and the increasing burden of chronic disease, further efforts are needed[8].

International policy on Non-Communicable Diseases (NCD): a call for action

The World Health Organization (WHO) calls to adopt different approaches when tackling risk factors for chronic disease suggesting that cost-effective actions should therefore be adapted to the culture of the country and, due to the nature and slow evolution of most chronic diseases, it is essential to take effective actions. According to the WHO estimations, the total annual number of deaths from non-communicable diseases will increase to 55 million by 2030 if nothing is changed. To that extent, the World Health Assembly in resolution WHA64.11 developed a global action plan to prevent and control non-communicable diseases at global, regional and national level for the period 2013–2020. The actions include international and inter-country collaboration to exchange lessons, experiences and best practices as a mechanism to increase the body of evidence and to enhance the capacity of countries to face the challenges and sustain achievements.[9]

In Europe, there exist many practices developed to improve chronic conditions at local, national and international level. However understanding if these practices are functional (i.e. if they are or not effective, or how they can be improved to make them better, or how an organization can make intelligent choices about which promising practices are likely to work best in their community) is still a pending issue.

European policies seeking the identification and evaluation of good practices

Nonetheless, over the past years, there has been an unequivocal increase of initiatives towards the use of assessment processes to understand and improve practices. The assessment of practices in chronicity could help organizations and institutions to choose the ones which potentially do better and facilitate their transfer to other contexts or even countries, overcoming the usual and extended "trial and error" practice.

Many initiatives tackling chronic conditions have ended up in an exercise of identification and evaluation of practices. National and international experiences show that some chronic disease practices have been more successful than others and it is important to learn from these experiences and adapt programs as necessary. In turn, the European Commission's approach to cope with NCD highlights the need of identifying, disseminating and exchanging good practices among the Member States with a view to help them to implement actions meant to improve effectiveness and sustainability of health systems and the health of EU citizens[10] Indeed, the Commission's role in the exchange of best practices was included in the Lisbon Treaty (Article 168); so, “the Commission may, in close contact with the Member States, take any useful initiative to promote [...] initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practices, and the preparation of the necessary elements for periodic monitoring and evaluation”. This Treaty, the 3rd Health Programme 2014-2020 clearly referred to the need for good practices implementation as part of the EU Public Health Policy.

Existing evaluative initiatives at European level

There are some initiatives in Europe aiming at the identification of good practices. So, for example, the *ICARE4EU project* (Innovating care for people with multiple chronic conditions in Europe)[11] provides insight into current practices of integrated care for people with multimorbidity in European countries. They constructed a Development

Model for Integrated Care (DMIC) based on the Chronic Care Model[12] which includes nine groups of elements or actions that are relevant contributors to the development of good integrated care (i.e. Patient-centeredness, Delivery system, Performance management, Quality of professional care, Inter-professional teamwork, roles and tasks, Commitment to integrated care and Room for innovation and change). Each practice received a score ranging from 0 to 10 on each of the integrated care. Integrated care initiatives that meet the nine DMIC groups are deemed to be effective in providing good quality care to people with multimorbidity. The final objective was the exchange of knowledge on the implementation of good innovative multimorbidity care experiences between stakeholders and policy-makers in Europe.

In turn *Scirocco*[13] (Scaling integrated care in context), developed a methodology to assess the maturity of healthcare system based on the B3-Maturity Model developed by the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA)'s B3 Action Group on Integrated Care. In this maturity model, integrated care activities were assessed according to 12 dimensions -Readiness to Change, Structure & Governance, eHealth Services, Standardisation & Simplification, Funding, Removal of Inhibitors, Population Approach, Citizen Empowerment, Evaluation Methods, Breadth of Ambition, Innovation Management and Capacity Building. The Scirocco tool was derived from a pragmatic bottom-up approach involving integrated care decision-makers from 12 European countries; so, experts were interviewed about how healthcare systems are managing to deliver more integrated care services to citizens. The maturity model was operationalized as an online self-assessment tool that yielded a radar graph summarizing the level of current maturity level for each domain, then informing on the strengths and gaps of each region or country. Out of the self-assessment regions and stakeholders will ultimately be informed about those key features that ensure the successful transferability and adoption of good practices in integrated care developed and implemented in different health and social care contexts.

The third initiative on good practice exchange is the European Joint Action on reducing alcohol related harm (RARHA)[14]. They developed a repository of assessed good practices whose aim was to contribute to the implementation of the EU strategy on alcohol reduction, focusing on concrete examples of good practice approaches that are already implemented in the Member States. To assess the practices and provide practitioners and policymakers with hands-on advice, they adapted the Dutch classification system for evaluating health-based interventions by the National Institute for Public Health and Environment, which rates interventions with a continuous scale of evidence, ensuring that a number of minimum requirements are met[14]. All the interventions are assessed using good practice toolkit based on four criteria: a) *the intervention is well described* (description of nature, severity and possible consequences of the problem); b) *the intervention is implemented in the real world/feasible/transferable* (is accepted by the target group); c) *the intervention has a theoretical base*; and, d) *the intervention has* *been evaluated*. When an intervention met the criteria, it was subsequently categorized to the levels of evidence which range from a basic level [theoretically sound (i.e. the problem, risk or theme is completely and clearly described with data about) to strong indications of effectiveness [i.e. there is a baseline measurement, prior to/at the start of the intervention, and a follow-up measurement (at the end of the intervention), without a control condition].

The fourth project to consider was a 2008 joint initiative between WHO/Europe and WHO collaborating centres, the Directorate-General for Health and Food Safety of the European Commission (EC DG SANTE) and the Consumers, Health and Food Executive Agency (CHAFEA) under the framework of the European Public Health Programme 2008-2013, on "Monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union (EU)"[15]. This initiative was established to evaluate the status of country development and implementation of policies and actions in the area of nutrition, physical activity and obesity prevention in the European Union. Its main outcome was a database (NOPA database) that included information from the WHO European Member States about progress on nutrition, diet, physical activity and obesity, containing country policy documents, policy implementation tools and information on good practices. To determine the quality of the identified practices, they built a good practice appraisal tool to assess practices, preventive programs, projects, initiatives and interventions that aimed to counteract obesity and improve nutrition and physical activity.

The tool comprised 43 questions clustered into three sections: a) *Main intervention characteristics* (questions related to the general design and planning of a programme, such as the main objectives, planned activities, target group and involved stakeholders); b) *Monitoring and evaluation* (questions related to the monitoring and evaluation process and, subsequent indicators, statistics and measurements); and, c) *Implementation* (questions related to the implementation stage of the intervention when it comes to performance, programme management and target group participation). The survey yields a good practice score for each of the three sections as well as for the programme as a whole[16]. This system makes it possible for example to highlight programmes that may have a very good design but poor evaluation and implementation, or well-designed programmes well evaluated but are weak on design and implementation, or programmes that are not well-designed and evaluated but contrarily have an excellent implementation.

Stemming from the previous, a fifth initiative aimed at responding to the EU Action Plan on Childhood Obesity 2014-2020[17], plan to stop overweight and obesity in children and young people (0-18 years) by sharing good practices at local, national and European level. JANPA (2015-2017) (Joint Action on Nutrition and Physical Activity) whose aim has been to identify, select and share best practices has also proposed specific actions on nutrition and physical activity[18]. JANPA further developed the criteria from the WHO and DG Sante evaluation tool[16] and also included a formal assessment of practices using a Delphi methodology[19].

The Delphi yielded nine core assessment categories divided into three criteria: a) *intervention characteristics (i.e.,* it has been proven a positive impact on individuals and/or communities; objectives are clear and SMART; target group is defined); b) *implementation features* (i.e activities are using existing structures; target group is aimed to be empowered; and there is broad support for the intervention amongst the intended target populations); and c) *monitoring and evaluation (i.e o*utcome/impact evaluation showed significant contribution to the target behaviour; most of the planned activities have been performed and most of the objectives have been reached; and financial and human resources are in place for evaluation)[19].

JANPA developed this tool to support programme planners in designing effective and sustainable interventions in kindergartens and schools for childhood obesity prevention in order to help to identify gaps during the planning phase that, if addressed, could improve the intervention. They suggest that the self-assessment should be used before the programme is initiated but ongoing programmes can also be assessed. If the practice meets all nine core criteria, then the programme is a good practice according to JANPA standards and is included in the JANPA good practice database[18].

A sixth action that deserves a note is the EU-Compass for Action on Mental Health and Wellbeing (2015-2018)[20], a web-based mechanism used to collect, exchange and analyse practices on mental health. EU-Compass monitored the mental health and wellbeing policies and activities of EU countries and non-governmental stakeholders through several strategies including the identification and dissemination of European good practices in mental health. Intendedly, these practices should offer insight and guidance to other stakeholders to improve health and well-being and the delivery of healthcare and well-being services[21]. To evaluate the practices, EU-COMPASS developed an evaluation tool based on the common set of criteria approved by Member States under the Steering group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases in agreement with EU countries and the European Commission. These criteria draw from the Joint Action on Chronic Diseases and Healthy Ageing (JA-Chrodis) and the work by the Spanish Ministry of Health as well as a systematic literature review[10]. The criteria for the evaluation is composed of several categories such as Information, Relevance, Theory-based, intervention characteristics, Participation, Ethical aspects, Effectiveness and efficacy, Sustainability, Intersectoral collaboration, Transferability and Equity[21]. Specialists from a variety of sectors of mental healthcare and from countries evaluated the practices. They are also trained on a one-to-one basis to avoid bias. Two evaluators reviewed all practices that met the inclusion criteria (evaluated in some form) and were encouraged to discuss some disagreement or unsolved questions, coming to a final decision on whether the practice met the criteria for inclusion in the Good Practices brochure. Each criterion was further broken down and operationalized into sub-categories for each criterion. Indeed, depending on the health issue and type of intervention, the framework of criteria was adapted to emphasize specific criteria; for example, when applying the framework to health systems, criteria such as equity and sustainability of the health financing mechanisms had a greater weight.

Finally, many European countries and organizations have formulated a variety of responses in an attempt to improve the care for chronic patients and reduce the economic burden. Taking Spain as an example, the Ministry of Health defined a strategy to identify good practices across the national health system. Framed under the principles of the Law of Quality and Cohesion of the Spanish National Health Services (SNHS), the Ministry of Health developed a Health Innovation Platform (PINNSA)[22] containing assessed good practices. The ultimate goal of this platform was the promotion and exchange of innovative practices within the National Health Service (NHS).

The criteria to determine the quality of a practice, which actually make it eligible for dissemination and exchange, were adequacy, relevance, being evaluated, being based on the best scientific knowledge, effectiveness, transferability, innovation, efficiency, sustainability, equity, gender equality, participation, interaction with the care delivery system and ethical aspects. The criteria were ordered by importance and the evaluation process ensured whether the practice complied with them. Those practices deemed not to be adequate, relevant or not evaluated were automatically excluded for further assessment and were disqualified as a good practice. When the practice complied with those three elements, the evaluation process continued producing an overall final score. Practices that reached 50% or more of the total score were discussed by the evaluation group and considered good practice for the Spanish NHS.

The CHRODIS Joint Action

Similarly, the Joint action on Chronic Diseases and Healthy Ageing across the life cycle (JA-Chrodis) was set up as a European attempt to respond and address NCD in a holistic manner. JA-Chrodis was a European collaboration that brought together over 60 associated and collaborating partners from national and regional departments of health and research institutions from 26 Member States. It was a three-year initiative (2014-2016) led by the Institute of Health Carlos III in Spain, and funded by the European Commission and the participating parties. These partners worked together to identify, validate, exchange and disseminate good practices for chronic diseases across EU Member States and to facilitate their uptake across local, regional and national borders.

Accordingly, the aims of the Joint Action were: firstly, to capture the lessons embedded in good practices on NCD across European countries and regions, with a specific focus on health promotion and primary prevention of chronic conditions, organizational interventions aimed at dealing with complex chronic patients with multiple conditions, patient empowerment interventions with chronic conditions and diabetes as a case-study; secondly, to promote and facilitate a process of exchange and transfer of these good practices across Member States.

The analysis of the JA-CHRODIS's good practices had also to look at health inequalities, potential for innovation, efficiency and patient-centeredness (for more details on the Chrodis JA see http://chrodis.eu/).

Unlike the other initiatives, where the development of criteria and indicators for the assessment of good practices had frequently built on expert opinions, developed usually from focal groups, the sets of criteria and indicators had been condition-based when most of the challenges are common to all chronic conditions (small focus on prevention, scarce patient empowerment, lack of continuity of care, etc) JA CHRODIS developed an assessment mechanism aiming the classification and comparison of practices according to formal consensus methodology that eventually could translate into a rating methodology. Thus within CHRODIS JA, a specific work package was developed to tackle the need of identifying true best practices by comparing their features and potential impact using criteria developed in the context of a formal consensus process. The upcoming pages will thoroughly describe in detail this consensus process and the results achieved.

1.2 Aim of the thesis

We hypothesized that, having a weighted set of criteria formally agreed at European level, and oriented to the assessment of whether a practice (i.e., health policy, strategy, program, service, or intervention) has the potential to achieve the results it aimed at given the health context in which it is developed, would facilitate the identification of best practices and the eventual exchange and transfer to other European contexts.

Therefore, the aim of this thesis was to describe the consensus process carried out in the context of the CHRODIS JA (i.e. at European level) to define weighted criteria to evaluate practices related to *health promotion and primary prevention of Chronic conditions*, *organizational interventions focused on dealing with chronic patients with multiple conditions*, *patient empowerment interventions with chronic conditions and diabetes*. To decide about the relevance and feasibility, and prioritize those criteria to identify "best practices" in the field of chronic conditions, a structured consultation RAND modified Delphi methodology was adopted.

2. METHODOLOGY

2.1 Study Design

The common methodology for each area of interest (i.e., practices related to *health promotion and primary prevention of chronic conditions*, *organizational interventions focused on dealing with chronic patients with multiple conditions*, *patient empowerment interventions with chronic conditions and diabetes*) developed on a three-step RAND modified Delphi method which took place between December 2014 and April 2016. This technique used qualitative as well as quantitative data sequentially through two online rounds and a subsequent face-to-face meeting.

The Delphi modified (Delphi-m) methodology is widely used in healthcare research when consensus between experts is needed, especially when evidence is poor quality or inexistent.[23,24] It is a formal structured method that allows consensus upon reasoned argumentation of the participant individuals, reducing the risk of over-representation of some ideas, allowing multidisciplinary approaches, and overcoming the risk of participation barriers of other consensus techniques related to geography, socio-economic status, or prevalence of professionals' views (as opposed to lay-people's), so that gaining legitimacy,[25,26] particularly when the selection of experts covers any of the potential actors involved in the problem of study.

Specifically, this RAND modified Delphi methodology combines the use of questionnaires to elicit responses in a systematic manner over two online rounds consultation using an online questionnaire (the Delphi part); and a face to face meeting to get the final consensus for a rating tool (the RAND modification).

As for the Delphi part, two on-line consultation rounds were conducted to elicit individuals' judgements and build the consensus. Two rounds are usually deemed sufficient to saturate the information and to reach agreement in most of the items[26]. During the online consultation process, participants never met or interacted directly to avoid bias or misrepresentation of expertise. During both rounds, experts were invited to comment on the methodology and encouraged to provide reflections on the general model. Most importantly, they were invited to provide additional items deemed relevant and missed in the questionnaire. Those comments were of major importance to improve the questionnaire and to better orient the face to face discussions in the RAND part.

As for the Rand part, after the online rounds, the face-to-face consensus meeting corrects the limitations of a classical Delphi method (the face to face meeting allows exchanging information to maximize the chance of covering and discussing the most important opinions and issues related to any criteria or category. During the meeting, experts have the opportunity of further analysis of 'no-approached' data, clarifying judgements, concepts and terminology that in the classical Delphi model would not be possible. In that sense, the group makes suggestions and modifications which preserve the advantages for the group, while relieving the problems for individual terminology. Accordingly, it facilitates a collection of views in which the criteria and categories are understood and applicable into their own context. During the face-to-face meeting (the only place with a limited interaction between the experts is possible); experts are required to set the final agreement of the question of interest using a structured methodology.

During the two phases, experts agreed on the relevance and feasibility of a series of criteria to assess whether a practice (i.e., policy, strategy, programme, service, or intervention) could be deemed as a 'good practice' in the area of interest of *Health Promotion and Primary Prevention of Chronic Conditions, Patient empowerment interventions with chronic conditions, Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions, and* on *Diabetes*. Notably, Diabetes was used as a case study as within the JA CHRODIS it was the archetypical chronic condition where all the areas studied in those other four Delphi should find a correlation.

In the following sections, a thorough description of the methodology and instruments is provided.

2.2. The Delphi-m process

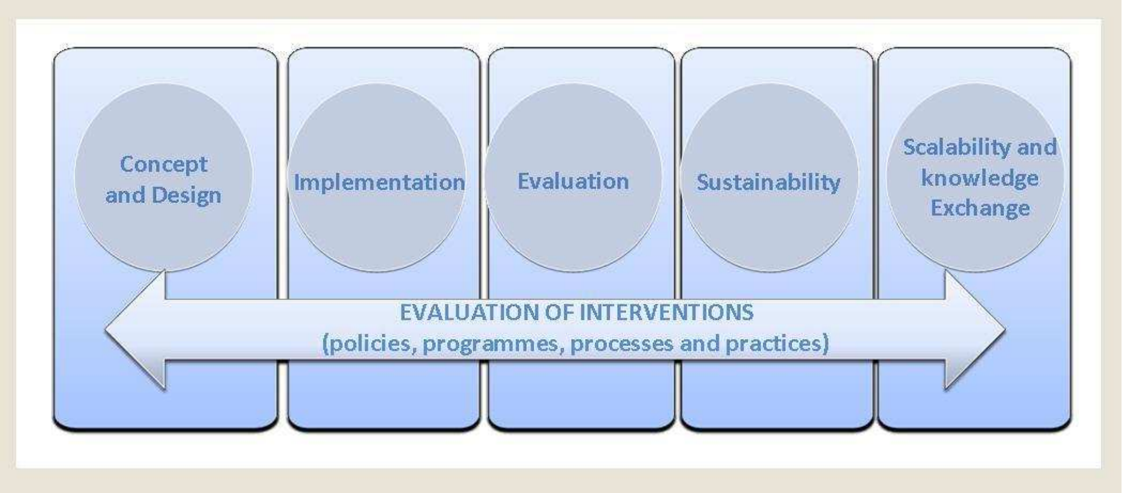
Each Delphi-m panel entailed a five-stage process, as follows: a) Development of the Delphi Questionnaires; 2) Setting up the panels of experts; 3) Designing the online consultation; 4) Carrying out the two-round online consultations; and, 5) holding the face-to-face meetings.

Step 1: Development of the Delphi-m Questionnaires

As mentioned the Delphi-m methodology implies the retrieval of experts' knowledge on a particular domain. To do so, Delphi-m methodology utilizes structured questionnaires where questions can be responded to using a Likert scale.

The critical issue in the development of the questionnaire (and the first task to fulfil) was the elaboration of the conceptual map for the five domains of interests. So, we used for that purpose the existing literature on other conceptual models and frameworks[27–31] and, after distilling the common elements across them, we found the following as relevant domains for the assessment of practices on chronic conditions and chronic care: the concept and design of the practice, how it has been implemented, what and how has been evaluated, and whether it is sustainable, scalable and transferable (figure 1).

Figure 1: conceptual model for the development of high-value criteria in the evaluation of practices on chronic conditions and chronic care



Source: own elaboration

Broadly, the *concept and design* of an intervention integrated various elements; so for example, how the practice was structured and articulated, its appropriateness and comprehensiveness, the population involved and the theory under which the practice was constructed. Within *implementation* there are elements that turn strategies and plans into actions in order to accomplish strategic objectives and goals of the practice. In turn, *evaluation* includes elements such as frameworks, monitoring mechanisms, methods and tools needed to evaluate the intervention results and process. *Sustainability* comprised dimensions to meet the needs for a practice to ensure long term continuation. Finally, *scalability* included specific elements that are deemed important to set an effective scaling up and/or transfer strategy of the practice to other settings.

In a later phase, the elaboration of questionnaires sought to include as many criteria as needed within each of the domains composing the conceptual model; thus, the set of specific criteria on concept and design, implementation, evaluation, sustainability and scalability and transfer should be specific for each of the fields of interest -criteria for practices on health promotion and prevention, practices on patient empowerment, practices on chronic care interventions and practices on diabetes.

In practical terms, the elaboration of each questionnaire required an in depth literature review and appraisal of primary and secondary documents that included conceptual models, assessment tools, frameworks, procedures existing guides, and other documents concerning evaluation criteria identified at national and international level for evaluation of good practices (to see the complete list of sources consulted in all Delphi-m refer to annex 1)

In addition to the literature review, other sources were included as background material. So, in the case of the *Health Promotion and Primary Prevention of Chronic Conditions* questionnaire, we used a set of National Good Practices assessment frameworks, programmes and practices in the area of HPPP collected in the context of CHRODIS JA. Likewise, in the case of diabetes, we used a collection of quality indicators for diabetes developed in CHRODIS-JA.

Once a comprehensive list of criteria was retrieved for each domain, a group of experts in each field, external to the Delphi-m process, were consulted in an iterative way in order to have a final refined set of criteria. Experts were asked to provide both general and specific comments regarding the criteria and categories relevant to the assessment of a practice in terms of appropriateness of the concepts and terminology used, pertinence of the criteria and categories included, and if any, missing criteria, etc. This final list of criteria composed the items in the Delphi-m questionnaires.

The specific case of the Delphi-m on Diabetes

Diabetes was considered as a case study within CHRODIS JA. Indeed, any approach to diabetes should consider questions on health promotion and primary prevention, on patient empowerment and how care is organized; thus questions present in the other three fields of interest in the Delphi-m process. In essence, the Delphi-m on Diabetes included as background material for the development of the questionnaire, the results of the other three Delphi-m processes plus[32] the aforementioned collection of diabetes quality indicators developed by CHRODIS JA.

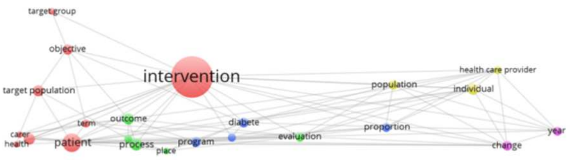
In this particular case, given the variety of sources, the elaboration of the Delphi-m questionnaire beforehand required the assessment of concordance and divergence between the evaluation criteria in the other Delphi-m and quality indicators developed in the CHRODIS JA; thus, criteria (i.e., broad domains) from the diabetes indicators and the results from previous Delphi-m were mapped out to check for coherence (overlapping) and divergence (criteria not considered in the other Delphi-m). The final set of criteria and categories out of that exercise yielded: 16 criteria with a total of 57 categories from the *Health Promotion and Primary Prevention of Chronic Disease* Delphi-m panel; 16 criteria and 61 categories from the *Organizational interventions focused on dealing with chronic patients with multiple conditions*; 14 criteria and 56 categories from the *Patient's empowerment interventions with chronic conditions*; and, finally, 10 criteria and 71 categories from the *Diabetes* work package (all Delphi-m questionnaires are in annex 2).

The large number of criteria and categories imposed the need to reduce dimensionality, to avoid conceptual (semantic) overlapping, while keeping the relevant information present. The evaluation for the overlapping was made following a two-step 2 process. Firstly, two independent reviewers evaluated the global set of criteria, retrieving information on each category aimed to measure both, the criteria from the previous Delphi-m and criteria from *Diabetes*. After this review, a semantic analysis on the corpus of literals and descriptors of the set of criteria was carried out using concepts extraction, based on co-occurrence methodology and cluster analysis[33,34], with the VOSviewer software[35,36] (see in figure 2, the global cluster analysis and refer to annex 3 for the cluster analysis, made for each of the criteria and its categories).

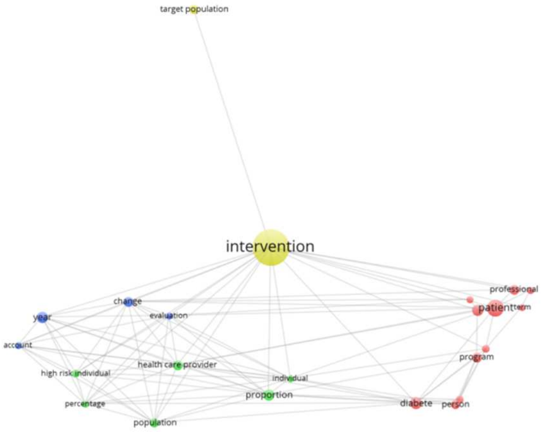
The summary of the specific contribution of each of the sources analysed and retained as relevant during the literature review following the previous conceptual model for each of the Delphi-m questionnaires can be consulted in annex 4. The final selection of assessment criteria to be included in the Delphi-m questionnaire on *Diabetes* is shown in annex 2.

Figure 2: Cluster analysis of all the categories that compound the questionnaire for the Delphi-m on Diabetes

Before solving overlapping categories

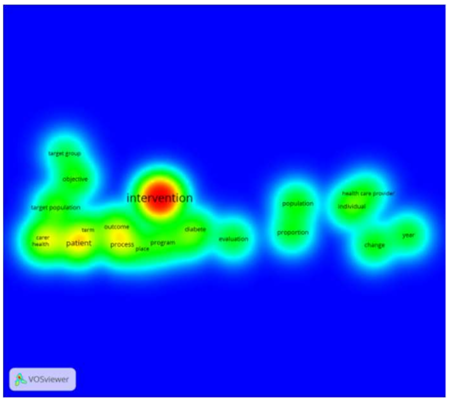


After solving overlapping



Heat map

Before solving overlapping categories



After solving overlapping categories

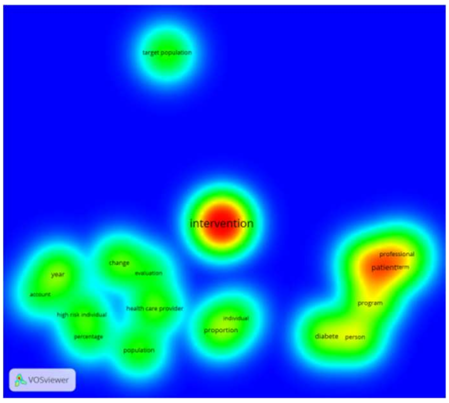


Figure 2 shows the outputs from the cluster analysis after text-mining major topics from the categories pooled from all Delphi-m panels plus the specific quality indicators on Diabetes. The major topics from several overlapping categories are represented as term nodes interconnected by theme. Additionally, thematic clusters are coded by colour in the network map (above) and by colour intensity in the heat map (below). Left and right figures represent the results of the cluster and semantic analyses before and after the elimination of redundant concepts and terms. Before eliminating redundancies, there were dense clusters with many categories grouped around the criteria; meaning that there was overlapping among categories. After eliminating redundancies, the relationship configuration was more scattered, and the categories were more heterogeneous and equidistant from the criteria, thus reflecting all relevant information was kept within the final questionnaire.

Step 2: Setting up the panels of experts

Once background material was collected and questionnaires developed several expert panels were summoned. For that purpose, the coordination team agreed on the type of profile required for an expert to be part of a specific panel. The recruitment process aimed at selecting participants with a variety of perspectives and expertise since a balanced composition is the critical point for a Delphi-m to produce unbiased consensual knowledge[26,37].

In order to get a balanced panel at European level, the Delphi-m leading team defined first the participants profile for each of the Delphi-m panels. Main requirements were to hold recognized experience and knowledge within the area of interest including a variety of perspectives (e.g., epidemiology, clinical experience, social intervention, care management, and policy) and social roles (e.g., health and social professionals, patients' advocates, policy makers, academics). In addition, the Delphi-m leading team also ensured gender balance and fair geographical representation. Once panel members were contacted, the goals and processes of the project were explained to them and consent to participate was obtained by email.

Regarding the panel size, some studies suggest that there has to be a minimum panel size and will vary according to the scope of the problem and resources available[38]; however, there is no standard method to calculate the panel size[39].
Nonetheless, in this Delphi-m case, where face-to-face meetings were planned, the Delphi-m leading team restricted the participation to a maximum of 30 panel members and a minimum of 15, providing enough margins for drop-offs. The final sample size was: 34 experts participated in the Delphi-m on *Health Promotion and Primary Prevention of Chronic Conditions* (14 men and 20 women) from Belgium, Bulgaria, Denmark, Estonia, Germany, Greece, Iceland, Ireland, Italy, Netherlands, Portugal, Serbia, Sweden and, United Kingdom. 24 experts (14 women and 10 men) from Belgium, France, Germany,

Ireland, Lithuania, Netherlands, Slovakia, Spain, Sweden and, United Kingdom participated in the Delphi-m on *Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions*. In the case of the Delphi-m on *Patient's empowerment interventions*, 26 experts (13 men and 13 women) from Belgium, Denmark, Finland, France, Ireland, Italy, Lithuania, Netherlands, Romania, Slovenia, Spain, Sweden and, United Kingdom ended up contributing. And, finally, in the case of the Delphi-m on *Diabetes* 28 experts (16 men and 12 women) were part of the panel, coming from Austria, Belgium, Finland, France, Germany, Greece, Ireland, Italy, Norway, Portugal, Romania, Slovenia, Spain and, United Kingdom.

Step 3: Designing the online consultation platform

Given that European-wide scope, the Delphi-m leading team decided to conduct an online approach using tested software -Health Consensus tool application (https://onsanity.com/?lang=en#home). In essence, after login, the expert found a landing screen with background material and a structured description of the Delphi-m process; then a second screen, invited the experts to declare sex, age and country of origin; finally, the experts had access to the actual questionnaire and were allowed to vote on all categories-questions on the basis of a Likert scale (total agreement to no agreement with the statement in the question).

As soon as the expert answered the questions, the choice was immediately displayed on the Likert scale represented on the right side of the screen, along with the median value out of other panel members' responses. So, in real time, experts were able to respond in light of the other panellists' opinions.

The tool also allowed to keep the relevant information from the first on-line round to inform panellists responses in the second round (see step 4). So, those categories for which consensus was reached and those for which further assessment was required were displayed in a different colour.

Finally, the tool included a glossary of terms to help experts' panel to understand the concepts used in the questionnaires and reduced the risk of bias due to semantic issues (see Annex 5 for the glossary of terms).

Step 4: Carrying out the two-round online consultations

The on-line consultation was held as follows: a) for the Delphi-m on *Health Promotion and Primary Prevention of Chronic Conditions* the questionnaire was available from December 2014 till March 2015; b) for the Delphi-m on *Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions* the tool was accessible from May 2015 to September 2015) for the Delphi-m on *Patient's empowerment interventions* the questionnaire was active from October 2015 to January 2016; and, in the case of the Delphi-m on *Diabetes* the questionnaire was accessible from March 2016 to April 2016.

The online consultation process, whose aim was the identification of criteria to assess good practices across Europe, consisted of two rounds. In the first round*,* experts were asked to judge on the relevance of the assessment categories included in the questionnaire. So, based on their knowledge and experience they responded using a nine-point Likert scale ranging from "not relevant at all (1)" to "of most relevance (9)". For the second round, those categories on which experts had agreed as being relevant were presented back to the expert for rating on the basis of their priority in an eventual assessment exercise, ranging from "the lowest priority (1) to "the highest priority (9)". Only experts who responded to the first round were eligible to participate in the second round. In both rounds experts were blinded to each other and responded independently; so that their opinions were just nuanced by the way real time results were displayed.

The relevance of a specific category was determined using the median score achieved. Categories scoring 1 to 3 were interpreted as 'non relevant'; those in the range of 4 to 6 were considered as 'not clearly relevant'; and, those within the range of 7 to 9, were deemed as 'relevant (figure 3). In turn, the level of agreement was determined by the interquartile interval (IQ) of the distribution of votes. So, when the interquartile interval was plus or minus 1, it was concluded that there was an agreement among the experts on the irrelevance, the uncertainty or the highly relevance of a specific category. Only those categories for which agreement converged around 'relevance' were kept for priority setting in the second round; agreements on irrelevance or not clearly relevant led to dropping the category. Those categories that did not reach any agreement were kept for reassessment of relevance in the second round (figure 4).

Figure 3: answers range and possibilities of agreement (relevance)

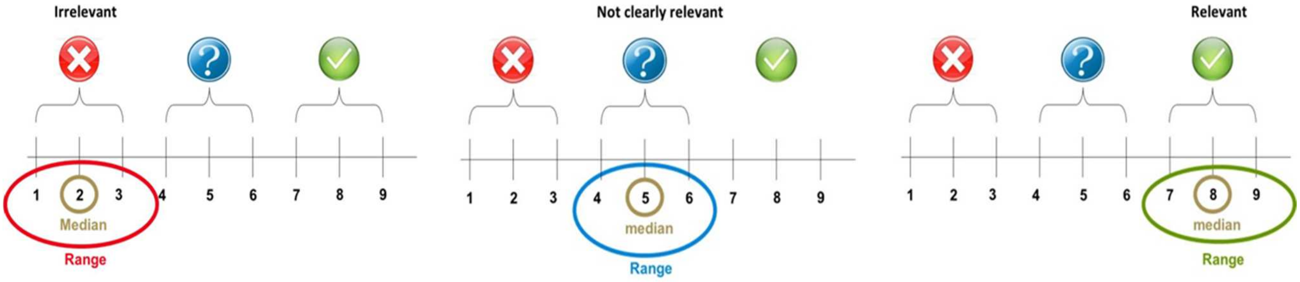
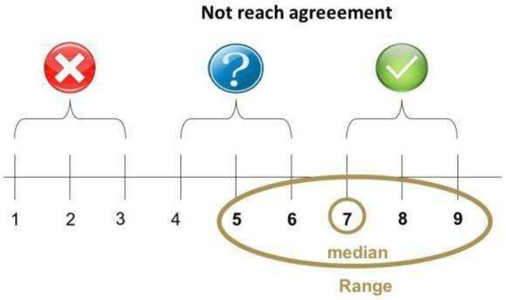


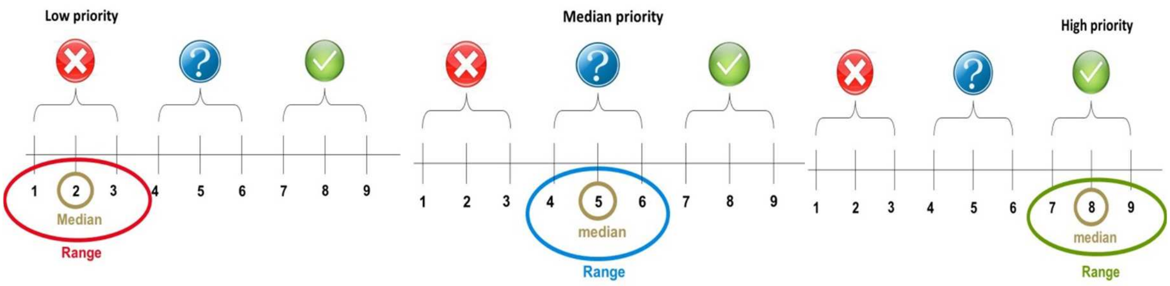
Figure 4: answers rate that did not reach agreement



Likewise, the median and interquartile interval of the distribution of votes per category were examined to determine whether experts agreed on the level of priority in the eventual case of assessment; so, categories within the range 1 to 3 were deemed low priority; those within 4 to 6 were considered moderate priority; and, those within the range 7 to 9 were deemed high priority (figure 5). Categories with high priority (median 7 to 9) and high level of agreement (IQ +/- 1) passed onto the face-to-face meeting for further discussion; agreement on low and medium priority led to dropping the category (figure 5).

Categories, for which the experts had not reached agreement in the first round, were presented again this time, alongside with the median and range of variation of experts' marks obtained in each category in the previous round, to give them the opportunity to change their score in view of the group's response obtained in the first round. In light of this information, panellists were asked to re-rank again their agreement with each category according to the proposed relevance scale (from 1=not relevant at all to 9=highly relevant). Only those categories that were considered relevant passed onto the face-to-face meeting for further discussion (figures 3 and 4).

Figure 5: answers range and possibilities of agreement (priority)



In the case of the Delphi-m on *Diabetes*, the process was slightly different. Since the criteria and categories used to elaborate the Diabetes's-m questionnaire originally came, as specified earlier, from the other Delphi-m (i.e., they had already been prioritized), experts were asked to re-prioritize them rather than check for the level of relevance. Likewise, those categories that did not reach any agreement were kept for reassessment in the second round (figure 4).

Step 5: The Face-to-face meetings

The 2-day face-to-face meetings, a modification of the regular Delphi-m panels using the RAND methodology, were meant to provide weights to both the criteria and the categories within each criterion that should be eventually considered when assessing a practice. Formally, a trained facilitator, who was not a member of the Delphi-m leading group, conducted the discussions following a structured and directive consensus methodology. Also, two rapporteurs provided support in rephrasing and rewording the criteria and categories, and most importantly, reported back to the panel live. In addition, sessions were tape-recorded (with experts' consent) to enable accurate reporting for qualitative analysis and to better interpret the quantitative part (i.e., the weights allocated to both criteria and categories).

The process was equivalent in each of the Delphi-m panels. For those criteria and categories retained as a consequence of the online consultation, panel members (those who had completed both rounds) were invited to semantically agree with both criteria and categories, merging, rephrasing and reallocating them if considered by the experts. Once full consensus was reached, the panel was invited to vote on the relative importance of those criteria and categories (within criteria) in the assessment of a practice. The relative weight was built on the concept of handing out 100 points among all the retained criteria and 100 points for each category within the criteria. Panel members were invited to allocate their points and cast ballots for counting. In table 1, there is an example of criteria and categories with their allocated weight.

Table 1: Example of criteria and their categories weight

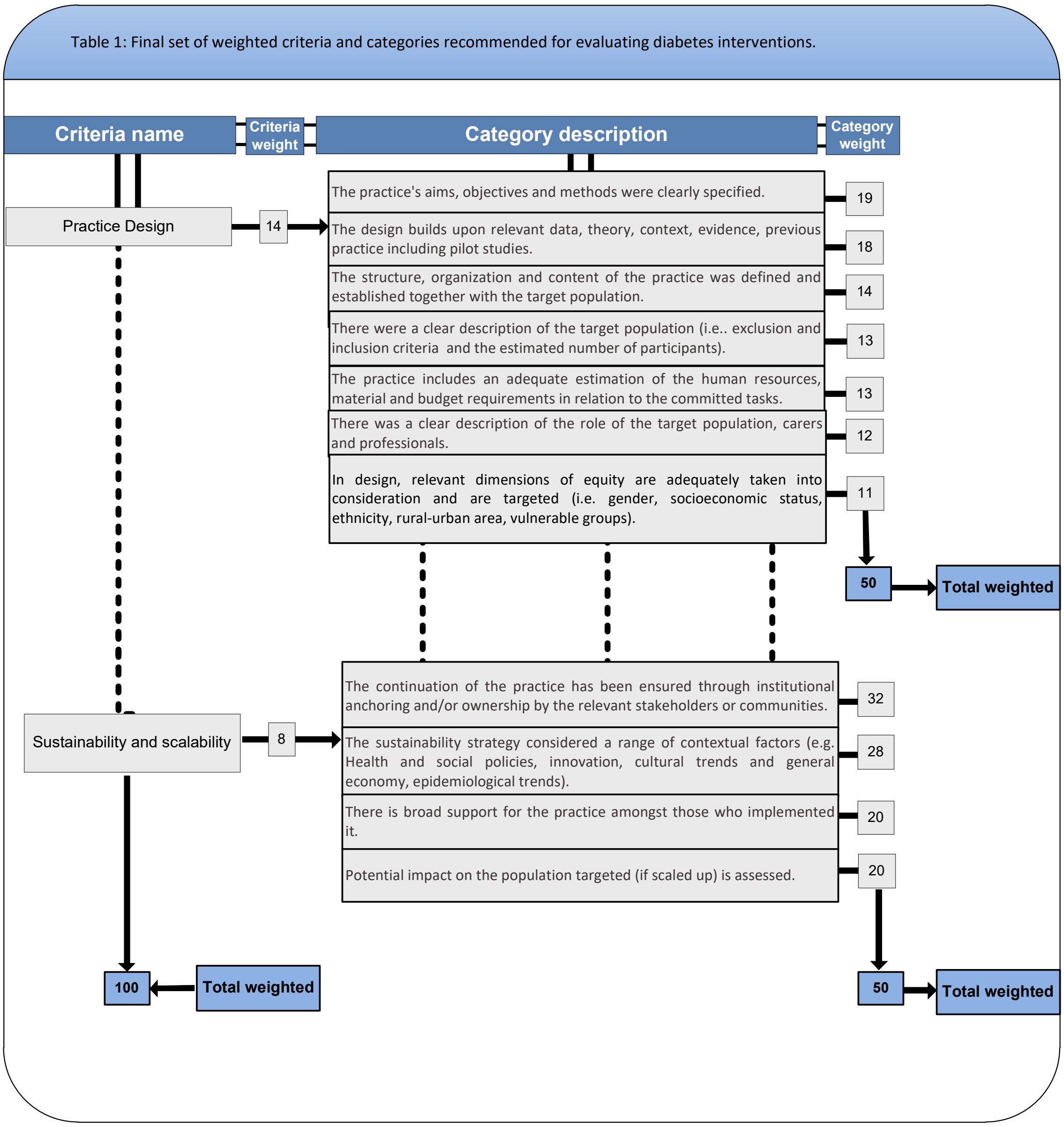


Table 1: Final set of weighted criteria and categories recommended for evaluating diabetes interventions.

Criteria name	Criteria weight	Category description	Category weight
Practice Design	14	The practice's aims, objectives and methods were clearly specified.	19
		The design builds upon relevant data, theory, context, evidence, previous practice including pilot studies.	18
		The structure, organization and content of the practice was defined and established together with the target population.	14
		There were a clear description of the target population (i.e.. exclusion and inclusion criteria and the estimated number of participants).	13
		The practice includes an adequate estimation of the human resources, material and budget requirements in relation to the committed tasks.	13
		There was a clear description of the role of the target population, carers and professionals.	12
		In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).	11
		Total weighted	50
Sustainability and scalability	8	The continuation of the practice has been ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities.	32
		The sustainability strategy considered a range of contextual factors (e.g. Health and social policies, innovation, cultural trends and general economy, epidemiological trends).	28
		There is broad support for the practice amongst those who implemented it.	20
		Potential impact on the population targeted (if scaled up) is assessed.	20
		Total weighted	50
Total weighted	100		

All the face-to-face meetings were held in Brussels. The Delphi-m on *Health Promotion and Primary Prevention of Chronic Conditions* was summoned on April 23rd and 24th 2015; Delphi-m on *Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions* was conducted on 22nd and 23rd October 2015; in the case of the Delphi-m on *Patient’s empowerment interventions with chronic conditions* was in 18th and 19th February 2016 and for the Delphi-m on *Diabetes* was realized on 12th-13th may 2016.

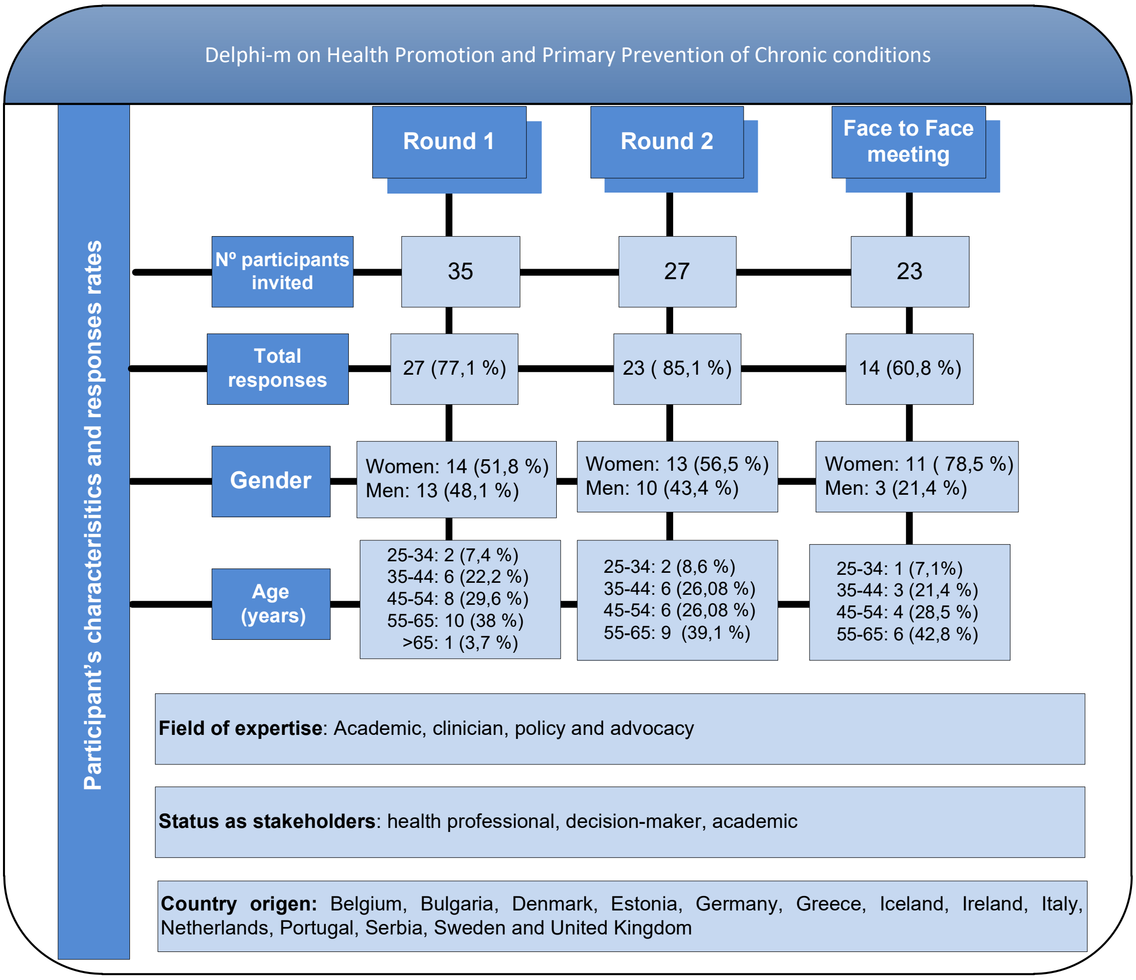
3. RESULTS

3.1 Delphi-m in Health Promotion and Primary Prevention of Chronic Conditions.

3.1.1 Expert Panel composition

The characteristics of the expert panel are described in figure 6. The Delphi-m recruited 35 panellists from the field of Health Promotion and Primary Prevention in Chronic Conditions with expertise in advocacy, policy making and analysis, medicine and academic research (the list and affiliation of the expert panel who were involved in the Delphi is presented in annex 6).

Figure 6: Expert panel composition of the Delphi-m on Health Promotion and Primary Prevention of Chronic Conditions



3.1.2 First Round (Online) – Relevance Assessment

This round was launched on the 2nd of December 2014 and closed on the 25th of January 2015. All assessment criteria, except *criteria 1: Length of experience threshold*, were accepted as relevant in this first round, so they passed to the second round and criteria 1 dropped. Within these criteria experts deemed relevant 40 categories (i.e., 7 to 9 median score +/- 1 IQ) that passed to the second round (table 2 in Annex 6) for priority assessment. The panellists also reached agreement as to the relative irrelevance of 6 out of the 57 categories that got discarded for the second round (table 3 in Annex 6). No other criteria or categories were found missed in accordance to experts' comments.

As for the remaining 11 categories, there was no consensus among the experts, with opinions evenly split between the "not clearly relevant" and "relevant" brackets of the scale. Those categories passed onto the second round for reassessment, this time in light of the median and range of the valuations allocated in the first round (table 4 in Annex 6).

3.1.3 Second Round (Online) – Relevance Assessment and Prioritization

This second round lasted from the 16th of February to the 16th of March 2015. Regarding the 11 categories that the panel reached no agreement in the first round, 3 of them were considered relevant and retained for discussion at the face-to-face meeting (table 5 in Annex 6). The other 8 categories were deemed unclear or not relevant, and finally got dropped from the list (table 6 in Annex 6).

As for the 40 categories agreed as relevant in the previous round, they all rated in the area of high priority in the second one and they were further discussed during the face to face meeting (the scores obtained for each category and the corresponding criterion are summarised in table 7 in Annex 6).

During both rounds, experts were invited to add any category or criterion they thought relevant and missing from the list provided and encouraged to add comments to individual categories, criteria, or the general model. Despite no additional categories being suggested, experts' comments made during both rounds proved very informative as to how they were facing their task and the conceptual difficulties they identified in the process (see Experts' Comments with regard to relevance and priority in Annex 6).

3.1.4 Face-to-face meeting – Discussion and Final Prioritization

The last part of the Delphi-m process was the expert face to face meeting aiming the refinement of the wording, the semantic homogeneity and the weighting of both criteria and categories within each criterion. This 2-day meeting took place on the 23rd and 24th April 2015 in Brussels.

The initial 14 criteria obtained from the second online round (table 7 in Annex 6) were further discussed by the Delphi-m research team to identify redundancies. Thus, a proposal for merging criteria and reallocating categories was presented to the expert panel and thoroughly discussed during the meeting. The experts finally agreed on a list of 10 criteria made up of 28 weighted categories composing each criterion. Table 8 shows the final list of categories, criteria and their weights agreed by the expert panel.

As observed, when it comes to the criteria, equity issues were considered the most important in the assessment of a practice. Nonetheless, the differences in the weights allocated showed no major differences across criteria, with governance and management of the practice and potential of transferability and scalability being the criteria with the lowest importance in accordance to the panel.

When it comes to the categories weighting, in the case of “sustainability” and, to a lesser extent, “comprehensiveness if the intervention” and “ethical considerations”, weights were distributed more unevenly than in the rest of criteria.

Table 8. Final set of weighted criteria and categories recommended for evaluating Health Promotion and Primary interventions of Chronic Conditions

Health Promotion and Primary Prevention of Chronic Conditions

NEW Criteria name	*Criteria Weight*	*Categories*	*Category Weight*
Equity	13	In implementation, specific actions are taken to address the equity dimensions.	60
		In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).	40
Total must equal 100			**100**
Comprehensiveness of the intervention	12	The intervention has a comprehensive approach to health promotion addressing all relevant determinants, (e.g.. including social determinants) and using different strategies (e.g. setting approach).	50
		An effective partnership is in place (e.g. multidisciplinary, inter-sector, multi-/ and alliances).	30
		The intervention is aligned with a policy plan at the institutional, local, national and international level.	20
Total must equal 100			**100**
Description of the practice	12	The design is appropriate and builds upon relevant data, theory, context, evidence, previous practice including pilot studies.	50
		The design thoroughly describes the practice in terms of purpose, SMART objectives, methods (e.g. recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration).	50
Total must equal 100			**100**
Ethical Considerations	11	The intervention is implemented equitably, i.e. proportional to needs.	47
		Potential burdens, including harms, of the intervention for the target population are addressed.	31

		The intervention's objectives and strategy are transparent to the target population and stakeholders involved.	22
Total must equal 100			**100**
Evaluation	11	There is a defined and appropriate evaluation framework assessing structure, process and outcomes considering, e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome).	25
		Evaluation results achieve the stated goals and objectives.	25
		Information /monitoring systems are in place to regularly deliver data aligned with evaluation and reporting needs.	25
		The intervention is assessed for outcomes, intended or unintended.	25
Total must equal 100			**100**
Empowerment and Participation	10	The intervention develops strengths, resources and autonomy in the target population(s) (e.g. assets-based, salutogenic approach).	39
		The intervention achieves meaningful participation among the intended target population.	34
		The intervention is designed and implemented in consultation with the target population.	27
Total must equal 100			**100**
Target population	9	Target population/s is defined on the basis of needs assessment including strengths and other characteristics.	60
		The engagement of intermediaries/multipliers is used to promote the meaningful participation of the target population.	40
Total must equal 100			**100**
Sustainability	8	The continuation of the intervention is ensured through institutional ownership that guarantees funding and human resources and/or is mainstreamed.	60

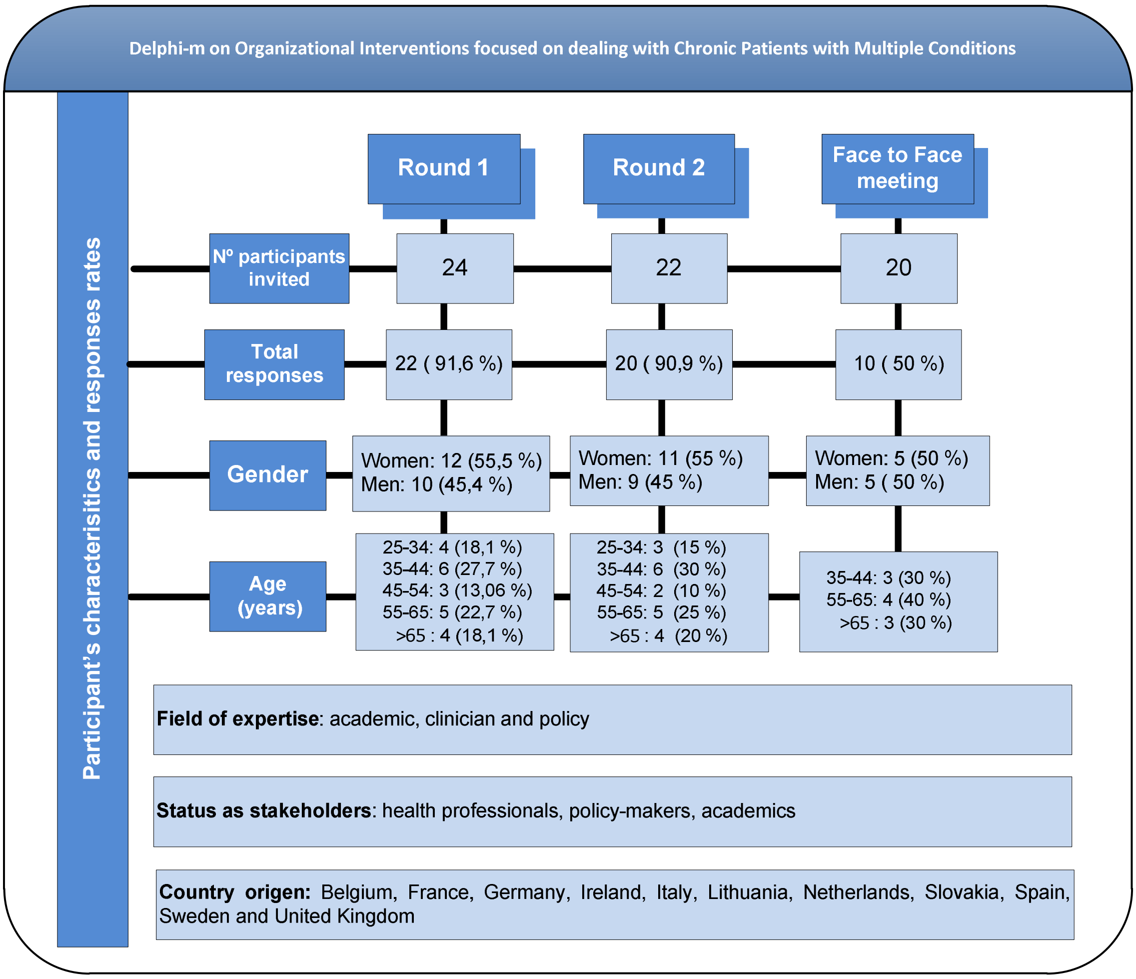
		There is broad support for the intervention amongst those who implement it.	20
		There is broad support for the intervention amongst the intended target populations.	20
Total must equal 100			**100**
Governance and project management	7	The intervention includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.	40
		Sources of funding are specified in regards to stability and commitment.	30
		Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	30
Total must equal 100			**100**
Potential of scalability and transferability	7	Potential impact on the population targeted (if scaled up) is assessed.	40
		There is a specific knowledge transfer strategy in place (evidence into practice).	30
		An analysis of requirements for eventual scaling up such as foreseen barriers and facilitators (e.g. resources, organisational commitment, etc.) is available.	30
Total:	**100**		**100**

3.2 Delphi-m in Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions

3.2.1 Expert Panel composition

The characteristics of the expert panel are described in figure 7. The 24 participants had a consolidated experience in the field of chronic care and complex organizations. Their expertise was academic, clinical, managerial and on policy topics. The range of countries represented showed a good sample of the variety of health systems (i.e., chronic care models) in Europe (the list and affiliation of the expert panel who were involved in the Delphi is presented in annex 7).

Figure 7: Expert panel composition for the Delphi on Organizational Interventions focused on dealing with Chronic Patients with Multiple Condition



	Round 1	Round 2	Face to Face meeting
Nº participants invited	24	22	20
Total responses	22 (91,6 %)	20 (90,9 %)	10 (50 %)
Gender	Women: 12 (55,5 %) Men: 10 (45,4 %)	Women: 11 (55 %) Men: 9 (45 %)	Women: 5 (50 %) Men: 5 (50 %)
Age (years)	25-34: 4 (18,1 %) 35-44: 6 (27,7 %) 45-54: 3 (13,06 %) 55-65: 5 (22,7 %) >65 : 4 (18,1 %)	25-34: 3 (15 %) 35-44: 6 (30 %) 45-54: 2 (10 %) 55-65: 5 (25 %) >65 : 4 (20 %)	35-44: 3 (30 %) 55-65: 4 (40 %) >65 : 3 (30 %)

Field of expertise: academic, clinician and policy

Status as stakeholders: health professionals, policy-makers, academics

Country origen: Belgium, France, Germany, Ireland, Italy, Lithuania, Netherlands, Slovakia, Spain, Sweden and United Kingdom

3.2.2 First Round (Online) – Relevance

The first round was launched on the 18th of May of 2015 and closed on the 22nd June of 2015. After the first round, all the original criteria, except *criteria 13: Assessment of coordination and organizationa*l aspect that dropped remained and experts agreed on 51 categories, passing them all to the second round for priority assessment (Table 9 in Annex 7). For the remaining 10 categories, no consensus among the experts was achieved (Table 10 in Annex 7), so they passed to the second round for reassessment by the experts. Experts did not find any category lacking, so no new additions were made along the first round.

3.2.3 Second Round (Online) – Relevance Assessment and Prioritization

The second round started on the 10th of July and closed on the 15th September 2015 (note that the consultation period was longer than usual due to European summer break).

In relation to the 10 categories in which there was no agreement among the experts during the first round, 2 of them were deemed relevant and retained for discussion in the face-to-face meeting (table 11 in Annex 7). The remaining eight categories continued to be unclear or not relevant, so that they were discarded from the list (table 12 in Annex 7).

Finally, from the 51 categories agreed as relevant in the previous round, all rated in the area of high priority except for one category (category 56), which was assigned a low priority on the second round. They all were kept for discussion at the face-to-face meeting. The final scores obtained for each criterion and the corresponding categories are summarised in table 13 in Annex 7.

As it happened in the first round, experts were also invited to add any category or criterion they thought relevant and missing from the list provided and encouraged to add comments. Although no additional categories were suggested, experts made some comments about the process (see experts' comments with regard to relevance and priority in Annex 7).

3.2.4 Face-to-face meeting – Discussion and Final Prioritization

The last part of the Delphi-m process was the expert face to face meeting aiming the refinement of the wording, the semantic homogeneity, and the weighting of both criteria and categories within each criterion. This 2-day meeting took place on the 22rd and 23th of October of 2015 in Brussels.

The initial sets of criteria obtained from the second online round (table 13 in Annex 7) were further discussed by the Delphi-m research team to identify redundancies. Thus, a proposal for merging criteria and reallocating categories was presented to the expert panel and thoroughly discussed during the meeting. The experts finally agreed on a list of 8 criteria made up of 50 weighted categories composing each criterion. Table 14 shows the final list of categories, criteria and their weights agreed by the expert panel.

As observed, when it comes to the criteria, experts allocated the weights unevenly; so, the highest weight for experts was in the “Care intervention designed” (19% of the total valuation of a practice) while, at the other end, “Interaction with relevant societal structures” was rated just with a 3% of the potential value in the assessment. Contrasting, the distribution of weights across categories within criteria was fairly even.

Table 14. Final set of weighted criteria and categories recommended for evaluating organizational interventions focused on dealing with chronic patients with multiple conditions ranked by criteria weight.

Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions			
NEW Criteria name	***Criteria Weight***	***Categories***	***Category Weight***
Context and Needs Analysis	7	The intervention was based on a clear assessment of needs of the population it will serve.	30
		The intervention was based on a clear understanding of the contextual factors that would affect the outcomes (i.e. characteristics of the health system, coverage, characteristics of the population, socioeconomic environment, legal and political environment).	20
		There had been an explicit process of relevant stakeholders’ engagement prior to the implementation of the intervention	15

		There had been an explicit process of public consultation prior to the implementation of the intervention.	10
		Assessment of cost-effectiveness of relevant interventions was carried out (or accounted for if it already existed).	25
Total must equal 100			100
Objectives and Target group	10	The intervention's aims and objectives were clearly specified and adjusted to the SMART rule (Specific/Measurable/Acceptable/Realistic/Time framed).	30
		Target groups were risk-stratified using evidence-based methodology and taking into account relevant dimensions (e.g. quality of life, clinical and functional status, frailty).	30
		There was a clear inclusion and exclusion criteria.	15
		There was a detailed description of the estimated number and profile of the patients targeted by the intervention.	10
		The intervention was sensitive to cultural beliefs and socioeconomic characteristics of the individuals including the main characteristics of the area and population in which the intervention was implemented.	15
Total must equal 100			100
Care Intervention Design	19	The different professional disciplines (including social sector)and services involved in the intervention are clearly identified, with appropriate mechanisms of coordination among them.	10
		The intervention defined specific care pathways for patients based on their clinical assessment.	10
		The intervention was designed to foster discussion and agreement with patients about their care plans (including goal-setting).	10
		Key elements of the intervention were clearly defined and related to the intended effect (based on strong theoretical basis, providing a clear understanding of the chain of causation and the interactions between processes).	10
		There was an individual contact point for the patient across the diagnostic and therapeutic processes, including the definition of a case manager role when needed.	10
		Patient adherence to medical plans was specifically addressed in the design of the intervention.	10

		Problems related to poly-pharmacy were taken into account.	10
		The intervention placed a specific role/function for caregivers, involving them in care support infrastructure for dependent patients.	10
		There was a detailed description of the care settings of the intervention.	10
		The intervention included mechanisms to support patient engagement and self-management (e.g. Bidirectional communication, assistance at home, counselling, integration in patient's community, monitoring, emergency care rapid response, telephone follow-up, etc.).	10
Total must equal 100			100
Change Management	14	There was a defined a strategy to align staff incentives and motivation with the intervention objectives.	20
		The intervention included a learning system to support reflective healthcare practice among professionals involved.	10
		The intervention included organisational elements, identifying the necessary actions to remove legal, managerial, financial or skill barriers.	10
		There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined.	30
		The professionals involved are trained and competent to support individual's self-management (e.g. through professional development programmes to promote patient empowerment).	30
Total must equal 100			100
Interaction with relevant societal structures	10	The intervention was integrated or fully interacting with the regular care delivery system.	40
		Communication across all care providers (i.e. health and social services and different levels or instances within them) facilitates transition and sufficient access to relevant information.	30
		The intervention fostered continuous engagement and coordination with different community resources (i.e. main town halls, social services, pharmacies and local associations).	30
Total must equal 100			100

Resources and infrastructure	10	There was an integrated system of patient data that can be accessed and updated by patients in real time.	10
		There was an integrated system of patient data that can be accessed and updated by professionals in real time across the various care levels.	15
		The intervention integrated different information and communication technologies (e.g. accessible channels of communication, dedicated software etc.).	10
		The best available evidence (guidelines, protocols, etc.) was easily available for health professionals.	15
		There was a defined policy to ensure acceptability of information technologies among users (professionals and patients), to enable their involvement in the process of change.	10
		Investment in human capital by means of training/education activities for caregivers and patients was present.	15
		The workload (cognitive, physical, time) for the organization and the professionals involved had been estimated as adequate.	10
		There was an explicit human resources policy, with a definition of professional roles involved, criteria for professional recruitment and training plans (including a clear definition of qualifications and skills).	15
Total must equal 100			100
Evaluation	15	The intervention included a monitoring and evaluation system with an information system feeding defined indicators and standards of care.	10
		Evaluation activities followed clear milestones and were sustained along the intervention.	10
		There was a baseline multidisciplinary assessment for all the relevant outcomes and processes.	10
		Evaluation took into account social economic aspects from both patient and formal and informal caregivers’ perspectives.	10
		The evaluation included changes in healthcare organisation and utilisation across levels of care.	10
		The outcomes framework was shared among providers.	10
		Outcomes assessment included health and social impact and care experience.	10
		Evaluation outcomes were linked to the stated goals and objectives.	10

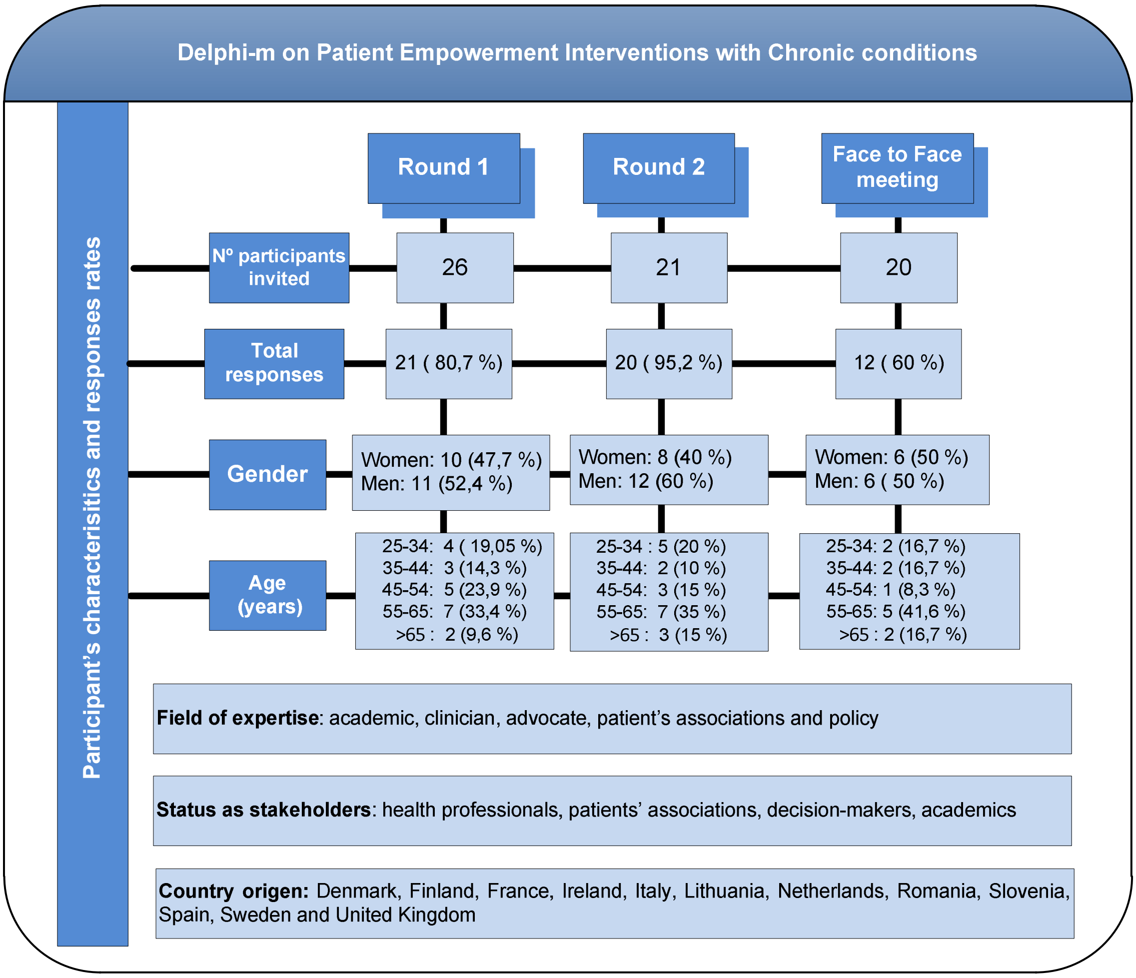
		Evaluation outcomes were shared among stakeholders and linked to actions to foster continuous learning and improvement.	10
		Outcomes assessment enabled performance-based contracts.	10
Total must equal 100			100
Sustainability and Scalability	15	The continuation of the project was ensured through ownership and/or institutional anchoring, and there was enough support for the intervention among stakeholders.	40
		The financial viability of the intervention was guaranteed in the long term.	20
		The sustainability strategy considered a range of contextual factors (e.g. Health and social policies, innovation, cultural trends and general economy).	20
		The intervention potential for scalability was assessed.	20
Total:	**100**		100

3.3 Delphi-m in Patient's empowerment Interventions with Chronic Conditions

3.3.1 Expert Panel composition

Expert panel characteristics for the Delphi-m process on patients' empowerment with chronic conditions are described in figure 8. All the 26 participants composing the panel held vast knowledge and experience in the field of patient's empowerment from academia, advocacy groups, patient organizations, health professionals and policy arena (the list and affiliation of the expert panel who were involved in the Delphi is presented in annex 8).

Figure 8: Expert panel composition for the Delphi-m in Patient Empowerment interventions with Chronic Conditions



Delphi-m on Patient Empowerment Interventions with Chronic conditions

Participant's characterisitics and responses rates

	Round 1	Round 2	Face to Face meeting
Nº participants invited	26	21	20
Total responses	21 (80,7 %)	20 (95,2 %)	12 (60 %)
Gender	Women: 10 (47,7 %) Men: 11 (52,4 %)	Women: 8 (40 %) Men: 12 (60 %)	Women: 6 (50 %) Men: 6 (50 %)
Age (years)	25-34: 4 (19,05 %) 35-44: 3 (14,3 %) 45-54: 5 (23,9 %) 55-65: 7 (33,4 %) >65 : 2 (9,6 %)	25-34 : 5 (20 %) 35-44: 2 (10 %) 45-54: 3 (15 %) 55-65: 7 (35 %) >65 : 3 (15 %)	25-34: 2 (16,7 %) 35-44: 2 (16,7 %) 45-54: 1 (8,3 %) 55-65: 5 (41,6 %) >65 : 2 (16,7 %)

Field of expertise: academic, clinician, advocate, patient's associations and policy

Status as stakeholders: health professionals, patients' associations, decision-makers, academics

Country origen: Denmark, Finland, France, Ireland, Italy, Lithuania, Netherlands, Romania, Slovenia, Spain, Sweden and United Kingdom

3.3.2 First Round (Online) – Relevance Assessment

The first round was launched on October 19th and closed on November 16th of 2015. In this first round, all the criteria and categories passed onto the second round. Agreement about relevance was reached in about 38 categories (7-9 score), thus they passed onto the second round for priority assessment (table 15 in Annex 8). For the remaining 18 categories, no consensus was achieved among the experts, so those questions passed onto the second round for reassessment again, this time in light of the median and range of the valuations assigned during the first round (table 16 in Annex 8). All the original criteria remain and experts did not find any additional criterion lacking.

3.3.3 Second Round (Online) – Relevance Assessment and Prioritization

The second round launched on the 14th of December of 2015 and closed on the 18th of January 2016. In relation to the 18 categories where the panel reached no agreement in the first round, only 1 ended up deemed relevant and retained for discussion in the face-to-face meeting (table 17 in Annex 8). The other 17 categories were considered unclear or not relevant; therefore they were discarded from the list (table 18 in Annex 8).

In addition, from the 38 categories agreed as relevant in the previous round, 35 rated in the area of high priority and 3 in the area of low priority (category 36, category 54 and category 56). All of them were kept for discussion in the face-to-face meeting. The scores obtained for each category and the corresponding criteria are summarised in table 19 in Annex 8.

As happened in the two previous Delphi, experts were invited to add any criterion or category they thought relevant or missing during the consultation process and provide comments. Despite no additional categories or criteria being suggested during this process, experts made some comments about their task or other difficulties they might have identified in the process (see experts' comments with regard to relevance and priority in Annex 8).

3.3.4 Face-to-face meeting – Discussion and Final Prioritization

The last part of the Delphi-m process was the expert face to face meeting aiming the refinement of the wording, the semantic homogeneity and the weighting of both criteria and categories within each criterion. This 2-day meeting took place on the 18th and 19th February 2016 in Brussels.

The initial 13 criteria obtained from the second online round (table 19 in Annex 8) were further discussed by the Delphi-m research team to identify redundancies. Thus, a proposal for merging criteria and reallocating categories was presented to the expert panel and thoroughly discussed during the meeting. The experts finally agreed on 7 criteria made up of 28 weighted categories composing each criterion. Table 20 shows the final list of criteria, categories, and their weights.

As observed, when it comes to the criteria, experts allocated the weights rather evenly; so, the highest weight was assigned to "Care intervention design" (19% of the potential value for an assessment), while the criteria with the lowest score (11% of total potential value) were "Interaction with the health and care system", "Ethical considerations" and "Sustainability, Scalability and Transferability".
Likewise, the distribution of weights across categories within criteria was fairly even except in the criterion "Interaction with the health and care system".

Table 20. Final set of weighted criteria recommended for evaluating patient's empowerment interventions with chronic conditions.

Patient's Empowerment Interventions with Chronic Conditions			
NEW Criteria name	***Criteria Weight***	***Categories***	***Category Weight***
Goals, scope and mechanisms	17	The intervention actively promotes patients' empowerment by using appropriate mechanisms (e.g. self-management support, shared decision making, education-information, value clarification, etc.).	40
		The intervention is aligned with patients and/or carers specific values, preferences, beliefs, needs, capacities, circumstances and /or expectations.	30

		The intervention considered all stakeholders’ * needs in terms of enhancing/acquiring the right skills, knowledge and behaviour to promote patient empowerment (*patients, carers, health and care professionals, policy makers, etc.).	30
Total must equal 100			100
Care intervention design	19	The intervention was co-designed and implemented with the target population (patients, carers and professionals).	30
		All relevant stakeholders (patients, carers, professionals, community groups, statutory bodies, etc.) were considered and key stakeholders identified.	15
		There was a clear description of the patients, carers and professionals’ specific role and their contribution was appropriately planned, supported and resourced	20
		Organisational structures supporting patients' empowerment were clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	20
		Key stakeholders (other than target population) were involved in the design and implementation of the intervention.	15
Total must equal 100			100
Leadership, Capacity and Communications	17	There was a clear commitment to the intervention from the leadership of the participating organisations.	20
		Leadership of the intervention exhibits commitment to patients' empowerment and is both credible and effective.	20
		All team members involved had appropriate capacities, experience, training and support to accomplish their tasks.	15
		The provision of resources covers all the elements of the intervention and is sufficient for the described tasks.	15
		The information generated by the intervention was systematically recorded and is accessible to professionals and patients, and where appropriate embedded in existing information systems.	15
		The intervention included an effective mechanism for internal communication.	15
Total must equal 100			100
Interaction with the health and care system	11	The intervention considers creating effective linkages with all relevant parts of the health and care system.	30
		The intervention enhances and supports the patients and/or carers' ability to effectively interact with the health and care system.	70
Total must equal 100			100
Ethical considerations		Patients' and/or carers' rights to be informed, to decide about their care, participation and issues regarding confidentiality, were respected and enhanced.	40

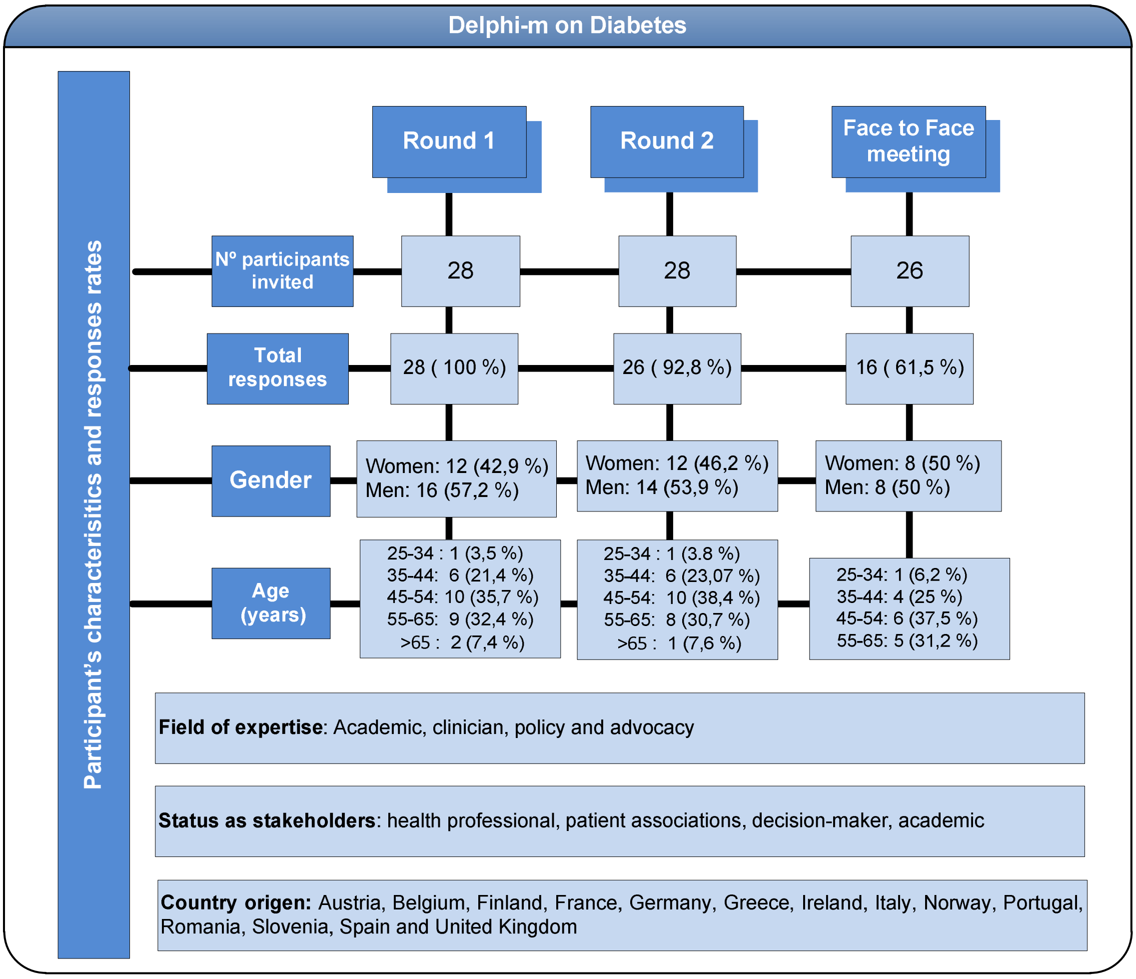
	11	The intervention's objectives and strategy were transparent to all involved stakeholders.	30
		All the potential burdens, benefits and harms of the intervention were addressed for both patients and/or carers.	30
Total must equal 100			100
Evaluation and monitoring	14	There was a stated method and information system for regular monitoring and evaluation of the progress (formative) and/or impact (summative) of the implemented intervention.	25
		The evaluation framework includes assessment of all relevant outcomes including those selected by patients and/or carers.	25
		The evaluation results are relevant and linked to the stated goals and objectives.	15
		There is a process in place to reshape the implementation according to the evaluation results.	20
		The evaluation process and dissemination of the results involved relevant stakeholders.	15
Total must equal 100			100
Sustainability, Scalability and Transferability	11	The continuation of the project has been ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities.	28
		Human and financial resources for the long term future of the project have been identified and action has been taken to secure them.	22
		Advocates or champions for the continuation of the project have been identified and nurtured (e.g. Patients and carers' groups, community leaders, policy makers, organisations leaders, professionals, etc.).	28
		There is an analysis of requirements for potential scalability and transferability	22
Total must equal 100			100

3.4 Delphi-m in Diabetes

3.4.1 Expert panel composition

The features for the Diabetes experts' panel are described below in figure 9. The 28 experts held knowledge and experience in the field of diabetes with expertise in care delivery, policy perspective and advocacy, as well as in the academic approach to diabetes. A well of health systems were represented in this panel (the list and affiliation of the expert panel who were involved in the Delphi is presented in annex 9).

Figure 9: Expert panel composition for the Delphi-m in Diabetes



Delphi-m on Diabetes

Participant's characterisitics and responses rates

	Round 1	Round 2	Face to Face meeting
Nº participants invited	28	28	26
Total responses	28 (100 %)	26 (92,8 %)	16 (61,5 %)
Gender	Women: 12 (42,9 %) Men: 16 (57,2 %)	Women: 12 (46,2 %) Men: 14 (53,9 %)	Women: 8 (50 %) Men: 8 (50 %)
Age (years)	25-34 : 1 (3,5 %) 35-44: 6 (21,4 %) 45-54: 10 (35,7 %) 55-65: 9 (32,4 %) >65 : 2 (7,4 %)	25-34 : 1 (3.8 %) 35-44: 6 (23,07 %) 45-54: 10 (38,4 %) 55-65: 8 (30,7 %) >65 : 1 (7,6 %)	25-34: 1 (6,2 %) 35-44: 4 (25 %) 45-54: 6 (37,5 %) 55-65: 5 (31,2 %)

Field of expertise: Academic, clinician, policy and advocacy

Status as stakeholders: health professional, patient associations, decision-maker, academic

Country origen: Austria, Belgium, Finland, France, Germany, Greece, Ireland, Italy, Norway, Portugal, Romania, Slovenia, Spain and United Kingdom

3.4.2 First Round (Online) – Priority assessment

The first round questionnaire on diabetes was launched on March 21st and closed on April 11th 2016. In this first round, all criteria remain and from the initial 71 categories presented in the questionnaire, agreement among the experts was reached in 50 categories passing directly to the face-to-face meeting for further discussion (table 21 in annex 9). Other 8 categories were considered as median and low priority; therefore, they were discarded (table 22 in annex 9). The remaining 13 categories, on which experts did not reach any agreement, passed to the second round for reassessment. (table 23 in annex 9). No further criteria and categories were added by the panel.

3.4.3 Second Round (Online) – Priority Assessment

The second round was launched on April 18th and closed on April 25th 2016. In relation to the 13 categories in which the panel reached no agreement in the first round, only 2 were deemed high priority with high level of agreement and were retained for discussion at the face-to-face meeting (table 24 in annex 9). The remaining 11 categories were considered median and low priority; therefore they were discarded from the list (table 25 in annex 9).

Likewise, the 50 categories agreed as high priority in the previous round, and the 2 new categories in this second round were all kept for discussion in the face-to-face meeting. The scores obtained for each category and the corresponding criterion are summarised in table 26 in annex 9.

As happened in the previous Delphi-m, comments (about the process, model or individual criterion or categories) were provided by the experts during both rounds. Though no additional criteria or categories were suggested during this process, likewise their comments proved very informative (see experts' comments in relation to priority in Annex 9).

3.4.4 Face-to-face meeting – Discussion and Final Prioritization

The last part of the Delphi-m process was the expert face to face meeting aiming the refinement of the wording, the semantic homogeneity and the weighting of both criteria and categories within each criterion. This 2-day meeting took place on the 12th and 13th of May 2016 in Brussels.

The initial 10 criteria obtained from the second online round (table 26 in Annex 9) were further discussed by the Delphi-m research team to identify redundancies. Thus, a proposal for merging criteria and reallocating categories was presented to the expert panel and thoroughly discussed during the meeting. The experts finally agreed on 9 criteria made up of 39 weighted categories composing each criterion. Table 27 shows the final list of criteria, categories, and their weights.

As observed, when it comes to the criteria, experts allocated the weights rather evenly; so, the highest weight was assigned to the criterion “Practice design” (14% of the total potential value), with “Sustainability and Scalability” reached the lowest weight (8% of total value). Likewise, the distribution of weights across categories within criteria was fairly even.

Table 27. Final set of weighted criteria and categories recommended for evaluating diabetes interventions.

DIABETES			
NEW Criteria name	***Criteria Weight***	***Categories***	***Category Weight***
Comprehensiveness of the practice	11	The practice has considered relevant evidence on effectiveness, cost-effectiveness, quality, safety, etc.	38
		The practice has considered the main contextual indicators*.	33
		The practice has considered the underlying risks of the target population (i.e. Validated tools to individual risk assessment).	29
Total must equal 100			100
Practice design	14	The design builds upon relevant data, theory, context, evidence, previous practice including pilot studies.	18
		The practice's aims, objectives and methods were clearly specified.	19
		There were a clear description of the target population (i.e.. exclusion and inclusion criteria and the estimated number of participants).	13
		In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).	11

		The structure, organization and content of the practice was defined and established together with the target population.	14
		The practice includes an adequate estimation of the human resources, material and budget requirements in relation to the committed tasks.	13
		There was a clear description of the role of the target population, carers and professionals.	12
Total must equal 100			100
Ethical considerations	11	The practice is implemented equitably* (i.e. proportional to needs).	25
		The practice's objectives and strategy are transparent to the target population and stakeholders involved.	25
		Potential burdens of the practice (i.e. psychosocial, affordability, accessibility, etc.) are addressed and there is a balance between benefit and burden.	25
		Target population rights to be informed, to decide about their care, participation and issues regarding confidentiality, were respected and enhanced.	25
Total must equal 100			100
Governance	10	There was a defined strategy to align staff incentives and motivation with the practice objectives.	10
		The practice included organizational elements, identifying the necessary actions to remove legal, managerial, and financial or skill barriers.	15
		The best evidence and documentation supporting the practice (guidelines, protocols, etc.) was easily available for relevant stakeholders (e.g. professionals and target populations).	10
		Multidisciplinary approach for practices is supported by the appropriate stakeholders (e.g. professionals associations, institutions etc.).	10
		The contribution of the target population, carers and professionals was appropriately planned, supported and resourced.	13
		The practice offers a model of efficient leadership.	13
		The practice creates ownership among the target population and several stakeholders considering multidisciplinary, multi-/inter-sectorial, partnerships and alliances, if appropriate.	11
		The practice is supported by different information and communication technologies (e.g. medical record system, dedicated software supporting the implementation of screening, social media etc.).	10

		There was a defined policy to ensure acceptability of information technologies among users (professionals and target population) i.e., enable their involvement in the process of change.	8
Total must equal 100			100
Interaction with regular and relevant systems	9	The practice was integrated or fully interacting with the regular health, care and/or further relevant systems.	42
		The practice enables effective linkages across all relevant decision makers and stakeholders.	30
		The practice enhances and supports the target populations' ability to effectively interact with the regular, relevant systems*.	28
Total must equal 100			100
Education and training	11	Relevant professionals and experts are trained to support target population empowerment.	30
		Trainers/educators are qualified in terms of knowledge, techniques and approaches.	30
		Educational elements are included in the practice to promote the empowerment of the target population (e.g. strengthen their health literacy, self-management, stress management….etc.).	40
Total must equal 100			100
Target population empowerment	13	The practice actively promotes target population empowerment by using appropriate mechanisms (e.g. self-management support, shared decision making, education-information or value clarification, active participation in the planning process and in professional training).	50
		The practice considered all stakeholders' * needs in terms of enhancing/acquiring the right skills, knowledge and behaviour to promote target population empowerment (* target population, carers, health and care professionals, policy makers, etc.).	50
Total must equal 100			100
Evaluation	13	Evaluation took into account social and economic aspects from both target population and formal and informal caregivers perspectives.	18
		Evaluation outcomes were linked to the stated goals and objectives.	25
		Evaluation outcomes and monitoring were shared among relevant stakeholders.	26
		The evaluation outcomes were linked to action to foster continuous learning and/or improvement and/or to reshape the practice.	31

Total must equal 100			100
Sustainability and scalability	8	The sustainability strategy considered a range of contextual factors (e.g. Health and social policies, innovation, cultural trends and general economy, epidemiological trends).	28
		There is broad support for the practice amongst those who implemented it.	20
		The continuation of the practice has been ensured through institutional anchoring* and/or ownership by the relevant stakeholders or communities.	32
		Potential impact on the population targeted (if scaled up) is assessed.	20
Total:	100		100

4. DISCUSSION

There is a need for sound and reliable methods that allow the assessment and identification of best practices on chronic conditions and chronic care, particularly when the interest lays on knowledge exchange, transferability and implementation. The goal of this work was to develop a set of assessment criteria that could eventually be used with such a view; for that purpose, a formal European-wide consensus exercise was carried out using a modification of the well-known Delphi methodology[27]. The development of the assessment criteria involved three thematic and one overarching consensus panels, involving 100 experts from 23 European countries. The panels discussed a total of 245 criteria, and selected 145 for a sound and reliable assessment of practices in chronic conditions and chronic care.

The concept of "good" practice is subjective so that a fair judgment can just be made using specific assessment criteria. In the case of practices where multiple actors play a role, or practices come from multiple contexts and international benchmarking is pursued, the judgment should only be based on criteria agreed on the basis of formal consensus methodologies. This work shows the methods, instruments and results of an international consensus approach built on a Delphi-m methodology.

The first overarching observation of the results, demonstrated that all the four Delphi-m showed a fairly high level of agreement. Already in the first round of the Delphi most of the categories assessed by the experts were deemed relevant with a high level of concordance. So, in the case of the Delphi-m on Health *promotion and primary prevention practices of chronic conditions,* only in 11 of the 57 categories agreement was not reached and needed further assessment in the second online round; in the case of the Delphi-m *on organizational interventions focused on dealing with chronic patients with multiple conditions*, just 10 out of 61 categories showed disagreement; 18 out of 56 for the Delphi-m on *Patient's empowerment interventions with chronic conditions* had to be assessed in the second round; and, finally, in the Delphi-m on *Diabetes* 13 out of 71 categories were discordant.

It is of even greater interest that a fairly high degree of agreement across the different Delphi rounds -different domains and experts agreed on the criteria that should be used to assess a practice.

So, the exercise has shown some consistency in dimensions related to the "design of the practice" (i.e. structure and organization of a practice, target population, equity) among the highest prioritized in all Delphi.

There was also consistency about allocating the lowest scores to the criteria on “sustainability”. While the experts emphasized the need for more sustainability during the face to face meetings, they also recognised that sustainability is usually not at the centre of the implementation strategy and seems not to be under the control of implementers but at the highest system level. So, experts associated sustainability with budgetary restrictions and the economic situation rather.

Some consistency was also found with the criterion related to “ethical considerations” obtaining similar assessment. However, this was not the case in the Delphi-m on *organizational interventions focused on dealing with chronic patients with multiple conditions*. This lack of emphasis on ethics in this Delphi-m might be due to a too focused approach to policies and organization omitting that in a “good” management of patients with multiple chronic conditions, ethics matters. Care fragmentation for example, affects more to those more fragile, entails lack of responsiveness, fosters safety problems, and leads to unequal access to effective care[40].

With regard to “interactions with relevant systems” which attempts to effectively interact with the health care, social care and educational systems, Delphi-m highlighted its relevance except, interestingly, in the Delphi-m on *Health promotion and primary prevention practices.* This is a surprising finding since it is key in health promotion programs to engage a variety of stakeholders[41]. The difficulty of making this engagement possible could explain the lack of agreement, so that experts responded more to feasibility than to use this criterion as a priority in the assessment of a health promotion and primary prevention practice. Another explanation could go on the lines of the difficulty of getting short term results from that engagement; so, experts considered that this criterion, although relevant, could not provide comprehensive information.

Conversely, as expected, some criteria showed some specificity in some panels. So, “equity” was exclusive of the panel of health promotion and primary prevention; the availability of “resources” was of paramount relevance in the panel on organizational interventions; “leadership” was highlighted of much importance in the panel on patients’ empowerment; and, in diabetes, “education and training” were deemed a priority in the assessment.

Finally, the consistency between the results from the Delphi on Diabetes where, by design, criteria and categories from the other panel were enriched with specific exercise on quality indicators for diabetes, show that the final set of criteria (i.e. "design of the practice", "target population", "empowerment", "evaluation", "comprehensiveness", "education and training", "ethical issues", "governance", "interaction with regular systems" and "sustainability") are agnostic to the condition of analysis (i.e., diabetes) and could be universally applied to any other chronic condition.

Comparison to other research on assessment criteria

As mentioned in the background section much work has been done by international and national organizations when it comes to collecting and selecting "good or best" practices on chronic conditions and fragile patients. So, there are multiple assessment exercises across Europe aiming to identify practices on chronic conditions, and flag those “good”, to facilitate exchange and transferability to different contexts. Although there might be some differences in the type of methodology used to reach a consensus, what is observed is that they do not provide accurate information equally or support desired interpretations evenly. Indeed, this is observed in the table 28 where there is a comparison between JA CHRODIS criteria (using the overarching exercise on diabetes) and the other initiatives. It is worth noting though that the Design of the practice, the Evaluation, the Sustainability and the Scalability are criteria that seem to be essential components in good practices and should be in any case assessed.

Table 28: Comparison of assessment criteria among European initiatives

Initative	**Assessments criteria**									
JA-CHRODIS-Diabetes		**Comprehensiveness of the practice**	**Practice design**	**Ethical considerations**	**Governance**	**Interaction with regular and relevant systems**	**Education and training**	**Target population empowerment**	**Evaluation**	**Sustainability and scalability**
ICARE4EU	Patient-centeredness, Delivery system, Performance management, Quality of professional care, Inter-professional teamwork, roles and tasks, Commitment to integrated care and Room for innovation and change.	Performance management	Delivery system	Quality of professional care	Commitment to integrated care / Roles and Tasks		Interprofessional teamwork	Patient-centeredness		Room for innovation and change
EIP on AHA	Description of the practice (i.e design, target population, intervention etc), Transferability, Type of organisation and Viability criteria (i.e Time to deployment, investment, Evidence, Maturity, Impact, and Transferability).		Description of the practice			Type of organization			Impact	Transferability / Viability criteria
Scirocco	Readiness to Change, Structure & Governance, eHealth Services, Standardisation & Simplification, Funding, Removal of Inhibitors, Population Approach, Citizen Empowerment, Evaluation Methods, Breadth of Ambition, Innovation Management and Capacity Building.	Breadth of Ambition / Population approach	Removal of inhibitors		Readiness to Change / Structure & Governance	eHealth Services / Standardisation & Simplification	Innovation managment and Capacity Building	Citizen Empowerment	Evaluation Methods	Funding
European Joint Action on reducing alcohol related harm (RARHA)	Description of the intervention, Intervention is implemented in the real world/feasible/transferable (is accepted by the target group), The intervention has a theoretical base, and The intervention has been evaluated.		Description of the intervention						Evaluation	Implemented in the real world/feasible/transferable
EU Action Plan on Childhood Obesity	The intervention characteristics (impact on individuals and/or communities; SMART; target group); Implementation features (i.e Activities are using existing structures; target group is aimed to be empowered; and there is broad support for the intervention amongst the intended target populations) and Monitoring and evaluation (i.e outcome/impact evaluation showed significant contribution to the target behaviour).		The intervention characteristics		Implementation features			Target group	Monitoring and Evaluation	
JAMPA										
EU-Compass for Action on Mental Health	Information, Relevance, Theory-based, Intervention characteristics, Participation, Ethical aspects, Effectiveness and efficacy, Sustainability, Intersectoral collaboration, Transferability and Equity.		Relevance, Theory-based, intervention characteristics	Ethical aspects,		Intersectoral collaboration				Sustainability, Transferability and Equity/ Effectiveness and efficacy
Public Health Best Practice										
PINNSA	Adequacy, Relevance, Evaluation, Be based on the best scientific knowledge, Effectiveness, Transferability, Innovation, Efficiency, Sustainability, Equity, Gender equality, Participation, Interaction with care delivery system and Ethical aspects.		Be based on the best scientific knowledge	Ethical aspects		Interaction with care delivery system			Evaluation	Sustainability, transferability, innovation, efficiency
MACVIA-ARIA	CHRODIS on Health promotion and primary prevention: Comprehensiveness of the intervention, Description of the practice, Equity, Ethical considerations, Target population, Empowerment and participacion, Governance and project management, Evaluation, Sustainability, and Potential of scalability and transferability.	Comprehensiveness of the intervention	Description of the practice	Ethical considerations	Governance and project management			Target population, Empowerment and participacion,	Evaluation	Sustainability, and Potential of scalability and transferability.

Also worth noting that Scirocco is the initiative whose criteria are similar to those in JA CHRODIS. Scirocco initiative extended the viability criteria by an EIP on AHA’s B3 Action

Group on Integrated Care, focusing on maturity, developing a maturity model to assess practices. Scirocco as in JA-Chrodis, derived in an online self- assessment tool that includes 12 dimensions with an objective to understand the maturity requirements of the Good Practice for its adoption and scaling-up in integrated care across regions.

While Chrodis criteria tried to pick “excellent practices” strongly based on the methodological quality of the design and the evaluation and the completeness of the dimensions and the data collected, Scirocco sought examples of integrated care in everyday practice and innovations implemented successfully in care as usual services. These give extra importance to the relevance, the results and the feasibility of good practice in real life, not so much to the methodology used in the design and evaluation. The feasibility is demonstrated from a more pragmatic professional management rather than scientific point of view as opposite to Chrodis criteria.

The practices included in SCIROCCO are also not designed to meet (or at least not in general) the standards of excellence asked in CHRODIS. That means that when trying to fit SCIROCCO practices into the CHRODIS repository, there are many categories with no information provided. They are especially those designed to assess practice methodological levels of evidence, ethical, equity and participation and empowerment. Therefore, if CHRODIS JA criteria were considered as the gold standard tool, many of SCIROCCO practices would not be deemed as good practices. However, they could be of interest for potential recipient regions, which are facing the same challenges and problems as the original ones.

This analysis displays that the purpose of the repository of CHRODIS is different to both the EIP-AHA and the SCIROCCO ones, even if they all seek to find best practices and transfer them between different European regions. One would argue that they are compatible, as long as the differences in aims and methodology are clearly set from the beginning.

Limitations

Despite the fact that Delphi modified methodology has been proven appropriate to arrive at consensus when a variety of perspectives and profiles are needed to grasp all the angles of complex interventions, which is the case of dealing with chronic conditions and chronic care, Delphi-m is a semi-qualitative framework that has to be adapted to each case of study and whose results have to be interpreted in light of the potential biases, caveats and limitations[25]. The following ideas come through such reflections.

A common limitation on this kind of semi-qualitative technique is the lack of a conceptual map specific to the matter of analysis. The lack of a conceptual map may end up in partially describing the problem or domain of interest, then missing a part of the reality that one wants to analyse. So, in the design phase of a Delphi-m methodology all critical domains that describe the phenomenon of interest have to be included in the questionnaire submitted to the experts. In this work, an exhaustive search on the scientific publications and grey literature, as well as interviews with domain experts were carried out. The resulting work led to building a conceptual map for each of the domains. This conceptual map was then face-validated by domain experts. Moreover, during the first round the panellists were invited to include any other missing criteria or category that they deemed absent, so as to reduce the risk of building the consensus out of a biased conceptual map. The efforts in building a conceptual map validated by domain experts (ex-ante and once the questionnaire was built) and afterwards, while the first round was taking place reduces the risk of construct and conceptual validity of the questionnaires, and ensures that the questions properly represented the domain of interest for which panellists were asked for.

A second typical limitation of Delphi panels is the risk of gathering a biased representation of experts, so that the results yield a biased view of the matter of interest. In this work, where the modified version of the Delphi methodology entailed summoning experts to a face-to-face consensus meeting, managing discussions required a limited number of panellists. The smaller number of experts necessarily implied a risk of bias when interpreting the results. To mitigate this limitation, the Delphi team carefully selected the type of profiles relevant to each domain of interest (i.e., knowledge and experience in the field), paying specific attention to the gender perspective (i.e., as the gender perspective is relevant in chronicity and chronic care) , but also to the different contexts (i.e., health systems where the practices, interventions and policies under assessment will take place). In spite of the careful design of the panels, the actual development of the consensus exercise implies additional risks. For example the response rate becomes reduced over the rounds (see below) and in the face to face meeting, non-English native speakers might have prevented themselves from a full discussion of their actual positions, affecting for example on the relative weight of criteria and categories.

The usual decline in response rate over Delphi-m rounds, though expected, may ultimately affect the reliability of the results and subsequent interpretations. A special effort was made to mitigate this risk and maintain involvement until the process is completed[30] as some studies suggest that to maintain the rigour of this technique, a response rate of 70% is required [31]. So, reminders by email and phone were done, and some flexibility in the timeline was allowed, adapting the response period according to experts availability. In addition, the Delphi-m team was available for experts to contact if any questions arise about the process. Upon those comments, the first two rounds of the Delphi got a moderate to high response rate. Hence, the range of the response rate was between 77,1% (the lowest rate found in the first round for the Delphi on Health promotion and Primary prevention) to 100% (first round Delphi on Diabetes). Cautiously, whether non-participants' opinions could be essentially different to those in the attendees is unknown, but given the response rates observed it is unlikely to think that the dropouts could be the cause of a potential lack of representativeness in the results.

As a fourth caveat, consensus processes built on multiple profiles entail gathering several semantic fields that might lead to misunderstandings, both when responding to the questionnaires or along the face-to-face meetings discussion. To mitigate semantic barriers, questionnaires were face-validated for content but also on how the questions had been drafted down. In addition, in the face-to-face meetings the first two hours were devoted to clarify the wording of the criteria and categories to be discussed, and native speakers in the room were invited to nuance the texting when more clarity was needed.

Finally, this methodology holds the advantage of anonymity when experts' respond to the questionnaires. So, both the level of consensus on the relevance of the criteria to evaluate a practice and whether are high- or low-priority when assessing a practice is far from being affected by biases linked to social desirability or difficulties with the spoken language.

A different point is the development of the face-to-face meetings, where the aim was weighting the criteria and categories, where dominant opinions or language barriers might have an impact prevailing those opinions defended by those panellists with experience in this kind of groups[25]. Renouncing to the face to face meeting could ensure a lower influence of this potential bias; however, this third round was deemed necessary as the ultimate objective of the Delphi was to develop an assessment tool that required the criteria and categories be weighted with a view to rate practices.

To mitigate the effect of dominant opinions, social desirability and language barriers, the face-to-face meetings were designed and conducted to allow all panellists to participate evenly, having all the decisions written down live on a screen so as to make all the process transparent, mitigating the language barriers and allowing all panellists to modify decisions if needed, and if discrepancies persisted, an anonymous voting system was used.

Potential implications of having consensual assessment criteria

The rise of chronic conditions in Europe in terms of their associated burden (e.g., premature mortality, physical dysfunctioning), care needs (e.g., higher use of health services, need of linkage with long term care and social services) and increasing costs (e.g., care and societal costs) have raised awareness on the need of identifying good practices at any level (i.e., clinical, organizational, policy-oriented) exchange the knowledge they yield and transfer out for implementation in different contexts. This approach has been the motto of the European Partnership on Active and Healthy Aging, ICARE4U, SCIROCCO, or the CHRODIS Joint Action, among others. Some formal exercises have been deployed to help stakeholders to decide what practices are worth the exchange and transfer. However, none except CHRODIS JA have formalized a consensus process whose ultimate goal was the development of an assessment tool that could eventually rate practices as best, good and promising, but also highlight those elements where a practice stands out.

This formal rating exercise has also materialized in the CHRODIS Platform©[42] where decision-makers, caregivers, patients, and researchers across the EU can find and share the best knowledge on chronic conditions. Compared to other initiatives that evaluate practices in chronic conditions, among other practicalities, the CHRODIS Platform© facilitates that any practice meant to prevent or manage chronic conditions in Europe can be assessed and rated according to the high-profile international consensus criteria obtained through the Delphi-m process. When compared with other self-assessment tool initiatives, each practice's developer gets a peer-review assessment and beyond the rating, a report on the strengths and weaknesses, so as to inform ways for improvement. Finally, having a practice assessed and rated makes the potential of transferability increase in those with a higher score.

An immediate impact of this CHRODIS JA consensus exercise has been the use of CHORDIS criteria in the Public Health Best Practice "one-stop shop" portal of the European Commission[43] and the EU compass for action on Mental Health and Wellbeing] tool] [10].

Finally, some other initiatives are using the JA CHRODIS consensus exercise. So **MACVIA-ARIA** Sentinel Network (MASK) is one of the good practices of SUNFRAIL (a Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries) which evaluate good practices in chronic conditions (www.sunfrail.eu).

They assess the *Allergic Rhinitis and its Impact on Asthma* (ARIA) practice by using the 28 categories of JA-CHRODIS *Health promotion and primary prevention of chronic conditions* Delphi results (see table 8 for the categories used)[44].

Nevertheless, at the time of writing this work, it remains unclear to what extent the results generated will be applied by different countries or whether this will be a field for future research in implementation science. In any case, this is indeed the first European consensus process to develop a set of criteria to rate practices under a validated consensus framework that formally attempts to provide hands-on advice for policy makers to make appropriate choices when exchanging knowledge and transfer practices and policies on non-communicable diseases across member states.

5. CONCLUSIONES

En este trabajo se ha presentado la metodología y los resultados del desarrollo de un consenso internacional mediante técnica Delphi-modificada, cuyo objetivo era definir de forma consensuada criterios para la valoración de prácticas, intervenciones y políticas sanitarias orientados a la enfermedad crónica y sus cuidados. Como principales conclusiones de nuestro trabajo destacamos:

Con anterioridad al ejercicio de consenso presentado en esta tesis, las distintas iniciativas europeas adolecían de falta de una descripción más sistemática en la obtención de los criterios de evaluación y cómo se han priorizado unos criterios sobre otros, dificultando la interpretación y transferabilidad de los resultados obtenidos.

El uso de la metodología Delphi modificada ha permitido formalizar un consenso internacional sobre criterios de evaluación para valorar la bondad de una práctica, intervención o política sanitaria a la hora de obtener los resultados para la que fue diseñada.

La modificación RAND de la técnica propuesta ha permitido otorgar pesos a los distintos criterios de valoración, eventualmente facilitando una mejor comprensión de aquellas características que resultan más relevantes para la evaluación de la bondad de una práctica.

La credibilidad de los resultados obtenidos descansa no sólo en las cualidades intrínsecas a la técnica Delphi sino también en la participación de 100 expertos de disciplinas complementarias procedentes de 23 países europeos.

En los diferentes paneles de consenso, un denominador común a las mejores prácticas sería disponer de un buen diseño de la práctica, intervención o política, de un sistema para la evaluación de su implementación y consecuencias, y prever su sostenibilidad y su potencial de escalabilidad. De entre estas cuatro características, hubo acuerdo en el peso específico otorgado a cada una, siendo el más valorado disponer de un diseño apropiado.

Algunos elementos diferenciales entre los distintos paneles Delphi son: a) el criterio de equidad para valorar la bondad de una práctica fue solamente considerado en el panel de Promoción de la salud y Prevención Primaria; b) la disponibilidad de recursos e infraestructura fue considerado únicamente en el Delphi-m sobre Intervenciones organizacionales enfocadas en el tratamiento de pacientes crónicos con condiciones múltiples; c) Liderazgo, capacidad y comunicación resultó un criterio relevante solamente en el panel de Empoderamiento de los pacientes con condiciones crónicas; y, d) disponer de programa formativo y educativo fue exclusivamente considerado en el panel de Diabetes.

La congruencia de resultados entre los distintos paneles, validados en el caso de diabetes, usualmente considerada epítome de las condiciones clínicas crónicas, soporta la hipótesis de que los criterios de valoración acordados sean transferibles y aplicables a la evaluación de prácticas, intervenciones y políticas desarrolladas sobre otras condiciones crónicas.

En comparación con otras iniciativas europeas este ejercicio de consenso aporta además de un acuerdo sobre los criterios de evaluación, un consenso sobre el peso relativo de cada criterio y de las categorías que lo definen. Esta metodología ha permitido que los resultados del consenso (por tanto, los pesos específicos para cada criterio y categoría dentro de cada área de interés) pudiesen portarse a una Plataforma (CHRODIS Platform ©) online de evaluación e intercambio de prácticas valoradas, con una metodología confiables y reproducible.

Desde el punto de vista de su potencial utilización, la aproximación utilizada otorgando pesos a los criterios y categorías de evaluación permite sumarizar la bondad de las prácticas, intervenciones y políticas con un valor numérico por cada criterio y para el conjunto de la práctica, y eventualmente categorizarlas, por ejemplo, como prometedoras, buenas o excelentes. Este sistema de rating permite enfocar el debate sobre aquellas características de una práctica que resultan más (menos) relevantes en su potencial éxito así como facilitar su transferencia a otros contextos.

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The author of this work declares no conflicts of personal interests or loyalties that could reasonably be seen as requiring disclosing and managing in connection with this piece of work.

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FIGURES AND TABLES

1- FIGURES

Methodology

Results

2- TABLES

Methodology:

Results:

Delphi-m in Health Promotion and Primary Prevention of Chronic Conditions

First round

Second round

Table 5. Criteria and categories (no reached agreement in the first round) assessed as relevant for interventions' assessment obtained in the second round

Table 6. Criteria and categories (no reached agreement in the first round) discarded for interventions' assessment obtained in the second round

Table 7. Relevant criteria and categories for intervention's assessment ordered by their average priority scores

Face to Face meeting

Table 8. Final set of weighted criteria and categories recommended for evaluating Health Promotion and Primary interventions of Chronic Conditions

Delphi-m in Organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions

First round

Table 9. Relevant criteria and categories for interventions' assessment obtained from the first online round

Table 10. No consensus criteria and categories for interventions' assessment obtained in the first round

Second round

Table 11. Criteria and categories (no reached agreement in the first round) assessed as relevant for interventions' assessment obtained in the second round

Table 12: Criteria and categories (no reached agreement in the first round) discarded_for intervention's assessment in the second round

Table 13. Relevant criteria and categories for intervention's assessment ordered by their average priority scores obtained from the second round.

Face to Face meeting

Table 14. Final set of weighted criteria and categories recommended for evaluating organizational interventions focused on dealing with chronic patients with multiple conditions ranked by criteria weight.

Delphi-m in Patient's empowerment Interventions with chronic conditions

Table 27. Final set of weighted criteria and categories recommended for evaluating diabetes interventions.

Discussion:

Table 28: Comparison of assessment criteria among European initiatives

6. ANNEXES

Annex 1. List of Sources for all the Delphi-m

1. Delphi-m in Health Promotion and Primary Prevention of Chronic Conditions

1. Practice appraisal tools

- SUCCEED tool
- EQUIHP tool
- Assessment of Chronic Illness Care (ACIC): A Practical Tool to Measure Quality Improvement - MacColl Institute for Healthcare Innovation (USA)
- Patient assessment of chronic illness care (PACIC and PACIC plus)—MacColl Institute for Healthcare Innovation (USA)
- Quint-essenz: Swiss quality criteria for health promotion and prevention programmes www.quint-essenz.ch

2. Practice appraisal frameworks

- Canadian best practice portal http://cbpp-pcpe.phac-aspc.gc.ca/]
- Preventing and Managing Chronic Disease: Ontario's Framework
- Centers for Disease Control and Prevention (CDC): Program Evaluation in Public Health, steps and standards. http://thecommunityguide.org/toolbox/assess-and-evaluate.html

3. WHO Non Communicable Diseases (NCD) documents

- Global Status Report on Non Communicable Diseases (2010). https://apps.who.int/iris/bitstream/handle/10665/44579/9789240686458_eng.pdf;jsessionid=33653B889F0FA802A1C612AEFFC23F52?sequence=1
- Draft comprehensive global monitoring framework and targets for the prevention and control of NCD 2013. https://apps.who.int/iris/handle/10665/105633

4. Documents from Chrodis collaborators and associated partners:

National GP assessment frameworks: Bulgaria, Cyprus, Estonia, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Norway, Netherlands, Portugal, Spain and UK

5. Documents related to innovation

- WHO Innovative Care for Chronic Conditions: Building blocks for action 2012
- PAHO Innovative Care for Chronic conditions: Organizing and Delivering High Quality Care for Chronic Non communicable Diseases in the Americas 2013-Eng

- Excellent Innovation for Ageing a European guide for the Reference sites of the European Innovation Partnership on Active and Healthy Ageing

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6. Documents related to Scalability

- Scaling up: a framework and lessons for development effectiveness from literature and practice. Hartman and Linn. Wolfensohn Center for Development Working Paper 5, 2008

2. Delphi-m in Organizational interventions focused on dealing with chronic patients with multiple conditions

1. Practice appraisal tools

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- Patient assessment of chronic illness care (PACIC and PACIC plus)—MacColl Institute for Healthcare Innovation (USA)

- PACIC (http://www.improvingchroniccare.org/downloads/pacic_copy1.pdf) and PACIC PLUS (http://www.improvingchroniccare.org/downloads/pacicplus.pdf)

- Chronic disease management audit tools. A fact sheet for Primary Care Partnerships. Victoria Department of Health. Australia http://www.health.vic.gov.au/pch/downloads/factsheet02.pdf

- Organisational Skills Analysis Tool. Chronic disease Care (OSAT-CDC) by Gill & Willcox www.gillandwillcox.com.au

- Highly Adoptable Improvement Assessment and Discussion Guide. Canada. http://www.highlyadoptableqi.com/uploads/HAI_Guide.pdf

2. Practice appraisal frameworks

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- Oslo Manual guidelines for collecting and interpreting innovation data. Third edition. A joint publication of OECD and Eurostat. http://www.tubitak.gov.tr/tubitak_content_files/BTYPD/kilavuzlar/Oslo_Manual_Third_Edition.pdf

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3. Delphi-m in Patient's empowerment Interventions with chronic conditions

1. Practice appraisal tools

- SUCCEED tool

- EQUIHP tool
- A compilation of Good Practices Replicating and Tutoring Integrated Care for Chronic Diseases, Including Remote Monitoring at Regional Level http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/gp_b3.pdf#view=fit&pagemode=none
- Assessment of Chronic Illness Care (ACIC): A Practical Tool to Measure Quality Improvement - MacColl Institute for Healthcare Innovation (USA)
- Patient assessment of chronic illness care (PACIC and PACIC plus)—MacColl Institute for Healthcare Innovation (USA)
- CDC Program Performance and Evaluation Office (PPEO) – Program Evaluation Steps
- Quint-essenz: Swiss quality criteria for health promotion and prevention programmes www.quint-essenz.ch

2. Practice appraisal frameworks

- Expert Panel on effective ways of investing in Health (EXPH), Final report on Future EU Agenda on quality of health care with a special emphasis on patient safety, 9 October 2014. http://ec.europa.eu/health/expert_panel/opinions/docs/006_safety_quality_of_care_en.pdf
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- Empathy. Empowering patients in the management of chronic disease.
- Canadian best practice portal http://cbpp-pcpe.phac-aspc.gc.ca/]
- Preventing and Managing Chronic Disease: Ontario's Framework
- Centers for Disease Control and Prevention (CDC): Program Evaluation in Public Health, steps and standards. http://thecommunityguide.org/toolbox/assess-and-evaluate.html

3. World Health Organization (WHO) documents

- Coulter A, Parsons S and Askham J. Where are the patients in decision-making about their own care? World Health Organization and World Health Organization, on behalf of the European Observatory on Health Systems and Policies. (2008)

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- Draft comprehensive global monitoring framework and targets for the prevention and control of NCD 2013. https://apps.who.int/iris/handle/10665/105633

4. Documents from Chrodis collaborators and associated partners

National GP assessment frameworks: Bulgaria, Cyprus, Estonia, Germany, Greece, Iceland, Ireland, Italy, Lithuania, Norway, Netherlands, Portugal, Spain and UK

5. Documents related to innovation

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- WHO Innovative Care for Chronic Conditions: Building blocks for action 2012
- PAHO Innovative Care for Chronic conditions: Organizing and Delivering High Quality Care for Chronic Non communicable Diseases in the Americas 2013-Eng
- Excellent Innovation for Ageing a European guide for the Reference sites of the European Innovation Partnership on Active and Healthy Ageing
- Burguess J POSITION PAPER Innovation and efficiency in health care: does anyone really know what they mean? Health Systems (2012) 1, 7–12

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6. Documents related to scalability

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4. Delphi-m in Diabetes

1. Criteria and categories to assess good practices from the three previous Delphi

- INTERIM REPORT 1: Delphi-m Panel on interventions in the area of health promotion and primary prevention of chronic diseases [Access: http://www.chrodis.eu/wp-content/uploads/2015/12/Delphi-1-report_27-nov15_HPPP.pdf].

- INTERIM REPORT 2: Delphi-m Panel in the area of organizational interventions focused on dealing with chronic patients with multiple conditions [http://www.chrodis.eu/wp-content/uploads/2015/12/Delphi-2-report_multimorbid.pdf].

- INTERIM REPORT 3: Delphi-m Panel in the area of patient's empowerment interventions with chronic conditions (http://www.chrodis.eu/our-work/).

2. Documents from collaborators and associated partners on Diabetes

- Indicators on the quality of care for people with type 2 diabetes
- Quality indicators for health promotion interventions targeting people with type 2 diabetes
- Quality indicators for diabetes prevention programs in health-care targeted at people at high risk
- Quality indicators for education and health professionals training programs for people with type 2 diabetes

Annex 2. Delphi-m Questionnaires

1. Questionnaire for the Delphi-m on Health Promotion and Primary Prevention of Chronic Conditions

Criterion 1: **Length of experience threshold**

Q1: The intervention must have been implemented for a minimum length of time (n years) to be eligible for assessment as good practice

Criterion 2: Comprehensiveness of the intervention

Q2: The intervention is aligned with a comprehensive approach to health promotion

Q3: The intervention addresses several risk factors or determinants of health at the same time

Q4: The intervention is aligned with a policy plan at the local, national, institutional or international level

Criterion 3: Context and Determinants analysis / Evidence

Q5: Empirical data has been collected regarding the nature, size and distribution of the problem

Q6: A systematic review has been conducted to collect evidence on the determinants of health (i.e. Social and economic environment, Physical environment, target population and persons' individual characteristics and behaviours)

Q7: A comparison to existing alternatives has been carried out and includes economic analysis (e.g. cost effectiveness analysis, cost minimisation analysis, cost utility analysis)

Q8: A comparison to existing alternatives has been carried out and includes Health Impact Assessment (HIA)

Q9: There is an analysis of the budget impact of implementing the intervention (BIA)

Q10: Theoretical basis of the intervention are provided: description of the chain of causation

Q11: Theoretical basis of the intervention are provided: description of interactions between key stakeholders

Q12: Theoretical basis of the intervention are provided: description of interactions between processes

Criterion 4: Aims & Objectives

Q13: The concept includes a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed)

Criterion 5: Description of intervention strategies and methods of implementation

Q14: The design is theoretically justified and addresses the sequence, frequency, intensity, duration, recruitment method and location of the intervention

Q15: The method of the intervention is thoroughly described in concrete activities including time frame or chronograms

Criterion 6: Equity

Q16: Different dimensions of equity are taken into consideration and are targeted (i.e. gender, socioeconomic status, education level, ethnicity, rural-urban area, vulnerable groups)

Q17: Efforts are made to facilitate vulnerable group's access to relevant services ("low threshold" approach)

Criterion 7: Target population

Q18: Target population/s are defined on the basis of needs assessment

Q19: Specific characteristics and strengths of target population/s are documented

Q20: Methods used for selection of target population/s are documented

Q21: The intervention aims to create a health promoting environment through a "setting approach"

Q22: There is a communication strategy which includes intermediaries/multipliers addressing stakeholders that are of relevance to promote the use of /participation in the intervention (e.g. community doctors and local school teachers at the are made aware of the existence of a community counselling service)

Criterion 8: "Empowerment and Participation"

Q23: The intervention aims to support the target population(s) in an autonomy-developing process
Q24: The intervention has been designed in consultation with the target population
Q25: The intervention creates ownership among the target population and stakeholders
Q26: Strengths and resources of the target population are developed (salutogenetic approach)

Criterion 9: Multi-Stakeholder Approach

Q27: Different dimensions of a multi-stakeholder approach are taken into consideration (i.e multidisciplinary, multi-/ inter-sector, partnerships and alliances)

Criterion 10: Ethical Considerations

Q28: Analysis of conflict of interests among stakeholders and individuals involved

Q29: Potential burdens of the intervention for the target population are addressed

Q30: Benefits and burdens of the intervention are fairly balanced

Q31: The intervention is implemented equitably, following the principle of 'proportional universalism': universal provision with a scale and intensity that is proportional to needs

Q32: The intervention's objectives and strategy are transparent to all individuals and stakeholders involved

Criterion 11: "Adequacy, capacity and resources"

Q33: The concept includes an adequate estimation of the human resources, material, non-material and budget requirements

Q34: Sources of funding are specified in regards to stability and commitment

Criterion 12: Participation and structural commitment

Q35: Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities)

Q36: Human resource needs assessed, defined and in clear relation with committed tasks

Criterion 13: Evaluation

Q37: Defined evaluation framework assessing structure, process and outcome

Q38: Use of (validated) evaluation methods and/or tools

Q39: Information /monitoring systems are in place to deliver data aligned with evaluation and reporting needs

Q40: Regularity of monitoring reports

Q41: Evaluation results are linked to the stated goals and objectives at each stage of implementation process

Q42: The results of evaluation are linked to actions to reshape the implementation accordingly

Q43: The intervention is assessed for efficiency

Q44: The intervention is assessed for impact (i.e. health impact and in a broader sense, any consequences derived from the implementation of the intervention such as raising specific taboos among certain groups, unforeseen resistances in the implementation, etc.)

Criterion 14: Sustainability

Q45: There is broad support for the intervention amongst those who implement it

Q46: There is broad support for the intervention amongst the intended target populations

Q47: The continuation of the project is ensured through follow-up funding and human resources

Q48: The continuation of the project is ensured e.g. through ownership, structural continuity and/or institutional anchoring

Criterion 15: Scalability

Q49: Intervention scalability is assessed in terms of potential size of the population targeted if scaled up

Q50: Intervention scalability is assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators

Q51: Intervention scalability is assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring)

Q52: There are specific knowledge transfer strategies in place (evidence into practice)

Q53: There are systematic networking efforts to foster the exchange of information, mutual support and cooperation with other community resources

Criterion 16: Innovation

Q54: The intervention implements new ways of coordination for decision making involving key separate institutional and community instances/resources

Q55: The intervention implements new ways of funding coordination across key separate institutional and community instances/resources

Q56: The intervention implements new ways of coordination for information systems involving key separate institutional and community instances/resources

Q57: The intervention includes new (as yet un-trialled) ideas and approaches to resolve known problems

2. Questionnaire for the Delphi-m on Organizational Interventions focused on dealing with Chronic Patients with Multiple conditions

Drive 1: Defined intended effect

Q1: key elements of the intervention were clearly defined and related to the intended effect (based on strong theoretical basis, providing a clear understanding of the chain of causation and the interactions between processes)

Q2: The intervention was based on a clear assessment of needs of the population it will serve

Drive 2: **Theory grounds**

Q3: The intervention was aligned with the political agenda at the institutional, local, national or international level

Q4: The intervention included change management elements, identifying the necessary actions to remove legal, organisational, financial or skill barriers

Q5: The intervention was based on a clear understanding of the contextual factors that would affect the outcomes (i.e. characteristics of the health system, coverage, characteristics of the population, socioeconomic environment)

Q6: There had been an explicit process of public consultation and stakeholders' engagement prior to the implementation of the intervention, with clear procedures to foster collaboration

Q7: An explicit comparison to existing alternatives of intervention was carried out *(or accounted for if already existed*) including impact on different dimensions of health care such as quality and safety

Q8: An explicit comparison to existing alternatives of intervention was carried out *(or accounted for if already existed*) in terms of impact of different dimensions such as equity, solidarity and responsiveness

Q9: An economic evaluation comparing incremental cost-effectiveness of existing alternatives of intervention was carried out *(or accounted for if already existed*)

Drive 3: **Aims and objectives**

Q10: The intervention's aims and objectives were clearly specified and adjusted to the SMART rule (Specific/Measurable/Acceptable/Realistic/Time framed)

Q11: The aims and objectives of the intervention were related to a situation analysis and needs assessment

Drive 4: **Target group / population addressed**

Q12: Target groups were risk-stratified using evidence-based sound methodology and taking into account different dimensions (quality of life, frailty, clinical susceptibility, functional autonomy, mental health)

Q13: There was a detailed description of the estimated number and profile of the patients receiving the intervention

Q14: Instruments for patient needs' assessment were selected on the basis of an explicit review of the uptodate evidence

Q15: Clear protocols were developed to identify the individual patient needs and to determine eligibility for service and referral to/from other agencies

Q16: The intervention was sensitive to cultural beliefs and socioeconomic characteristics of the individuals

Drive 5: Intervention design

Q17: There is a detailed description of the location of the intervention, including the main characteristics of the area and population in which the intervention was implemented

Q18: The different professional disciplines and services that were involved in the intervention are clearly identified, with appropriate mechanisms of coordination among them

Q19: The intervention defined specific care pathways for patients based on their clinical assessment

Q20: Patients' care plans (including goal-setting) were discussed and agreed with the patients or their representatives

Q21: There was an individual supervision of the patient across the diagnostic and therapeutic processes (including the definition of the case-manager role)

Q22: Poly-pharmacy and patient adherence to treatments were specifically addressed in the design of the intervention

Q23: The intervention placed a specific role/function for caregivers, involving them in care support infrastructure for dependent patients

Q24: There was a defined plan for social marketing activities, including communication and reaching-out strategies, definition of material and messages targeting specific groups and other community and social actions (training materials, job aids,…)

Drive 6: Strategies and methods of implementation

Q25: All the processes involved in the intervention were clearly defined and mapped, with explicit milestones that allow for an adequate monitoring of the intervention

Q26: There was an explicit human resources policy, with a definition of professional roles involved, criteria for professional recruitment and training plans (including a clear definition of qualifications and skills)

Q27: There was a defined a strategy to align staff incentives and motivation with the intervention objectives

Q28: The intervention included a learning system to support reflective healthcare practice among professionals involved

Drive 7: Leadership

Q29: There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined

Drive 8: Stakeholders involvement and participation

Q30: There was explicit commitment and support among stakeholders involved in the intervention (e.g providers, patients, community, governing boards of the healthcare system,...)

Q31: The professionals involved in the intervention and/or the organisation team members supported individual's self-management (e.g. through patient education, patient activation and empowerment)

Q32: The intervention included a system to support patient engagement and self-management (bidirectional communication, assistance at home, counselling, integration in patient's community, monitoring, emergency care rapid response, telephone follow-up, etc.)

Drive 9: Interaction with regular care delivery structure and society network

Q33: Social care and healthcare were integrated into a functionally unified assistance network

Q34: The sharing and flow of information across all care providers (i.e. health and social services and different levels or instances within them) was shaped to facilitate transition and sufficient access to relevant information within the scope at any level

Q35: The intervention was integrated or fully interacting with the regular healthcare delivery system to avoid creation of self-contained parallel circuits functioning in the margins of established devices of care

Q36: The intervention fostered continuous engagement and coordination with different community resources (i.e. main town halls, social services, pharmacies and local associations)

Drive 10: Capacity and resources

Q37: Investment in human capital by means of training/education activities for healthcare providers, caregivers and patients was present

Q38: The workload (cognitive, physical, time) for the organization and the professionals involved had been previously estimated

Drive 11: Information systems

Q39: The intervention integrated different Information and Communication Technologies (e.g. accessible channels of communication, dedicated software,…)

Q40: The intervention included prescription support tools allowing communication among the healthcare professionals

Q41: There was an integrated system of patient clinical data that can be accessed and updated by professionals in real time across the various care levels

Q42: There existed a specific funding programme for the information systems (including management and clinical practice)

Q43: The best available evidence (guidelines, protocols, etc.) was easily available for health professionals

Q44: There existed a defined policy to ensure acceptability of information technologies among their users (professionals and patients), including involvement of end-users in the process of change

Drive 12: Evaluation framework and regularity

Q45: The intervention included a monitoring & evaluation system with a defined framework for assessment and a information system feeding defined indicators and standards of care

Q46: Evaluation activities followed clear milestones and were sustained along the intervention

Q47: The evaluation framework included a baseline multidisciplinary assessment for all the relevant outcomes (i.e. health problem, safety, clinical effectiveness).

Q48: Indicators took into account economic aspects (i.e. budgetary impacts, efficiency gains) as well as patient and caregivers perspectives.

Q49: The outcomes framework was shared among providers to foster collaboration and integration.

Q50: Outcomes assessment focused on health impact (i.e. mental, physical and social status or functioning, patient assessment, symptoms control and pain treatment, quality of life) and satisfaction with care experience.

Q51: The evaluation included healthcare utilisation and quality and safety improvements in the different levels involved in the intervention (e.g. hospital care, community care, primary care, specialists visits, pharmaceutical consumption or institutional long term care).

Drive 13: Assessment of coordination and organizational aspects

Q52: Rapid consultation and response devices were in place linked to the intervention monitoring (i.e. phone use when fast response is needed, use of a "call centre" as core enabling proactive problem solving and activation of resources).

Q53: The patient and main caregiver/family roles were strengthen in the intervention incorporating specific devices for psychological/emotional support

Drive 14: Relevance of assessment outcomes

Q54: Evaluation results were relevant and linked to the stated goals and objectives.

Q55: Evaluation results were linked to actions to reshape the implementation accordingly.

Q56: Outcomes assessment enabled outcome-based contracts (few, clear, concise and readily communicated indicators).

Drive 15: Sustainability

Q57: The continuation of the project was ensured through ownership and/or institutional anchoring, and there was enough support for the intervention amongst both those who implemented it and the target group.

Q58: The financial viability of the intervention was guaranteed in the long term (including a risk-adjusted funding scheme, identification of necessary resources and budget impact of the implementation, including all relevant costs and its distributions among stakeholders, partners, and the organisation.

Q59: The sustainability strategy considered a range of contextual factors (i.e. structural funds, resources from project partners, synergy with local industry and technology involving private and public sector and citizens).

Drive 16: Scalability and knowledge exchange

Q60: The Intervention potential for scalability was assessed in terms of prospective size of the population targeted, key factors, barriers and facilitators.

Q61: There were systematic networking efforts (i.e. knowledge exchange and learning networks, strategies of communication and dissemination, tailored diagnosis of scaling up possibilities) to foster the exchange of information, mutual support and cooperation with other community resources.

3. Questionnaire for the Delphi-m on Patient's empowerment interventions with chronic conditions

Criterion 1: Defined intended effect

Q1: Key elements of the intervention embraced patient-centred care seeking self-management improvement as stated effect.

Q2: Key elements of the intervention embraced patient-centred care seeking shared decision making as stated effect.

Q3: Key elements of the intervention embraced patient-centred care seeking education-knowledge as stated effect.

Q4: The objectives showed alignment with patient preferences and values

Q5: The objectives showed alignment with adopted guidelines, programmes and policies, and a relevant scope for expansion.

Criterion 2: Theory grounds of the intervention

Q6: The intervention was aligned with a comprehensive approach to patient's empowerment.

Q7: The practice follows a strategic framework, seeking to develop a systemic vision of the implications of empowering patients for the organization.

Q8: The intervention was based on the patient's and/or carer's specific values, preferences, beliefs, needs, capacities, circumstances and wishes.

Q9: The intervention was tailored to the health system organizational characteristics and socioeconomic environment.

Q10: There was a baseline assessment of the situation (including team and other stakeholders readiness to engage) used to better shape the intervention according to the established 'departing point'.

Q11: The intervention considered health professionals' needs in terms of enhancing/acquiring the right skills, knowledge and attitudes to foster patient empowerment (i.e. Self-management, shared decision making, education-knowledge and value concordance).

Q12: A comparison to existing alternatives of intervention was carried out including impact on different dimensions of patient empowerment (i.e. Self-management, shared decision making, education-knowledge and value concordance).

Q13: A comparison to existing alternatives of intervention was carried out including impact in terms of health care utilization (e.g. visits, hospitalizations, treatments, tests...)

Criterion 3: **Aims and objectives**

Q14: The concept included a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed).

Criterion 4: **Target group/population addressed**

Q15: All actors intervening in the care chain (patients, carers, professionals….) were identified and considered in the intervention.

Q16: The needs of the intervention's target group/s in the setting were adequately identified and considered (a comprehensive assessment of patients/users/professionals specificities has been carried out).

Q17: Methods used for selection of target population/were described, documented and suitable to their characteristics

Criterion 5: **Intervention design**

Q18: The design thoroughly described the methodology of intervention: recruitment, location, concrete activities and timeframe (sequence, frequency, duration).

Q19: The intervention was designed and implemented in consultation with the target population (patients, carers and professionals).

Q20: There was a clear description of the patients, carers and professionals' specific role and/or contribution at each point in the care chain.

Q21: Organisational structures supporting patient empowerment were clearly defined and described (i.e., responsibility assignments, flows of communication and work and accountabilities).

Q22: Patient and stakeholder participation/involvement was planned and programmed (activation, tracking systems, formal commitments, contracts or agreements regular mechanisms for communicating are established).

Q23: Community engagement was planned and organised to include relevant stakeholders from the local civil society (i.e., main town halls, NGOs, business, individuals….)

Criterion 6: **Leadership**

Q24: The institutional leadership was aligned with the scope of the implementation.

Q25: There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined.

Q26: The leader was a person of reference/"champion" for the involved stakeholders with experience, trajectory and connections to the relevant networks.

Criterion 7: **Multi-Stakeholder involvement**

Q27: The principal actors in each setting were involved in the planning and implementation of the project.

Q28: All the actors intervening in the care chain to empower patients were identified/ considered (health authorities, health administration, health professionals, communities….) and their support was secured.

Q29: Social support (in terms of gaining the support of stakeholders outside the health system) is arranged.

Criterion 8: **Adequacy, capacity and resources**

Q30: The project leaders and all others involved in the project were adequately qualified to accomplish their tasks.

Q31: The allocation of funding and resources were specified in regards to stability and commitment.

Q32: The provision of resources covers all the elements of the intervention (addressed to patients, professionals and carers) and justifies sufficiency for the described tasks.

Q33: Organisational structures were clearly defined and described (i.e responsibility assignments, flows of communication and work and accountabilities).

Criterion 9: **Information systems**

Q34: The information generated by the intervention was systematically registered and integrated within the regular circuits of health care information in place (electronic health record, patient file, clinical notes…).

Q35: The architecture of the information system allowed professionals and patients Personal Health Care Information access and management (including Health Care Record, patient file, and clinical notes, open health information, decision support for patients and professionals).

Q36: The intervention included tools and social networks allowing communication among different stakeholders (patients and professionals).

Criterion 10: **Interaction with care delivery system**

Q37: The intervention was inserted in the existing organization of care consistently over time.

Q38: The intervention addressed the patient's transition across different levels of care ensuring communication and cooperation between professionals, centres, programmes or services.

Q39: The intervention sought linkage and coordination between community services and health care delivery system to empower patients.

Criterion 11: **Ethical considerations**

Q40: Conflict of interests among stakeholders and individuals involved were analysed.

Q41: Rights on information access and right to refuse to be informed or treated were respected and enhanced.

Q42: The intervention's objectives and strategy were transparent to patients /carers involved and professionals.

Q43: Potential burdens, including harm of the intervention for patients were addressed.

Criterion 12: **Evaluation**

Q44: The evaluation process involved the engagement of stakeholders, including those participating in program operation, those served or affected by the program; and primary key users/participants.

Q45: There was a validated method and/or tools for regular evaluation in place for assessing the progress and/or impact of the implemented intervention on patient/user empowerment.

Q46: Information /monitoring systems were in place to regularly deliver data aligned with evaluation and reporting needs.

Q47: The evaluation framework included assessment of all relevant outcomes: quality of life, costs, service/system utilization, self-management, patient's experience, professional satisfaction, shared-decision making and education/knowledge.

Q48: The evaluation results were relevant and linked to the stated goals and objectives.

Q49: The results of evaluation were linked to actions to reshape the implementation accordingly.

Criterion 13: **Sustainability**

Q50: The continuation of the project was ensured through ownership and/or institutional anchoring.

Q51: The intervention promoted alliances, collaborative framework with other stakeholders.

Q52: The financial viability of the intervention was guaranteed in the long term.

Criterion 14: **Scalability**

Q53: There was an analysis of requirements for potential scalability such as adaptability and perceived challenges for healthcare organization/governance (trialability, stepwise introduction, technology support requirements…).

Q54: There was an analysis of requirements for potential scalability such as patient characteristics, (i.e. stage of disease/dependence of patients and, other characteristics of importance for the elements of patient empowerment i.e education-knowledge, shared decision-making and self-management).

Q55: There was an analysis of requirements for potential scalability such as patient's support i.e. community resources, patient networks.

Q56: There were specific knowledge transfer strategies in place (evidence into practice).

4. Questionnaire for the Delphi-m in Diabetes

Criterion 1: **Comprehensiveness of the intervention**

Q1: comprehensive assessment of relevant interventions was carried out (or accounted for if it already existed) (i.e. efficacy, cost-effectiveness, quality, safety, etc.)

Q2: The intervention is aligned with a policy plan implemented at the institutional, local, national and international level.

Q3: The intervention has a comprehensive approach to diabetes addressing relevant contextual indicators (i.e. prevalence of diabetes in the population, percentage of the population physically inactive, prevalence of overweight, obesity and abdominal obesity in population, prevalence of population following national recommendations on nutrition, etc.).

Q4: Risk-profiling protocol to identify levels of risk has been evaluated at national level (risk-stratification).

Q5: Validated risk assessment tools are available during the intervention to stratify patients by their individual risk profile.

Q6: The intervention placed a specific role/function for caregivers, involving them in care support infrastructure for patients when appropriate, and the patient agrees.

Criterion 2: Care intervention design

Q7: The design is appropriate and builds upon relevant data, theory, context, evidence, previous practice including pilot studies.

Q8: The design thoroughly describes the practice in terms of purpose, SMART objectives, methods (e.g., recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration).

Q9: There were a clear inclusion and exclusion criteria regarding program participation, including an estimated number and profile of the patients targeted by the intervention.

Q10: In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).

Q11: Target population is defined on the basis of needs assessment including strengths and other characteristics (e.g. motivation, readiness for change, awareness, interpersonal relationships and support, cultural/spiritual/religious and community involvement, etc.)

Q12: The intervention was designed to foster discussion and agreement with patients about their care plans (including goal-setting).

Q13: Follow up of mutually agreed care plans was specifically addressed in the design of the intervention.

Q14: Problems related to poly-pharmacy were taken into account.

Q15: Clinical pathways are defined for the intervention.

Q16: Structure and content of the intervention has been defined and established at individual level including specific targets and a follow-up plan.

Q17: The coverage of the program is explicitly declared (e.g. local, regional or national level).

Q18: A theoretical basis of the program exists and includes a description of the method, description of activities within a chain of causation and time frame, and a description of interactions between key stakeholders and processes.

Q19: The following elements of the program are described and theoretically justified in terms of frequency, intensity, duration, selection and recruitment method, location (setting).

Q20: There is a detailed description of care setting (location: in/out-patient, health care provider) or social environment (e.g. through group sessions).

Q21: All relevant stakeholders (patients, carers, professionals, community groups, statutory bodies, etc.) were considered and key stakeholders identified.

Q22: The intervention includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.

Criterion 3: Ethical considerations

Q23: The intervention is implemented equitably (i.e. proportional to needs).

Q24: The intervention's objectives and strategy are transparent to the target population and stakeholders involved.

Q25: Potential burdens of the intervention (i.e. psychosocial, affordability, accessibility, etc.) are addressed and the benefit -burden balance are fairly balanced.

Q26: Patients' and/or carers' rights to be informed, to decide about their care, participation and issues regarding confidentiality, were respected and enhanced.

Criterion 4: Governance and project management

Q27: There was a defined strategy to align staff incentives and motivation with the intervention objectives.

Q28: The intervention included organizational elements, identifying the necessary actions to remove legal, managerial, and financial or skill barriers.

Q29: The intervention integrated different information and communication technologies (e.g. accessible channels of communication, dedicated software etc).

Q30: Information technology systems supporting the implementation of screening are available to health care provider level.

Q31: The information generated by the intervention was systematically recorded and is accessible to professionals and patients, and where appropriate embedded in existing information systems.

Q32: There was a defined policy to ensure acceptability of information technologies among users (professionals and patients), to enable their involvement in the process of change.

Q33: The best available evidence (guidelines, protocols, etc.) was easily available for health professionals.

Q34: Organizational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).

Q35: Multidisciplinary approach for interventions is supported by the health care provider

Q36: Medical record system supports the intervention.

Q37: There is a clear description of the health care organizations (i.e. governmental body, insurer, primary care organizations, hospitals, etc.) and/or relevant stakeholders (i.e. patient's associations, diabetes specialized care associations, NGOs, etc.) who planned and initiated the intervention.

Q38: Training needs of the health professionals are assessed and taken into account in the development of the program/intervention.

Q39: There was a clear description of the patients, carers and professionals' specific role and their contribution was appropriately planned, supported and resourced.

Q40: There was an efficient leadership and clear commitment to the intervention from the participating organizations.

Q41: All team members involved had appropriate capacities, experience, training and support to accomplish their tasks.

Criterion 5: **Interaction with the health and care delivery system**

Q42: The intervention was integrated or fully interacting with the regular care delivery system.

Q43: In health promotion interventions for diabetes, health care providers collaborate with other stakeholders.

Q44: The intervention creates ownership among the target group and several stakeholders considering multidisciplinary, multi-/inter-sectorial, partnerships and alliances, if appropriate.

Q45: The intervention considers creating effective linkages with all relevant parts of the health and care system.

Q46: The intervention enhances and supports the patients and/or carers' ability to effectively interact with the health and care system.

Criterion 6: Education and training

Q47: Prevention strategies, adapted to different levels of risk, are included in the education of the health care professionals.

Q48: Educational and training programs are evidence-based and fully described in terms of content and format, considering individual needs and learning styles (e.g. description of didactical principles, scheduling and number of sessions, etc.)

Q49: Trainers/educators are adequately qualified in terms of knowledge, techniques and approaches they use.

Q50: An education program is in place to empower patients with diabetes to strengthen their health literacy, self-management, health promotion and prevention of diabetes complications, stress management…).

Criterion 7: Patient empowerment and participation

Q51: The intervention achieves meaningful participation of the target population (during design and implementation) developing its strengths, resources and autonomy (e.g. assets-based and/or salutogenic approach).

Q52: The intervention actively promotes patient empowerment by using appropriate mechanisms (e.g. self-management support, shared decision making, education-information or value clarification).

Q53: The intervention considered all stakeholders' * needs in terms of enhancing/acquiring the right skills, knowledge and behavior to promote patient empowerment (*patients, carers, health and care professionals, policy makers, etc.).

Q54: Organizational structures supporting patients' empowerment were clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).

Q55: Leadership of the intervention is effective in exhibiting commitment to patients' empowerment and is both credible and effective.

Q56: The professionals involved are trained and competent to support individual's self-management (e.g. through professional development programs to promote patient empowerment).

Criterion 8: Evaluation

Q57: There was a baseline multidisciplinary assessment for all the relevant outcomes and processes.

Q58: Evaluation took into account social and economic aspects from both patient and formal and informal caregiver's perspectives.

Q59: Evaluation outcomes were linked to the stated goals and objectives.

Q60: Evaluation outcomes were shared among stakeholders and linked to actions to foster continuous learning and improvement.

Q61: Outcomes assessment enabled performance-based contracts.

Q62: There is a defined and appropriate evaluation framework assessing structure, process and outcomes considering, e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome).

Q63: There is a defined monitoring process to assess the outcomes of the interventions (i.e. proportion of high-risk individuals achieving clinically significant changes in risk factors at 1 year follow-up, proportion of planned intervention visits completed over 1 year, proportion of persons with diabetes with parameters under/above a defined target; mortality rate from cardiovascular event, quality of life, etc.)

Criterion 9: Sustainability

Q64: The sustainability strategy considered a range of contextual factors (e.g. health and social policies, innovation, cultural trends and general economy).

Q65: There is broad support for the intervention amongst those who implement it.

Q66: There is broad support for the intervention amongst the intended target populations.

Q67: The continuation of the project has been ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities.

Q68: Human and financial resources for the long term future of the project have been identified and action has been taken to secure them.

Criterion 10: Scalability and Transferability

Q69: Potential impact on the population targeted (if scaled up) is assessed.

Q70: There is a specific knowledge transfer strategy in place (evidence into practice).

Q71: There is an analysis of requirements for potential scalability and transferability.

Annex 3: Cluster analysis of all the categories that compound the questionnaire for the Delphi-m on Diabetes

Criterion 1: Comprehensiveness of the intervention

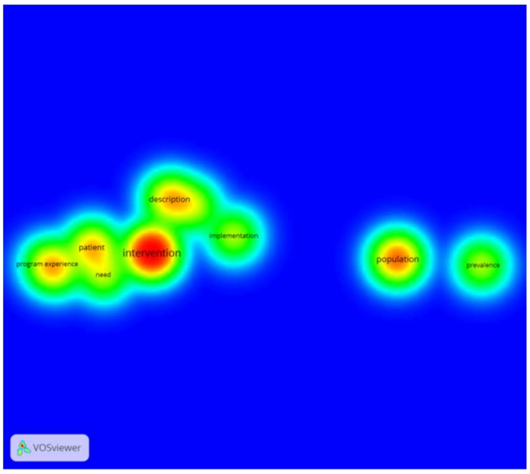
Network map

Before solving overlapping categories

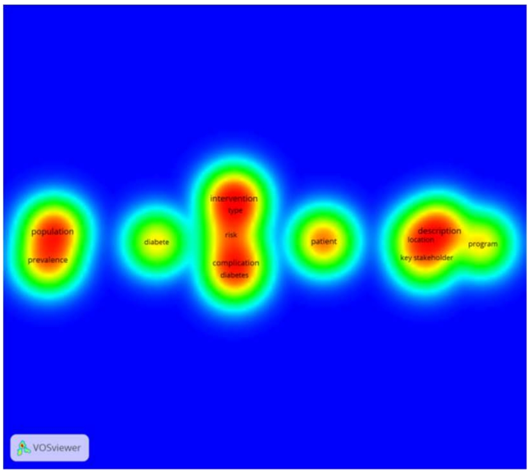
After solving overlapping categories

Heat map

Before solving overlapping categories



After solving overlapping categories



Criterion 2: Care intervention design

Network map

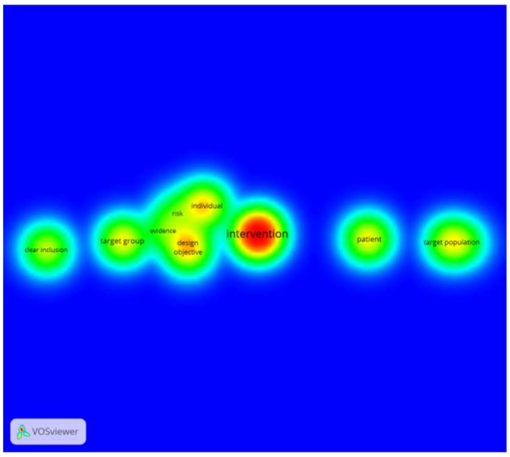
Before solving overlapping categories

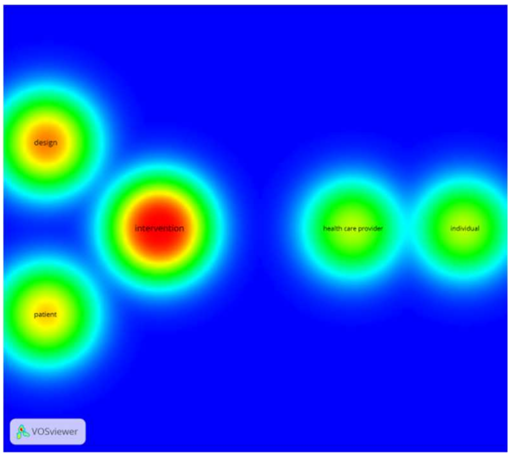
After solving overlapping categories

Heat map

Before solving overlapping categories

After solving overlapping categories



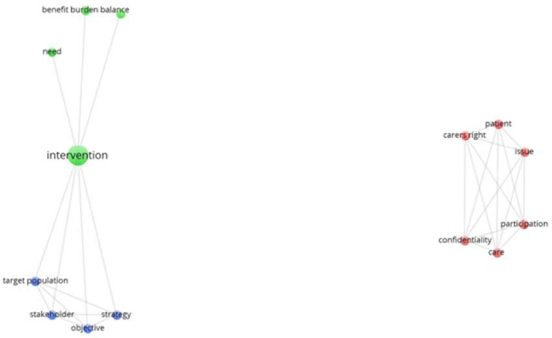


Criterion 3: Ethical considerations

Network map

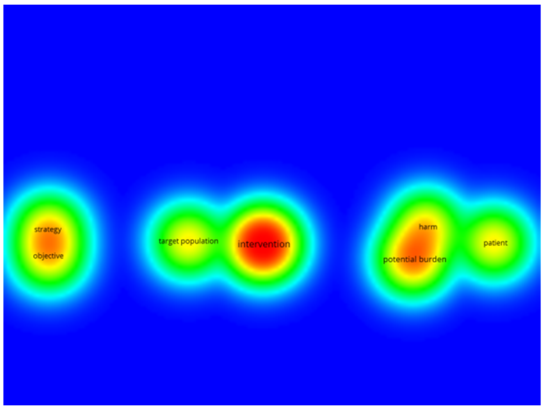
Before solving overlapping categories

After solving overlapping categories



Heat map

Before solving overlapping categories



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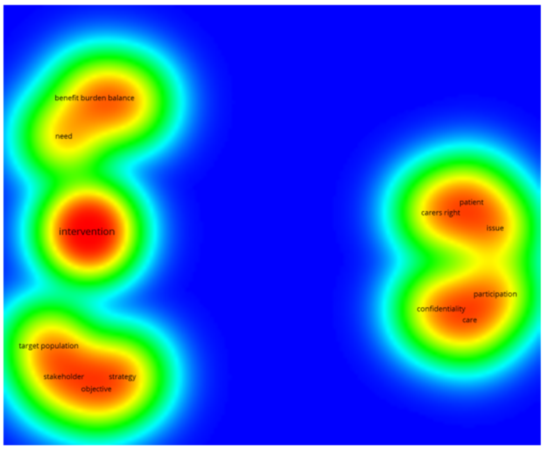
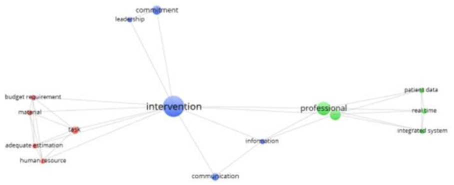


Criterion 4: Governance and project management

Network map

Before solving overlapping categories



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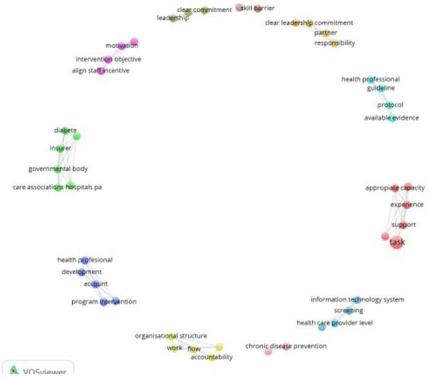

Heat map

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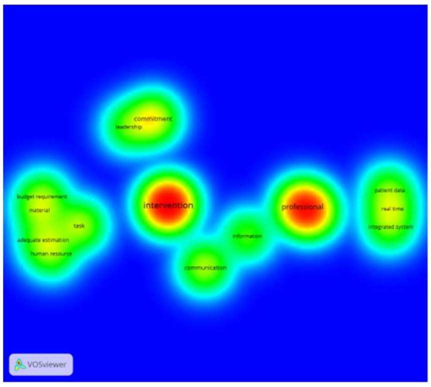

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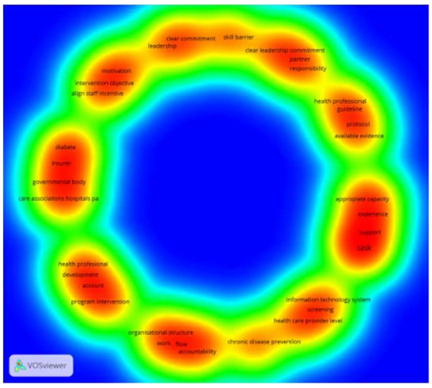
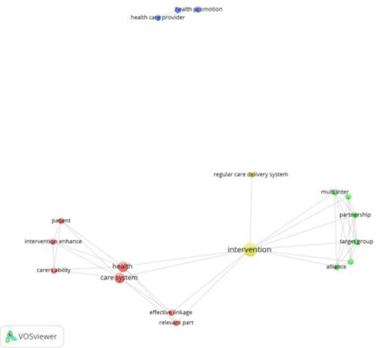


Criterion 5: Interaction with the health and care delivery system

Network map

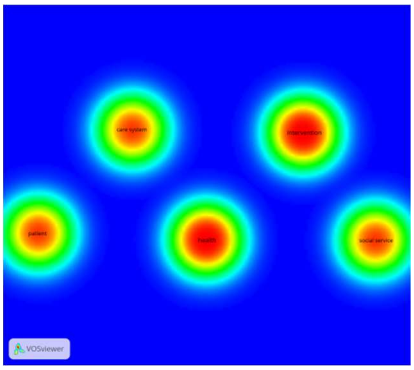
Before solving overlapping categories

After solving overlapping categories



Heat map

Before solving overlapping categories



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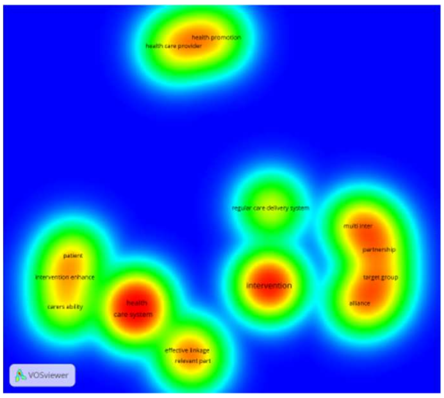
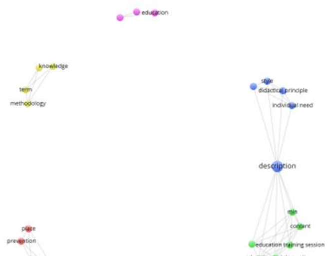


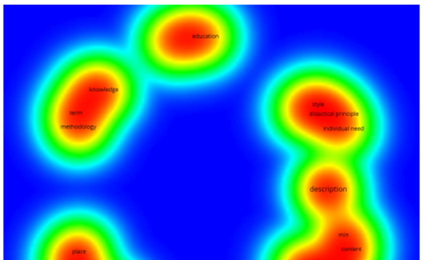
Criterion 6: Education and training

This criterion was unique to the Delphi-m on diabetes and it was constructed from the collection the diabetes quality indicators (http://chrodis.eu/wp-content/uploads/2017/02/wp7-deliverable-recommendations-final-draft.pdf).

Network map



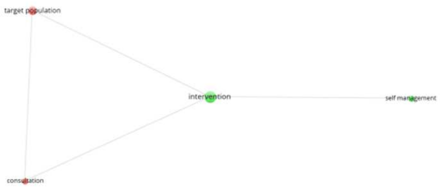
Heat map



Criterion 7: Patient empowerment and participation

Network map

Before solving overlapping categories



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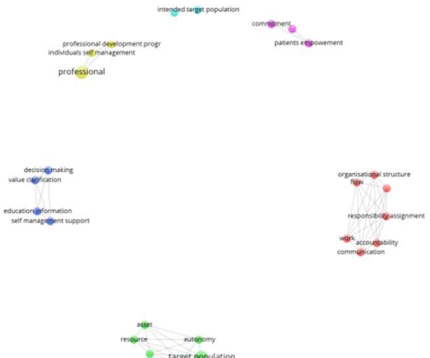

Heat map

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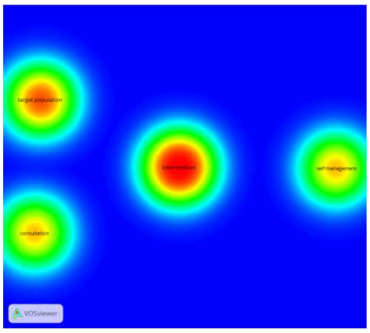

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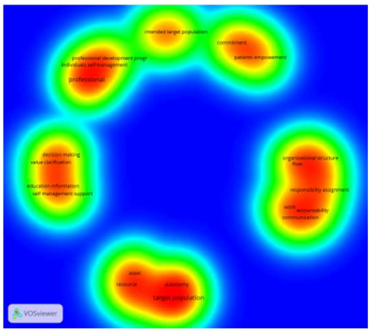
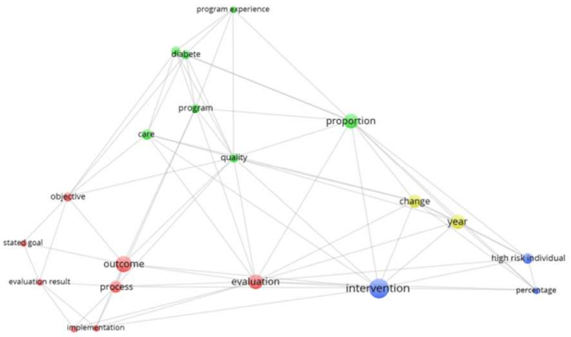


Criterion 8: Evaluation

Network map

Before solving overlapping categories



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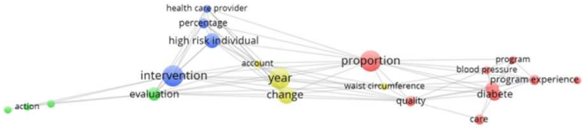
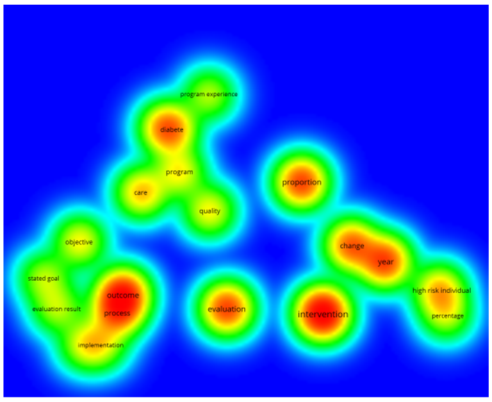


Heat map

Before solving overlapping categories



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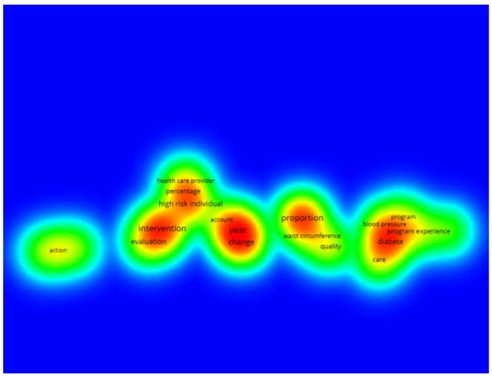


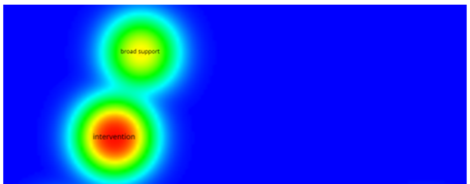
Criterion 9: Sustainability and Criterion 10: Scalability and transferability

These two criteria were considered jointly or separated depending on the questionnaire. Therefore, a semantic analysis was made by merging all both criterions to check whether they showed similar categories overlapping. After the analysis, it showed that the information loses were greater jointly than after splitting them up in two different criteria for the case of Diabetes.

Before solving overlapping categories

Network map

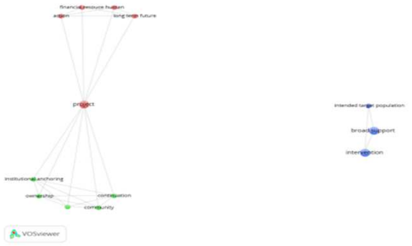
Heatmap



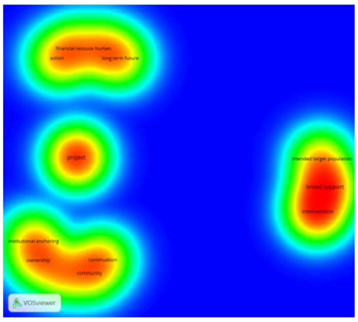
Criterion 9: Sustainability

After solving overlapping categories

Network map



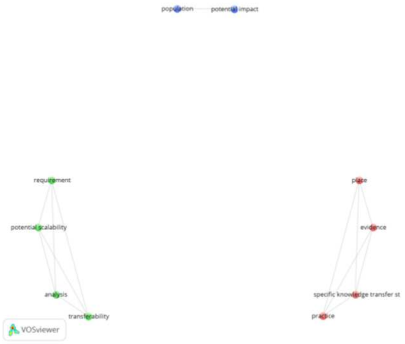
Heat map



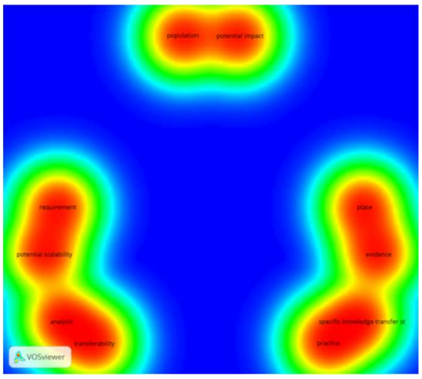
Criterion 10: Scalability and transferability

After solving overlapping categories

Network map



Heat map



Annex 4. Summary of Evidence

1. Delphi-m Health Promotion and Primary prevention of Chronic Conditions

1.1. Practice appraisal tools

DOCUMENT: SUCCEED. A quality Improvement Tool for HIV Prevention Projects

Summary

Succeed is a tool designed to help HIV prevention projects, assess their objectives, and analyse their ability to meet them with sound, high quality activities.

The SUCCEED tool allows project personnel, and important stakeholders, to review their own work and improve it while its implementation. Succeed is based on scientific research about success factors in the field of health promotion. It has been specifically adapted for its use in HIV prevention. It can be used to review existing interventions or a draft of a new one, using a straightforward questionnaire to capture critical data points about the quality of the project.

The questionnaire broadly addresses three widely-recognized work aspects on quality improvement: Structure, Process and Results. Each part has several sections in which one can choose the questions that apply to the project in order to be assessed. At the end of each section, you can develop and document your own recommendations and actions for improvement.

The SUCCEED tool has been conceived primarily as a self-diagnostic approach to quality improvement.

Contribution to CHRODIS GP assessment dimensions

Two new domains were added from this tool:

- Ethical implications of the project
- Sustainability of the project. (*This item will be stated from the result of the programme assessment)*

It also contributes to the reinforcement of the following “criteria”:

- Theory grounds (well specified and measurable main goal and sub-goals)
- Expected size of the effect
- Time Schedule
- Leadership (and responsibility)
- Key population and target population
- Community linkages
- Financing and sources of funding
- Participation and commitment
- Mapping of relevant stakeholders
- Impact of the implementation in current organization
- Specific knowledge transfer strategies planned or already in place
- Regularity of monitoring reports and consequences derived from assessment
- Evaluation framework assessing process and outcomes

Other comments

Although the SUCCEED tool has been specifically adapted for its use on HIV prevention programs implementation, it is usually considered as a good self-assessment framework for organizations with the intention of implementing broader promotion and prevention programs.

DOCUMENT: European Quality Instrument for Health Promotion (EQUIHP)

Summary

The EQUIHP has been developed as a European consensus tool, facilitating the assessment and improvement of quality in health promotion. It is based on the review of existing tools and European consensus. EQUIHP consists of two components: a Scoring Form (checklist) and a User manual (guideline).

The criteria are clustered into four topics, identifying the areas that are considered essential to achieve quality for effective health promotion: (I) the framework of health promotion principles, (II) aspects regarding project development and implementation, (III) aspects regarding project management, and (IV) sustainability. For each of these areas or 'clusters', a number of criteria have been formulated, as well as indicators to measure these criteria.

It is a tool for quality development and assurance of health promotion projects. It can be used throughout the process of planning, implementing and/or assessing a project.

The aim is to obtain more uniformity in quality indices and to facilitate cross-national comparisons and collaboration in enhancing quality in health promotion projects.

This approach embraces the principles of health promotion, including a positive and comprehensive approach to health, attention for the broad determinants of health, participation, empowerment, equity and equality.

Contribution to CHRODIS GP assessment dimensions

This document provided us with the theoretical framework (health promotion principles) used for structuring the general domains of analysis into a comprehensive map of areas and assessment criteria. Domains and subdomains of analysis were arranged to meet this working frame.

The 4 areas mentioned above, and most of the criteria configured in those 'clusters' were matched with the domains previously identified, positioning them into a broader context.

The final structure of the questionnaire includes:

I - Framework of health promotion principles

II - Project development & implementation

Analysis
Aims & objectives
Target group(s)
Intervention (strategies and methods) // Implementation strategy
Evaluation

III - Project management

Leadership
Capacity and resources
Participation & commitment
Dissemination // Knowledge transfer

Integration or interaction with the healthcare system

Community linkages // Networks
Ethical implications
IV- Sustainability

Participation & commitment

The ways in which various parties will be involved and committed to the project is clearly outlined. The following indicators will help you to determine the level of participation and commitment:

1. Has the way in which collaboration and synergy (networking) will be obtained been clearly specified?

2. Have the internal and external partners been identified who are required for adequate support and commitment at each stage of the project?

3. Will working methods be used that take into account the different perspectives and contributions of different partners?

4. Is the participation foreseen in the organisation of the project (e.g., steering/advisory committee)?

5. Have the potential opponents and obstacles of the project been identified?

6. Will participation of internal and external partners be formalised via agreements?

Other comments

The user manual includes a Glossary of terms as an annex which we used to complement our own glossary of terms.

Besides, as a part of the Scoring Form (checklist), we found the scale used to evaluate each indicator as ‘achieved’, ‘partially achieved’ and ‘not achieved’, appealing.

a) International experiences

DOCUMENT: Assessment of Chronic Illness Care (ACIC): A Practical Tool to Measure Quality Improvement - MacColl Institute for Healthcare Innovation (USA)

Summary

The content of the ACIC was derived from specific evidence-based interventions for the six components of the Chronic Care Model (community resources, health organization, self-management support, delivery system design, decision support and clinical information systems). Like the Chronic Care Model, the ACIC addresses the basic elements for improving chronic illness care at the community, organization, practice and patient level.

The ACIC provides subscale scores corresponding to each of the Chronic Care Model elements, as well as an overall score.

Contribution to CHRODIS GP assessment dimensions

From this tool, new domains or specifications have been added:

Community linkage between the health delivery system (or providers) and the Community (Linking Patients to Outside Resources, Partnerships with Community Organizations
Self-Management Support. Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.
Patient’s participation in the programme and to consider their empowerment as a final aim of the programme
The need of evidence based resources available for professionals and patient’s
Assessment and Documentation of Self-Management Needs and Activities
Self-Management Support
Addressing Concerns of Patients and Families
Effective Behaviour Change Interventions and Peer Support
Decision Support: Informing Patients about Evidence based Guidelines
Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care: appointment system, follow up, Planned Visits for Chronic Illness Care, continuity of care.

DOCUMENT: PACIC-tool: Patient assessment of chronic illness care. (PACIC-tool PLUS)

Synthesis

PACIC survey is a patient-centered instrument for evaluating the quality and patient-centeredness of chronic illness care received according to the Chronic Care Model paradigm.

In defining six aims for transforming healthcare in America, the Institute of Medicine Quality Chasm Report declared "patient centeredness" a central feature of quality, along with safety, promptness, effectiveness, efficiency and equity. Patient centeredness may be a first principle that can provide a lens to focus action, and as such can be used as the guide for achieving all six aims.

Historically, patient centeredness has been regarded as the assessment of needs and preferences to consider social and cultural factors affecting the clinical encounter or compliance with treatment. There is a growing consensus that patients have a more active role to play in defining and reforming healthcare, particularly in chronic disease management, where patients provide the majority of care in day-to-day management of their illness.

The revised documents correspond to the 20- and the 26-item version of the PACIC. They measure specific actions or qualities of care, congruent with the CCM, that patient's report they have experienced in the delivery system. The survey should be sufficiently brief to use in many settings. When paired with the ACIC, these tools can provide complementary consumer and provider assessments of important aspects of care for chronic illness patients.

Available from the Improving Chronic Illness Care webpage through the following link: http://www.improvingchroniccare.org/downloads/pacic.pdf

Contribution

Patient Activation (items 1-3)

- Empowerment (governance participation, social involvement, etc.)
- Self-management
- Quality of life

Delivery System Design/Decision Support (items 4-6)

- Bidirectional Communication
- Assistance at home (primary care, palliative care)

Goal Setting (items 7-11)

- Planification of care takes patient's plans into account

Problem-solving/Contextual Counselling (items 12-15)

- Education
- Integration in the patients community (NGO, support groups)
- Counselling (decision support (tools and personal assistance)

Follow-up/Coordination (items 16-20)

- Multidisciplinary, across levels coordination
- Monitoring, emergency care rapid response
- Telephone follow-up after contact with the healthcare system

Other comments

DOCUMENT: Quint-essenz: Swiss quality criteria for health promotion and prevention programmes www.quint-essenz.ch

Summary

Quality system Quint-essenz (www.quint-essenz.ch) has been funded and developed by Health Promotion Switzerland. Part of their work has been developing set of criteria for systematic project quality assessment, specifically for intervention projects in health promotion and prevention. It has been developed in partnership with scientist and practitioners.

Its objectives are:

- To systematically reflect and evaluate intervention projects during their different phases.
- To identify strengths and potential for improvement.
- To determine priority areas where improvement in the project is necessary.
- To set goals for quality and to define measures for improvement

The core of the system constitutes 24 quality criteria that are corroborated in terms of indicators which identify strengths and weaknesses, determine priority areas and define measures for improvement and make project's qualities visible.

An initial assessment is needed to determine which criteria and indicators are the most relevant for a project a t a specific point in time (project design, implementation or valorisation). To asses each phase-specific indicator on a scale from minus to maximum.

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following "criteria":

- Equity approach: considerations of gender, social status, cultural and linguistic diversity. Quint essenz includes this criteria in project design, implementation and evaluation
- Target population empowerment: reinforcing individual resources
- Participation and commitment of stakeholders and/or target groups:
  - The principal actors in each setting are involved in the planning and implementation of the project.
  - The project's structure is adequate and comprehensible for all concerned.
  - The project leaders and all others involved in the project are adequately qualified to accomplish their tasks.
- Evidence of the health problem addressed and need of the programme
- Practice shows alignment with broader health programme or national strategies.
- Contextual conditions as part of the systematic analysis of the health problem addressed.
- Potential for conflicts of interest in the project environment
- Project's objectives state clearly the desired effect on the various target groups
- Intervention strategies and methods:
  - Justification for proposed procedures
  - Time Schedule
  - Availability of necessary resources

- All the resources needed for the programme are in the budget

- Community linkages/Network: The project is making the most of possible networking opportunities in order to achieve its objectives.
- Evaluation:
  - The project is managed by periodical target-performance comparisons.
  - The evaluation contributes to the best possible management of the project and allows a conclusive assessment of the project.
  - The project's objectives have been reviewed and they have been attained.
- Dissemination, scaling up and knowledge transfer:
  - All the important aspects of the project have been documented in a comprehensible manner.
  - Sustainability: The project aims at long-term changes.
  - Results and experiences from the project are disseminated and made available in a purposeful manner.

Other comments

map of dimensions these criteria have not been considered:

- Attribution of indicators to specific project phases: Project Design (PD), Implementation (IM), Valorisation (VA).
- The communication processes within the project structure are adequate. The project management and the team are motivated to work in the best possible way.

1.2. Practice appraisal frameworks

DOCUMENT: Canadian best practice portal (http://cbpp-pcpe.phac-aspc.gc.ca/)

Summary

The Canadian Best Practices portal was originally launched in 2006 and supported by the Centre for Chronic Disease Prevention (CCDP) within the Public Health Agency of Canada. The portal includes a searchable list of Best Practice Interventions relevant to chronic disease prevention and health promotion.

The aim of the Best Practices Intervention Section is to provide decision-makers with access to published information about proven best practices.

The Best Practice Interventions include interventions, programs/services, strategies, or policies which have demonstrated desired changes through the use of appropriate well documented research or evaluation methodologies and have the ability to be replicated and the potential to be adapted and transferred.

For the practice to be included in the portal and be considered a Best Practice must satisfy five required criteria:

- The Type of intervention is appropriate
- Evaluation of the intervention
- Impact
- Replicability and adaptability
- Source

Contribution to CHRODIS GP assessment dimensions

Reinforcement of the following “criteria”:

- Ethical implications
  - Interventions must have been developed free of commercial interests that may compromise integrity
- Analysis: the practice is based on a systematic analysis of the health problem and its determinants
  - Addresses health determinants
  - Focuses on a population health
- Evaluation framework assessing process and outcomes

Other comments

DOCUMENT: Preventing and Managing Chronic Disease: Ontario’s Framework

Contribution to CHRODIS GP assessment dimensions

Productive interactions and relationships
Informed, activated individuals & families
Activated communities & prepared, proactive community partners
Self-management Supports
Clients are part of care team and engaged in shared decision making
Individuals empowered to be self-managers
Self-management support services organized for clients
Shared clinical guidelines
Follow-up
Innovative Patient Interactions : regular group-classes (vs 15 min. visits)
Telephone contact has been found to be effective, and is low-cost

Managing and preventing chronic disease successfully requires regular, ongoing contact with clients

Care Planning, Care Paths and Care Management:

Periodic planned visits between clients and their care team that focus solely on clients' chronic conditions, have been found to improve health outcomes and reduce the number of specialty and acute care visits.

Patient-centred care plan tailored to the client's specific needs, capacities, circumstances and wishes.

Enhanced Health Promotion and Prevention

Outreach, Population Needs-Based Care and Cultural Sensitivity : culture and Social Determinants of Health

Sharing access to Electronic Medical Records with clients has also been shown to increase clients' ability to self-manage chronic conditions and take charge of their health.

Public Participation Strengthening community action also involves mobilizing individuals and families to participate in organized community action.

Enhancing Local knowledge, Skills and Resources

Other Comments

DOCUMENT: Centers for Disease Control and Prevention (CDC): Program Evaluation in Public Health, steps and standards.

http://thecommunityguide.org/toolbox/assess-and-evaluate.html

Summary

This CDC evaluation framework gives public health professionals a starting point for evaluating public health programs. The evaluation includes six ordered steps that can be used as a starting point to tailor an evaluation for a particular public health effort, at a particular point in time. In general, the earlier steps provide the foundation for subsequent progress.

1. Engage stakeholders, including those involved in program operation; those served or affected by the program; and primary key users of the evaluation.
2. Describe the program, including the need, expected effects, activities, resources, stage, context and logic model.
3. Focus the evaluation design to assess the issues of greatest concern to stakeholders while using time and resources as efficiently as possible. Considering the purpose, users, uses, questions, methods and agreements.
4. Gather credible evidence to strengthen evaluation judgements and the recommendations that follow. These aspects of evidence gathering typically affect perceptions of credibility: indicators, sources, quality, quantity and logistics.
5. Justify conclusions by linking them to the evidence gathered and judging them against agreed-upon values or standards set by the stakeholders. Justify conclusions on the basis

of evidence using these five elements: standards, analysis/synthesis, interpretation, judgement and recommendations.

6. Ensure use and share lessons learned with these steps: design, preparation, feedback, follow-up and dissemination.

Attached to this, there is a document of evaluation standards (CDC), setting 30 standards assessing the quality of evaluation activities determining whether a set of evaluative activities are well-designed and working to their potential. These standards, adopted from the Joint Committee on Standards for Educational Evaluation, answer the question, "Will this evaluation be effective?"

The 30 standards are organized into the following four groups:

1. Utility standards, ensuring that an evaluation will serve the information needs of intended users.
2. Feasibility standards, ensuring that an evaluation will be realistic, prudent, diplomatic and frugal.
3. Proprietary standards, ensuring that an evaluation will be conducted legally, ethically and with due regard for the welfare of those involved in the evaluation, as well as those affected by its results.
4. Accuracy standards, ensuring that an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated.

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following “criteria”:

- Quality Management // Evaluation of the program (project):
  - Consulting insiders and outsiders
  - Taking special effort to promote the inclusion of less powerful groups or individuals
  - Coordinating and including stakeholder input throughout the evaluation design, operation and use
  - Identification of the purpose of evaluation (who and how the evaluation results are to be used)
- Intervention & Implementation strategy:
  - Characterizing the set of needs addressed
  - Listing specific expectations as goals with explicit criteria of success
  - Clarifying by an explicit logic model the relationships between program elements and expected changes
  - Assessing the program’s maturity or stage of development
  - Integration of the program (project) with other ongoing efforts
- Integrated action concept and networking: systematic networking to exchange information, mutual support and cooperation
- Quality management: framework to be tested on a regular basis for potential improvements:
  - Choosing indicators that meaningfully address evaluation questions

    - Description of practical methods for sampling, data collection, data analysis, interpretation and judgement
    - Existence of written protocols or agreements that summarize the evaluation procedures
    - Existence of clear roles and responsibilities for change management of the program (project) when critical circumstances change
    - Safeguarding the confidentiality of information and information sources
    - Using appropriate methods of analysis and synthesis to summarize findings
    - Interpreting the significance of results for deciding what the findings mean
    - Considering alternative ways to compare results with program objectives (comparison groups, past performances)
    - Recommending actions or decisions that are consistent with the conclusions and limiting conclusions to situations, time periods, persons, contexts, and purposes for which findings are applicable
- Dissemination and knowledge transfer:
    - Providing continuous feedback to stakeholders regarding interim findings, provisional interpretations and decisions to be made that might affect likelihood of use
    - Scheduling follow-up meetings with intended users to facilitate the transfer of evaluation conclusions into appropriate actions or decisions
    - Disseminating both the procedures used and the lessons learned from the evaluation to stakeholders, using tailored communication strategies that meet their particular needs

Other comments

gh there is framed into the context of a meta-evaluation of the assessment process; this document also includes a reference to a ‘Checklist for ensuring effective evaluation reports’ adapted from *Worthen BR, Sanders JR, Fitzpatrick JL. Program evaluation: alternative approaches and practical guidelines. 2nd ed. New York, NY: Addison, Wesley Logman, Inc. 1997*.

ecklist has been also reviewed in order to address in our evaluation model to some of those recommendations.

1.3 WHO Non Communicable Diseases (NCD) documents

DOCUMENT: Global Status Report on Non Communicable Diseases (2010)

https://apps.who.int/iris/bitstream/handle/10665/44579/9789240686458_eng.pdf;jsessionid=33653B889F0FA802A1C612AEFFC23F52?sequence=1

Summary

This report was prepared by the WHO Secretariat under Objective 6 of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs. It focuses on the current global status of NCDs and will be followed by another report to assess progress in 2013.

Contribution to CHRODIS GP assessment dimensions

Self-care programmes are seen as a vital form of prevention in those at high risk and in improving outcomes in people with NCDs. They have also been shown to reduce demand on health services and thereby cut costs of care (44). Self-care is defined by WHO as including "activities that individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness and restoring health". Techniques and approaches used in self-care programmes include the "patient as the expert" approach, nurse-led programmes, home self-monitoring techniques and programmes using new information technologies, such as mobile phones, computer networks, web-based tools and telemedicine. In general, self-care programmes aim to increase the interest and involvement of people in their own care, and by doing so, empower them to manage their condition. They use educational or self-management interventions to improve patients' management of their conditions. These interventions are designed to impart knowledge and skills to enable patients to participate in decision-making, to monitor and control the disease and to change behaviour. Published literature demonstrates that patient education for self-care can provide benefits in terms of knowledge, self-efficacy and health status (45). Although the amount of scientific c enquiry into the direct associations between increased health literacy and improved health outcomes on NCD-related health outcomes is scant, the impact of health education, an important component of self-care, is known (46), particularly in smoking cessation interventions directed towards individual smokers through individual and group counselling and mass education (47, 48). The effectiveness of individual patient education in the management of diabetes has also been reported to be positive (49) but it is not yet supported by quality evidence (50).

DOCUMENT: Draft comprehensive global monitoring framework and targets for the prevention and control of NCD 2013

https://apps.who.int/iris/handle/10665/105633

Summary

The review of this report did not add any additional information.

1.4 Documents from Chrodis collaborators and associated partners

DOCUMENT: WP5-Task 1. Questionnaire on "Good Practice in the Field of Health Promotion and Chronic Disease Prevention"

Summary

The objective of CHRODIS WP 5 (Objective Nº 2 in CHRODIS work programme) is to promote the exchange, scaling up, and transfers of highly promising, cost-effective and innovative health promotion and primary prevention practices.

In order to achieve this aim, WP5 developed the questionnaire on “Good practice in the field of health promotion and primary prevention” to get an overview of existing mechanisms and policies and to identify where good practice exists and where needs lie in the participating EU countries.

Responses to this questionnaire have constituted WP5 partners Country Reviews and describe how health promotion and primary prevention is currently being delivered in different countries and also set the stage to help partners identify promising practices being applied in their own countries.

Evidence extracted from the specific country responses are separately analysed in the following items

Contribution to CHRODIS GP assessment dimensions

From this questionnaire, a new domain have been added:

- Integration and/or interaction with Health delivery system and Community linkages Plus… Development or reinforcement of the following “criteria”:
- Estimated size of effect, effectiveness and economic analysis within section Analysis
- Dissemination, scaling up and knowledge transfer
- Equity approach in target population
- Definition of Integration and/or interaction with Health delivery system
- Capacity and resources: data collection systems, personal training, financing and Budget impact
- Leadership
- Evaluation

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Bulgaria

Summary

Bulgaria implemented a comprehensive national health strategy which entails different policies and guidelines in the field of CVD, stroke and Diabetes:

- National Program for Prevention of Chronic Non-communicable Diseases 2014-2020
- Better Healthcare Concept
- Health Strategy for Disadvantaged Ethnic Minorities
- National Strategy for Physical Education and Sports Development of Republic of Bulgaria 2012 - 2022
- National Strategy for Demographic Development in Republic of Bulgaria - update (2012-2030)
- National Strategy for Poverty Reduction and Social Inclusion Promotion 2020
- The National Strategy of the Republic of Bulgaria on Roma Integration (2012 - 2020)
- National Strategy for Long-term Care
- National Plan to Promote Active Aging among Elderly in Bulgaria (2012-2030)

The above-stated policies include monitoring and evaluation frameworks, timeframes for implementation and target indicators.

Health inequalities and the socio-economic gradient are addressed in the following policies - National Strategy for Poverty Reduction and Social Inclusion Promotion 2020 and National Strategy of the Republic of Bulgaria on Roma Integration (2012 - 2020).

The target group of older population (65 and over) is specifically addressed in the updated version of the National Strategy for Demographic Development in Republic of Bulgaria (2012-2030), National Plan to Promote Active Aging among Elderly (2012-2030), and National Strategy for Long-term Care.

Contribution to CHRODIS GP assessment dimensions

Criteria reflected in the Bulgarian health strategy:

- Comprehensiveness
    - Alignment with other strategies
- Aims & Objectives (Bulgaria's approach follows a clear structure
- Multi-stakeholder approach
- Empowerment (e.g. "enhancing the capacity of the community in the health field")
- Indicator "community linkage" ("Improving the network in support of health formed by local institutions, NGOs and individuals.")
- Equity approach (Commitments and strategies addressing health inequities and supporting socially vulnerable populations)

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Cyprus

Summary

Cyprus implemented a national health framework through the MoH which entails a strategic plan on Diabetes, currently under revision.

Policy development included the participation of stakeholders who were able to set specific goals and describe the mechanisms to facilitate the implementation of the strategy. These stakeholders are also responsible to implement the strategy.

Contribution to CHRODIS GP assessment dimensions

Criteria reflected by the Cypriotic approach:

- Comprehensiveness (e.g. through Health in all policies)
- Multi-Stakeholder Approach / Inter-sectoral work
- Equity
- Evidence / Context analysis

  Indicators:

    - Health Impact Assessment
    - Theoretical basis of the programme

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Estonia

Summary

Estonia has electronic database for health-promoting activities (Created by the National Institute for Health Development 2010) http://www.terviseinfo.ee/et/toeoevahendid/toovahendid/tervist-toetavate-tegevuste-andmebaas

(Before that electronic database Institute published annually a book with some of the selected best practices).

Prevention activities should be described by the target, location, and time. Activities can be searched by keyword or filter field.

All inserted activities are revised by health promotion specialist, to evaluate evidence base, and whether the action is justified by the need and methodology.

There is a need to develop special criteria to evaluate the “best practices” in that database. It has no proper assessment tool. At the moment there exists only a possibility to “like” the activities to signal either you like it or not.

Contribution to CHRODIS GP assessment dimensions

The following categories are applied in the database and included in the template (criteria/indicators in italic)

- Target group
    - Main target group
    - Main target group stratification
    - Main target age
    - Main target gender
    - Planned target area:
    - Actual presence of how many target persons
- Description
    - Objectives
- Methodology
- Evidence
- Evaluation of performance
- Reporting on results
- Final recommendation for the practice

- Budget and partners

Other comments

DOCUMENT: Questionnaire WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Germany

Summary

Information provided through Work Package 5 partner BZgA, Germany.

The cooperation network “Equity in Health” is a nation-wide strategy to tackle health inequities with a database for “Best Practice” Interventions as the core of the activities.

The presented concept follows the overarching aim to identify good practices in health promotion especially among socially disadvantaged and/or vulnerable groups.

Contribution to CHRODIS GP assessment dimensions

The following criteria have been taken into account:

- Target Group Orientation
- Innovation and Sustainability (this is a joint criteria in the German concept. The criteria were separately included in the template)
- Low Threshold
- Participation
- Empowerment
- Integrated Action Concept and Networking
- Documentation and Evaluation

Included but in different context:

- Concept and Statement of Purpose (dissolved within the dimension “Concept and Design -> Criteria Aims and Objectives”)
- Intermediary Concept (indicator of criteria “Scalability)
- Setting Approach (indicator under criteria “target group”)
- Quality Management (subsumed in “Evaluation”)
- Cost-Benefit Ratio (used as indicator, not a criteria on its own)

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Greece

Summary

There is no national mechanism or criteria to identify good practice and no good practice databases in Greece.

The Centre for Health Services Research at the University of Athens uses and advocates for the European Quality Instrument for Health Promotion (EQUIHP) - however it has not been adopted yet at a central level for the evaluation processes of the funded projects.

Contribution to CHRODIS GP assessment dimensions

See SoE on EQUIHP

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Iceland

Summary

Iceland implemented a national health strategy which is implemented through the development and provision of guidelines.

Icelands public health guidelines follows a life cycle perspective and provides guidelines and information on selected topics for different steps in the life cycle, e.g. healthy ageing.

Topics for public health practices for older people include

Health and wellbeing

- Alcohol and drug abuse and older people
- Mental health and older people
- Health of older people
- Exercise and older people
- Nutrition and older people
- Violence and the prevention of accidents and elderly people

- Dental care and older people
- Nursing and residential - numbers

In addition to domestic research and experiences, health promotion and primary prevention practice initiated by the health sector is usually based on guidance and recommendations published by e.g. WHO, EU and the Nordic council of ministers.

Contribution to CHRODIS GP assessment dimensions

The Public Health Fund of Iceland defines criteria for the funding of public health programmes (http://lydheilsusjodur.sidan.is/content/files/public/uthlutunarreglur.pdf – translation below through Google Translate).

Criteria which were included in the criteria template *(Criteria and Indicators in italic)*:

- Projects that are consistent with the policies and programs of the government in public health (*Alignment/Comprehensiveness)*.
- The value and importance of the project for public health (*Relevance*)
- Gender and residence distribution. (*Equity: Gender, Rural&urban*)
- Applications for funding for projects must be professionally processed and based on the results of research or equivalent professional data (*Evidence base*).
- Projects must have clear objectives and the projected results (*Aims and Objectives*).
- Provision of a manner in which performance will be assessed *(Evaluation, Effectiveness)*

Furthermore the following funding priorities of the City of Reykjavik prevention fund have been taken into account in the template:

(http://reykjavik.is/sites/default/files/2013_reglur_forvarnarsjods.pdf **)**

- Strengthening social capital in neighborhoods in the city *(Empowerment)*
- Systematic collaboration of residents, organizations and businesses for the benefit of preventive and social capital *(Scalability: Community linkages/Networks)*
- Projects that meet the goals set by the City Council, such as the prevention strategy goals of the City *(Concept and Design: Comprehensiveness)*

Other comments

Further funding criteria which were not included in the template because they are too specific for funding mechanisms rather than related to actual good practice identification:

- Applications must be accompanied by budget.
- Grants are generally awarded to companies, organizations and public authorities.
- Individuals are normally only awarded grants for research projects.
- normally does not exceed the amount allocated to the project by the local or institutions than their own contribution.
- If the applicant has previously received a grant for a project must be submitted for the final report, if continuing work involved shall be available for a progress report on implementation of the project.

- allowances are higher than 500.000kr. are normally paid in two installments and subsequent
- things only from progress reports and other requested data.
- Do supports the general management of institutions or organizations or to purchase furniture or other furnishings.
- No grants are given to conferences.
- No grants are given to projects that are profit applicant.
- Application and supporting documents should be sent within the period mentioned in the ad.
- Applications received after the scheduled deadline are not taken into consideration.

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Ireland

Summary

Ireland developed and implemented a comprehensive policy framework for health promotion and primary prevention which is aligned with the basic principles of the Ottawa charter.

Policies include

- Healthy Ireland (HI) framework
    - Tobacco control
    - Special Action Group on Obesity (SAGO)
    - Physical activity
- National strategies, e.g.
    - Building Healthier Hearts
    - Changing Cardiovascular Health
    - National positive ageing strategy

On the implementation level this entails approaches like

- The Health Promoting School Initiative
- The Health Promoting Health Services
- The Healthy Cities Project

Currently there is no systematic approach to collating and evaluating good practice on a national level in Ireland. However, in 2013/2014 the HSE undertook an auditing exercise to collect information on all ongoing projects directly funded by the HSE relevant to health promotion and disease prevention. It is intended that this audit will inform a more systematic approach to good practice review in Ireland in the future'.

Contribution to CHRODIS GP assessment dimensions

A special focus from the Irish partners was put on the Gender aspects in health care and health promotion.

Further basic principles and rules of action from the Irish approach considered in the template entail

- *Setting approach*
- *Indentifying and addressing the social determinants of health*
- *Equity*
    - *Gender*
- *Comprehensiveness*

Other comments

DOCUMENT

Questionnaire WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II-Italy

Summary

Information provided by ISS (Istituto Superiore di Sanita) and MINSAL (Ministrry of Health)

Good Practice Criteria provided through a proprietary evaluation framework “Pro.Sa”[1]

“Pro.sa” is grounded on the theories of evidence and best practices translation and exchange (knowledge translation and exchange), among different actors (practitioners on health promotion and prevention, stakeholders, decision makers). Through Pro.Sa database the project manager can submit his project to be evaluated as Good Practice. Two independent readers, properly trained in the use of the assessment tool and experts in the field of health promotion, read the project and give it a scaled score. The focus on good practices aims at:

- highlighting strength factors for the effectiveness of an intervention;
- promoting sustainability and transferability in other settings or contexts;
- building a professional network (community of practice) in the field of health promotion and prevention

Contribution to CHRODIS GP assessment dimensions

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[1] http://www.retepromozionesalute.it; http://www.guadagnaresalute.it/progetto/progettoProsa.asp

The following Good Practice criteria from ProSa were taken into account for the template (Criteria/Indicator):

1. Working group (multidisciplinary, multi-sector, including representatives of target groups) Multi-Stakeholder Approach
2. Equity in health
3. Empowerment
4. Involvement/Participation
5. Setting
6. Theoretical models and theories of design and behaviour change
7. Evidence of effectiveness and good practice examples
8. Context analysis
9. Determinants analysis
10. Resources, time and limits
11. Partnership and alliances
12. Objectives
13. Process evaluation
14. Interventions/activities description
15. Output and outcome evaluation
16. Sustainability
17. Communication
18. Documentation

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Lithuania

Summary

Lithuania follows a comprehensive policy approach in public health. The basic principles have been outlined in the Health System Law (1994), Lithuanian Health Programme (1998–2010) and the National Public Health Strategy (2006–2013). In 2002, the parliament adopted the Public Health Law and the Public Health Monitoring Law. Other relevant legal documents regulating public health service activities include the Law on Alcohol Control (1995), the Law on Tobacco Control (1995), the Law on Food (2000)

Implementation follows action plans as issued by the Ministry of Health through Ministerial orders, e.g.

- Action plan for healthy aging protection in Lithuania 2014-2023
- Action plan approval for reducing health inequalities in Lithuania 2014-2023
- Screening and prevention program funding approval for people attributable to high-risk cardiovascular diseases
- Procedure for the reimbursement of diabetes medicines

- Stroke control and prevention programme 2006-2008

The main national health policy in Lithuania is the “Resolution for Lithuanian health program approval 2014-2025”. It aims to achieve that the population is healthier and lives longer, improves population health and reduces health inequalities by 2025.

It entails the following purposes and tasks:

- To create a safer social environment, reduce health inequalities
    - To reduce poverty and unemployment
    - To reduce socio, economic population differentiation at country and community levels
- To create healthy occupational and living environment
    - To create safe and healthy working conditions, increase the safety of consumers
    - To create favorable conditions for leisure
    - To reduce road accidents and injuries
    - To reduce pollution of air, water, soil and noise
- Formation of healthy lifestyle and its culture
    - To reduce alcohol and tobacco use, prevent diversion of drug and psychotropic substances use and their accessibility
    - To promote habits of healthy nutrition
    - To develop habits of physical activity
- To ensure high quality and efficient health care needs of the population
    - To ensure the sustainability and quality of the health system by developing evidence-based health technologies
    - To develop the health infrastructure and improve the quality of healthcare, safety, accessibility and to patient-centered care
    - To improve maternal and child health
    - To strengthen chronic non-communicable diseases prevention and control
    - To develop Lithuanian electronic health system
    - To maintain the health care during the crisis and emergency situations

Contribution to CHRODIS GP assessment dimensions

Principles related to Good Practice criteria in the template:

- *Comprehensiveness*
    - *Alignment*
- *Context and determinants analysis*

- *Aims and Objectives*
- *Equity*
    - *Socioeconomic status*
    - *Education level*
    - *Vulnerable social groups*

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- the Netherlands

Summary

The RIVM (National Institute for Public Health and the Environment) Centre for Healthy Living (CGL) supports the delivery of efficient and effective local health promotion by clearly presenting available interventions, planning instruments, communication materials and links to relevant Dutch knowledge and support organizations on the portal Loketgezondleven.nl. This portal also presents information on the quality, effectiveness and feasibility of health promotion interventions.

Database with life style interventions

Organizations working in the field of health promotion interventions can request for including their intervention in de database with health promotion (lifestyle) interventions. Every organization with a grant for research or implementation of a lifestyle intervention needs to enter their intervention in the database of Loketgezondleven.nl.

Procedure for selecting best practices

To identify and select best practices, the Centre for Healthy Living developed an assessment system for interventions, i.e. the Dutch recognition system. The aim of the recognition system is to gain a better view into the quality and effectiveness of health promotion interventions and to increase the quality of professional practice in health promotion. Organizations are supported to submit an intervention using a standard submission form.

The registration desk of the Centre for Healthy Living checks the criteria for inclusion, the completeness and quality of the submitted forms provides and give initial feedback to improve the submission if necessary. They also check the relevance of the intervention. Then there are two types of assessment possible:

1. an assessment of the description of the objective, target group, approach and boundary conditions by professional practitioners or other experts from the sector concerned. This happens in the form of a peer review by practice panels. Based on this, interventions can receive the assessment **'Well Described'.**

2. an assessment of the theoretical basis and/or effectiveness of the intervention by an independent expert committee. Interventions that are assessed as good by the Recognition Committee receive a recognition **'Theoretically Sound' or 'Effective'** There are several subcommittees for different types of interventions, for example youth health care and health promotion for adults and elderly.

For both types of assessment, an evaluation for **Feasibility** is also possible, i.e. strong and weak features with respect to the feasibility of the interventions. Interventions that are assessed to be feasible are easy to adapt to another context.

Contribution to CHRODIS GP assessment dimensions

The Dutch system includes the following criteria (criteria/indicator in template)

- Manual of intervention available (Documentation)
- Process evaluation
- Two way assessment:
    - Description of the project / ‚well described'
    - Theoretical basis of the project
- Transferability (‚Feasability')
- Effectiveness
- Relevance

Other comments

Criteria not included in the template:

- Material for the next 2 years available
- Contact person

  too specific for the purpose of the template

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Norway

Summary

Norway developed and implemented a comprehensive policy framework with a Public Health Act from 2012 at its core.
The purpose of this act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental living conditions, and contribute to the prevention of mental and somatic illnesses, disorders and injuries. The act establishes a new foundation for

strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. It also provides a broad basis for the coordination of public health work across various sectors and actors and between authorities at local, regional and national level.

A dedicated Good Practice Database does not exist. However, basic criteria within the existing policy and implementation framework were identified and included in the Good Practice template.

Contribution to CHRODIS GP assessment dimensions

The following principles of the Norwegian approach were reflected in the criteria of the template:

- Comprehensiveness
    - Health in all policies
    - Alignment
- Equity
    - Gender
    - Socioeconomic status
- Multiple stakeholders
- Sustainable development
- Participation

Principles not reflected in criteria

Precautionary principle (“do no harm”)

Diametral to the purpose to identify good practice

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Portugal

Summary

Information in the questionnaire through Work Package 5 partners from Portugal:

- *Direcção - Geral de Saúde (DGS)*
- *Instituto Nacional de Saúde (INSA)*

Portugal implemented a national health plan, which is specified through nine national health programs and in particular for cardiovascular disease and stroke, a National Programme for Cardio-Cerebrovascular Diseases exists.

Criteria to identify good practices are used for the assignment of funding mechanisms.

Contribution to CHRODIS GP assessment dimensions

The following criteria have been taken into consideration:

- Project area facing health strategies and objectives (Alignment)
- Quality of methods proposed
- Post-funding sustainability of the project
- Potential for translation of the intervention or project
- Participative methodology with involvement of several stakeholders and or target groups
- Budget appropriateness in the face of expected work to be done and results

Other comments

Criteria not taken into consideration:

- Expected situation improvement in a before-after evaluation with adequate methodology

  Because: Lack of feasibility and applicability to health promotion programmes

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Spain

Summary

Information in the questionnaire provided by Spanish partners in WP 5:

- Consejería de Sanidad y Servicios Sociales, Comunidad Autónoma de Cantabria
- Consejería de Salud y Bienestar Social de la Junta de Andalucia
- Fundación Progreso y Salud
- Instituto de Salud Carlos III
- Ministerio de Sanidad, Servicios Sociales e Igualdad

Spain established a structured procedure to identify good practices across the National Health System (NHS). The procedure is embedded within different “Health Strategies of the NHS”.

The procedure entails inclusion criteria for programmes/practices:

- Adequacy (it covers the factors and issues considered in the Strategy)
- Relevance (its objectives correspond with the needs and characteristics of the population at which are aimed at or a regulatory rule)
- based on the best evidence available (efficacy proven)
- potential evaluation possible (registry systems in place)
- sustainability (being implemented for at least one year and funding in place).

Contribution to CHRODIS GP assessment dimensions

Prioritization criteria entailed in the approach include:

- Evaluation/ Effectiveness
- Efficiency: economic evaluation performed.
- Equity: it is evaluated the existence of an equity approach incorporated in the situation analysis and in the formulation of the different actions taking into account the different needs of population groups. Participation of the target population on different stages and intersectoral work are also considered here.
- Feasibility: it is suitable for transferability.
- Strategic adequacy: it is aligned with the main national and international strategies on the field.
- Comprehensiveness: it takes action on two or more risk factors/health determinants.
- Ethical issues: potential conflicts of interest of the different actors involved are being considered.

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- the United Kingdom

Summary

In the United Kingdom, health promotion and chronic diseases overarching policy development for the four constituent home countries (England, Scotland, Wales and Northern Ireland) takes place within the Departments (Ministries-equivalent) of Health for each country. As a result there are variations from home country to home country. Policies are initiated, developed and approved centrally, with input from regional and local health authorities/boards and from patient groups such as Diabetes UK and from clinicians and academics with an interest in the areas concerned.

Implementation is at a regional and local level. Recently, In England, local government has become involved with public health, including prevention of diseases. The delivery of prevention policies is made by clinicians, social workers and others.

PHE is therefore the national-level body setting the policy and strategic direction of public health and promotion, while, the delivery became a legal duty of local authorities in April 2013. Overall, public health is the duty of local authorities, while it used to be a combination of local health bodies and local authorities.

The UK developed an extensive range of clinical and best practice guidelines through the national body “NICE” on topics like

- Lifestyle and wellbeing[2]
- Diabetes and other endocrinal, nutritional and metabolic conditions[3]
- Cardiovascular conditions[4]
- Health inequalities[5]
- Value for money[6]

Contribution to CHRODIS GP assessment dimensions

The following principles of the UK’s system have been adopted for the template on Good Practice criteria:

- Comprehensiveness
    - Alignment
    - Several risk factors addressed at the same time
- Evaluation
- Cost effectiveness
- Risk assessment
- Multi-/Intersectoral approach
- Partnerships and alliances

- Equity
- Documentation
- Evidence base
    - Theoretical model
    - Health Impact Assessment
- Aims and Objectives
- Community linkage /Networks
- Sustainability

References

[2] https://www.nice.org.uk/GuidanceMenu/Lifestyle-and-wellbeingC
[3] https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions
[4] https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Cardiovascular-conditions
[5] https://www.nice.org.uk/advice/LGB4/chapter/introduction
[6] https://www.nice.org.uk/advice/LGB10B/chapter/introduction

1.5 Documents related to innovation

DOCUMENT: WHO Innovative Care for Chronic Conditions: Building blocks for action 2012

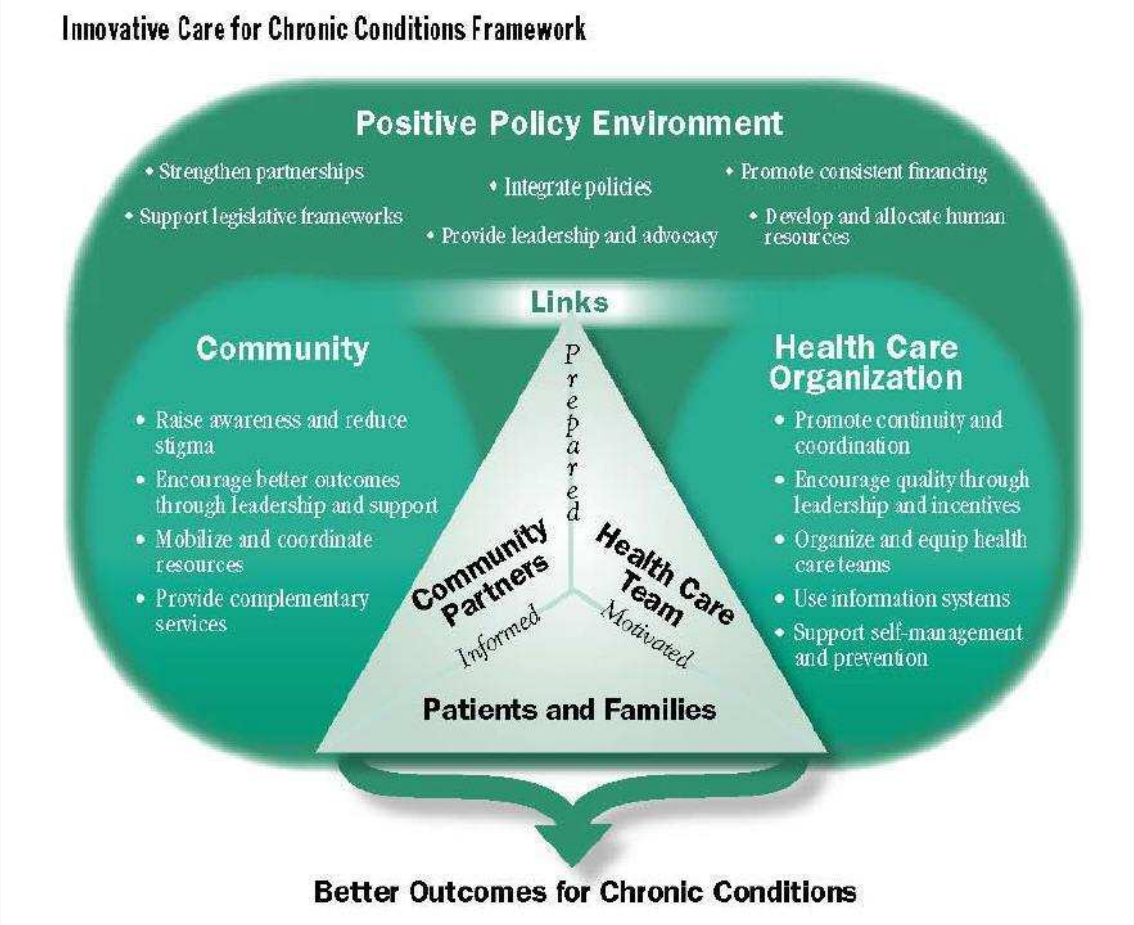
Summary

The World Health Organization created this document to alert decision-makers throughout the world about important changes in global health, and to present health care solutions for managing the rising burden. It establish the eight essential elements for taking action as:

1. Support a Paradigm Shift (from acute episodic model to chronic integrated care model)
2. Manage the Political Environment
3. Building Integrated Health Care
4. Align Sectorial Policies for Health
5. Use Health Care Personnel more Effectively
6. Centre Care on the Patient and Family
7. Support Patients in their Communities
8. Emphasize Prevention

This document describes the '*Innovative Care of Chronic Conditions Framework'* aimed to lead the pathway through innovative ways of addressing the chronic conditions care adapting health policies, systems and models.

It focuses on: Evidence-based decision making, population focus, prevention, quality, integration of care, flexibility and adaptability.



Contribution to CHRODIS GP assessment dimensions

This document provides us with a framework for innovative care for chronic conditions introducing or developing domains such as:

· Innovative Care

· Community Linkages

· Leadership and advocacy

· Self-management and prevention

· Sustainability

Other comments
The proposed framework was used to build up and organize the specific sub-domains included in the Innovation domain.

DOCUMENT: PAHO Innovative Care for Chronic conditions: Organizing and Delivering High Quality Care for Chronic Non communicable Diseases in the Americas 2013-Eng

Summary

The document concludes that the Chronic Care Model should be implemented in its entirety since its components have synergistic effects, where the whole is greater than the sum of the parts. Policy reforms and universal access to care are critical elements leading to better outcomes and reducing disparities in chronic disease care. It is critical to integrate PHC-based chronic care into existing services and programs. Chronic diseases should not be considered in isolation but rather as one part of the health status of the individual, who may be susceptible to many other health risks. A patient-centred care system benefits all patients, regardless of their health conditions or whether his/her condition is communicable or non-communicable. A care system based on the Chronic Care Model is better care for all, not only for those with chronic conditions.

Primary care has a central role to play as a coordination hub, but must be complemented by more specialized and intensive care settings, such as diagnostic labs, specialty care clinics, hospitals, and rehabilitation centres. Finally the ten recommendations for the improvement of quality of care for chronic conditions are:

1. Implement the Chronic Care Model in its entirety.
2. Ensure a patient centred approach.
3. Create (or review existing) multisector policies for CNCD management including universal access to care, aligning payment systems to support best practice.
4. Create (or improve existing) clinical information system including monitoring, evaluation and quality improvement strategies as integral parts of the health system.
5. Introduce systematic patient self-management support.
6. Orient care toward preventive and population care, reinforced by health promotion strategies and community participation.
7. Change (or maintain) health system structures to better support CNCD management and control.
8. Create PHC-led networks of care supporting continuity of care.
9. Reorient health services creating a chronic care culture including evidence-based proactive care and quality improvement strategies.
10. Reconfigure health workers into multidisciplinary teams, ensuring continuous training in CNCD management

Contribution to CHRODIS GP assessment dimensions

This document provided us with further insights into the development of the Chronic Care Model.

It also enhances the attention to several domains such as:

Theory grounds (well specified and measurable main goal and sub-goals)
Key population and target population
Community linkages
Patient Participation and commitment
Mapping of relevant stakeholders
Impact of the implementation in current organization
Regularity of monitoring reports and consequences derived from assessment
Development of integrated health information systems
Evaluation framework assessing process and outcomes

KEY ACTIONS FOR SELF-MANAGEMENT SUPPORT

Ensure patient participation in the process of care;
Promote the use of lay or peer educators;
Use group visits;
Develop patient self-regulatory skills (i.e., managing health, role and emotions related to chronic conditions);
Promote patient communication skills (especially with regard to interactions with health professionals and the broader health system);
Negotiate with patient goals for specific and moderately challenging health behaviour change;
Stimulate patient self-monitoring (keeping track of behaviours);
Promote environmental modification (creating a context to maximize success);
Ensure self-reward (reinforcing one’s behaviour with immediate, personal, and desirable rewards);
Arrange social support (gaining the support of others);
Use the 5As approach during routine clinical encounters (Asses, advise, agree, assist, arrange)

EXAMPLES OF EFFECTIVE INTERVENTIONS

Group based self-management support for people with type 2 diabetes (50)
Self-monitoring of blood pressure specially adjunct to care (51)
Patient educational intervention for the management of cancer pain alongside traditional analgesic approaches (52)
Patient educational intervention using the 5 As for reducing smoking, harmful use of alcohol and weight management (53)
Training for better control blood glucose and dietary habits for people with type 2 diabetes (54)
Lay educator led self-management program for people with chronic conditions, including arthritis, diabetes, asthma and COPD, heart disease and stroke (55-57)
Self-management support that involves a written action plan, self-monitoring and regular medical review for adults with asthma (58)
Self-management support for people with heart failure to reduce hospital readmission (59)
Patient oriented interventions such as those focused on education or adherence to treatment (60)

Other comments

This document fully endorses the Chronic Care Model committing to its development for structuring a new healthcare system addressing the care of chronic conditions.

DOCUMENT: Excellent Innovation for Ageing a European guide for the Reference sites of the European Innovation Partnership on Active and Healthy Ageing

Summary

This guide aims to take you on a special journey through Europe: a tour of regions, cities and communities where you can see innovation for active and healthy ageing in real life

References sites: self-assessed innovation cases

Contribution to CHRODIS GP assessment dimensions

Integrated flow of information through the healthcare chain increases the discharge rate and enables continuity once the patient is discharged and the municipality/home care takes over the care. The electronic communication also generate cost savings for all the actors involved in the process

Thanks to the innovation complex patients can be monitored directly from home, with positive impact on their mental health and quality of life.

Thanks to the participation of users in the development and testing phase, companies gain better insight and provide better services.

The best practice relies on rehabilitation after hospital discharge via e-learning and assistive technologies for both the elderly person and their family and carers who receive adapted training in assisting them at home.

The Memory Training (MT) programme aims to maintain, as long as possible, a good quality of cognitive life for the elderly.

The Adapted Physical Activity (APA) contribute:

- Reduce the hospitalization expenditures
- Improve Vitality of citizens though a client oriented and demand driven approach
- Improve inclusiveness (engagement) of citizens and social cohesion
- Improve participation, self-management, autarchy and self-reliance

supporting patient care near home, avoiding unnecessary hospitalisations and outpatient visits • achieving better outcomes through motivational care planning and improved engagement with patients • promoting self-care and support via information prescriptions, supporting behaviour change

DOCUMENT: Burguess J POSITION PAPER Innovation and efficiency in health care: does anyone really know what they mean? Health Systems (2012) 1, 7–12

Summary

Contribution to CHRODIS GP assessment dimensions

What do we mean by quality and what does it really mean to hold all this quality fixed? A particularly attractive definition for thinking about this is from the Institute of Medicine, which defines quality as multidimensional and characterized by care that is safe, timely, effective, efficient, equitable, and patient-centred (recently, this last term of patient-centred has begun to be viewed as too oriented toward sickness as opposed to wellness, so in a spirit of loss aversion is turning toward person-centred).

DOCUMENT: García-Goñi et al Pathways towards chronic care-focused healthcare systems: Evidence from Spain Health Policy 108 (2012) 236– 245

Summary

Contribution to CHRODIS GP assessment dimensions

Ten characteristics of a high-performing chronic care system (1) Ensuring universal coverage (2) Provision of care that is free at the point of use (3) Delivery system should focus on the prevention of ill health (4) Priority is given to patients to self-manage their conditions with support from carers and families (5) Priority is given to primary healthcare (6) Population management is emphasised through the use of tools to stratify people with chronic diseases according to their risk and offering support commensurate with this risk (7) Care should be integrated to enable primary healthcare teams to access specialist advice and support when needed (8) The need to exploit the potential benefits of information technology in improving chronic care (9) Care is effectively coordinated (10) Link these nine characteristics into a coherent whole as part of a strategic approach to change Source: Ham [10]

DOCUMENT: Margolis et al Collaborative Chronic Care Networks (C3Ns) to Transform Chronic Illness Care. Paediatrics 2013;131;S219

Summary

Contribution to CHRODIS GP assessment dimensions

Collaborative Chronic Care Networks

All participants in health care (patients and families, caregivers, clinicians, and researchers) care deeply about improving health. What is missing is a system to harness this motivation and focus participants' collective intelligence toward transforming care and outcomes. What if we could harness the collective intelligence of patients, clinicians, and researchers to create such a system? Wikipedia (the Web-based, collaborative encyclopaedia project), Linux (the open-source computer software operating system), and the open, rapid sharing of data that occurred in advance of publication in the human genome project are just 3 examples of how the production of knowledge, information, and know-how can be distributed over large groups of people, dramatically accelerating the discovery process. These models are transforming how individuals connect, exchange information, and produce knowledge, enabling previously unimaginably large groups of people to join together to make real their shared vision of the future. These models have rapidly achieved unprecedented innovation and performance, in part because they have built systems that allow inherent motivation of like-minded individuals to flourish through a culture of cooperation.[4] This form of production has been termed network-based or "social" production.[5]

Network-based production is particularly suited to complex systems such as health care, precisely because the knowledge, skills, and tools necessary to develop and implement real change are often beyond the capacity of 1 place, person, or organization because the stakeholders in the process (in this case, patients, clinicians, and researchers) are motivated and have skills that can be devoted to the task, and finally because the scientific questions about how to accomplish improvements in health and health care require a multidisciplinary complex systems science perspective. A C3N is a network-based production system for health and health care.

Building community starts with communicating a compelling vision; for the C3N Project, it is improving the health of all patients affected by a chronic illness. The project's core leadership team of patients, clinicians, and researchers share responsibility for defining this vision and purpose, communicating it, and creating strategies for implementation. Sharing stories is a powerful way to motivate action. A short film about Improve CareNow's work was created by renowned filmmaker Jesse Dylan, and a diverse group of participants, supporters, and collaborators (including Improve CareNow clinicians and staff, patients and family members, researchers, quality improvement experts, and health care innovators) post their personal stories regularly on LOOP, the official blog of Improve CareNow (http://improvecarenowblog.org/).

http://c3nproject.org/about-c3n-project#challenge

http://c3nproject.org/patients

DOCUMENT: Paulus et al. Continuous Innovation In Health Care: Implications Of The Geisinger Experience. Health Affairs, 27, no.5 (2008):1235-1245

Summary

Contribution to CHRODIS GP assessment dimensions

Adoption of integrated electronic health systems is the beginning of a long care-transformation journey.

Personal Health Navigator. EJEMPLO: Geisinger's "patient-centred medical home" initiative is designed to deliver value by improving care coordination and optimizing health status for each individual. Components designed to create a functional "Personal Health Navigator" for consumers include round-the-clock primary and specialty care access; a GHP-funded nurse care coordinator in each practice site; predictive analytics to identify risk trends; virtual care-management support; a person, called a personal care navigator, to respond to consumers' inquiries; and a focus on proactive, evidence-based care to reduce hospitalizations, promote health, and optimize management of chronic disease. Other features include home-based monitoring, interactive voice-response surveillance, and support for end-of-life care decisions.

Electronic Health Record access: EHR access is provided to all participants, including physicians, care managers, and consumers. Consumer EHR features include Internet-based lab results display and results trending over time, clinical reminders, self-scheduling, secure e-mail with providers, prescription refills, and educational content

Other comments

DOCUMENT: OECD Innovation strategy 2010.

Summary

It is centred on how to measure Innovation on every different area of progress.

It provides an extensive analysis of the situation of the innovation, measured by proxy indicators across the OECD countries and sectors, addressing the need of more research and measurement in how innovation is implemented and how can we promote it to reach new levels of development.

It proposes a framework for measuring innovation through their derivative products. Also it promotes people participation and addresses the main challenges to tackle in next years.

Contribution to CHRODIS GP assessment dimensions

This document provided us with a main framework for measuring innovation and develops this domain expanding the domains of:

· Innovation

· Sustainability

· Research Implementation

· Innovation measurement as a method to assess its impact on the healthcare systems

Other comments

1.6 Documents related to Scalability

DOCUMENT: Scaling up: a framework and lessons for development effectiveness from literature and practice. Hartman and Linn. Wolfensohn Center for Development Working Paper 5, 2008

Summary

The document is focused on development interventions, though the lessons drawn seem more generally applicable to other types of interventions and projects with a vocation to expand and stay in place (such as health promotion and primary interventions in European Member States).

The authors explore the possible approaches and paths to scaling up, the drivers of expansion and of replication, the space that has to be created for interventions to grow, and the role of evaluation and of careful planning and implementation.

They draw a number of lessons for the development analyst and practitioner. More than anything else, scaling up is about political and organizational leadership, about vision, values and mind-set, and about incentives and accountability—all oriented to make scaling up a central element of individual, institutional, national and international development efforts. The paper concludes by highlighting some implications for aid and aid donors.

Contribution to CHRODIS GP assessment dimensions

The Domain Scalability has drawn on this document incorporating 3 criteria:

- Size of the population targeted if scaled up
- Analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators
- Systematic networking efforts to foster the exchange of information, mutual support and cooperation with other community resources

2. Delphi-m in Organizational interventions focused on dealing with chronic patients with multiple conditions

2.1. Practice appraisal tools

DOCUMENT:

IEMAC-ARCHO. Assessment of Readiness for Chronicity in Health Care Organisations.

http://www.iemac.es/data/docs/Formulario_IEMAC_english_version.pdf

Summary

The management of chronic conditions is one of the greatest challenges faced by healthcare services worldwide. There is also a broad agreement on the need for new models to better manage chronic conditions due to there is not a universal model available in this field.

In recent years, new conceptual frameworks have been developed, based on procedures showing better outcomes in the management of chronic patients across a variety of settings. One of the models that has been most widely acknowledged and discussed is the Chronic Care Model (CCM), developed at the MacColl Institute for Healthcare Innovation.

Based on the Chronic Care Model, ARCHO is a Spanish instrument that enables healthcare organisations to self-assess their implementation of models for the management of chronic conditions. The instrument can help ascertain how well geared your organisation is towards prevention and the management of chronic patients and measure its performance with respect to certain dimensions, making this a valuable tool for identifying weak areas and, in turn, for improving the organisation.

The ARCHO instrument can also be used in a variety of contexts and across a range of organisational levels. It allows assessment across a variety of organisational settings and levels: macro (decisions on healthcare policies and resource allocation), meso (management of health organizations, large centres and programmes) and micro (practices of healthcare professionals, e.g., in health centres or multidisciplinary projects).

The principles inspiring the ARCHO model were:

- A systemic approach to chronic conditions that considers the organisation holistically and underscores the synergistic value of interventions.
- The use of evidence-based interventions, whenever possible
- A drive for continuous improvement and innovation to ensure progress in the management of chronic conditions.

The self-assessment process provides awareness of strengths in the management of chronic patients within your organisation, the Identification of areas for improvement, a rating of your organisation with respect to its approach to chronic conditions, and a basis on which to draw up action plans.

Contribution to CHRODIS GP assessment dimensions

Organisation of the health system

- Leadership commitment
- Strategic framework:
    - It is in place and based on a systemic vision developed with the collaboration of stakeholders, bringing together values, quality and responsible use of resources
    - There is a system for monitoring strategic planning (process and outcomes) in chronic care
- Population-based approach
    - Population stratification systems (classification of the population into groups that require different interventions or programmes depending on their health status, risk, complexity or needs)
    - Information system (the structure of the information system for evaluation improvement and innovation has been defined and there is awareness of it).
    - Funding scheme (a risk-adjusted per capita funding scheme has been rolled out)
    - Social and healthcare policies (policies to promote coordination and/or integration of social and healthcare have been defined and implemented, especially in case of frailty and dependence)
    - Communication

Community linkage

- Alliance with stakeholders (partnership and cooperation agreements are in place between healthcare providers and the management of community resources)
- Linking patients to community resources

Healthcare model

- Patient's centre care
- Professional competences related to chronic care (professionalism)
- Multidisciplinary work
- Continuity of care (pathways between primary and hospital care have been designed and put into place for the most common chronic conditions)
- Communication among different levels and services
- Active patient's follow up
- Innovation in interactions between patients and healthcare professionals (technology is used to allow remote interaction between patients and professionals: websites, social networks, telemonitoring….)

Self-management

- Patient assessment for self-management to identify the patient's needs, attitudes and skills for self-management (environment, social and family networks, workplace etc)
- Patient's education
- Share decision-making

Clinical decision support

- Protocols and clinical guidelines
- Liaison and consultation to exchange of knowledge and expertise among professionals

Information systems

- Information for management and clinical practice (health records, clinical indicators)
- Integration of patient clinical data (the electronic health record can be accessed and updated by all care areas)
- Communication of clinical information between professionals (a channel is in place for consultations between professionals in real time across the various levels of care.)

Other comments

DOCUMENT: PACIC-tool: Patient assessment of chronic illness care. (PACIC-tool PLUS)

Synthesis

PACIC survey is a patient-centered instrument for evaluating the quality and patient-centeredness of chronic illness care received according to the Chronic Care Model paradigm.

In defining six aims for transforming healthcare in America, the Institute of Medicine Quality Chasm Report declared "patient centeredness" a central feature of quality, along with safety, promptness, effectiveness, efficiency and equity. Patient centeredness may be a first principle that can provide a lens to focus action, and as such can be used as the guide for achieving all six aims.

Historically, patient centeredness has been regarded as the assessment of needs and preferences to consider social and cultural factors affecting the clinical encounter or compliance with treatment. There is a growing consensus that patients have a more active role to play in defining and reforming healthcare, particularly in chronic disease management, where patients provide the majority of care in day-to-day management of their illness.

The revised documents correspond to the 20- and the 26-item version of the PACIC. They measure specific actions or qualities of care, congruent with the CCM, that patient's report they have experienced in the delivery system. The survey should be sufficiently brief to use in many settings. When paired with the ACIC, these tools can provide complementary consumer and provider assessments of important aspects of care for chronic illness patients.

Available from the Improving Chronic Illness Care webpage through the following link: http://www.improvingchroniccare.org/downloads/pacic.pdf

Contribution

Patient Activation (items 1-3)

- Empowerment (governance participation, social involvement, etc.)
- Self-management
- Quality of life

Delivery System Design/Decision Support (items 4-6)

- Bidirectional Communication
- Assistance at home (primary care, palliative care)

Goal Setting (items 7-11)

- Planification of care takes patient's plans into account

Problem-solving/Contextual Counselling (items 12-15)

- Education
- Integration in the patients community (NGO, support groups)
- Counselling (decision support (tools and personal assistance)

Follow-up/Coordination (items 16-20)

- Multidisciplinary, across levels coordination
- Monitoring, emergency care rapid response
- Telephone follow-up after contact with the healthcare system

Other comments

DOCUMENT: Chronic disease management audit tools. A fact sheet for Primary Care Partnerships. Victoria Department of Health. Australia http://www.health.vic.gov.au/pch/downloads/factsheet02.pdf

Summary

Organisations that have committed to improve their systems for chronic illness care often, find an organisational audit of current practice to be a valuable process. This fact sheet has been developed by Victoria Department of Health to provide Primary Care Partnerships (PCPs) with a briefing on audit and assessment tools for chronic disease care to assist in guiding choice and implementation. An overview of a selection of audit tools is provided.

The tools reviewed fall into four broad categories.

- Tools that assess organisational systems
- Tools that assess consumer experience of chronic disease care
- Tools that assess specific components of chronic disease care
- Tools that assess general practice provision of chronic disease care

Three of the tools reviewed: Assessment of chronic illness care (ACIC), Organisational skills analysis tool-chronic disease care (OSAT-CDC) and Patient assessment of chronic illness care (PACIC), are described more in detail under separate documents.

In general, tools to assess organisational systems are recommended to be used with external facilitators and can be used periodically to monitor improvements in the organisations. The tools themselves encourage or facilitate creation of action plans for improving care delivery processes.

Authors emphasise that an audit tool will not be effective in creating improvements in chronic illness care unless the organisation commits to supporting the changes needed and provides the necessary resources (staff and time) to implement the changes.

Contribution to CHRODIS GP assessment dimensions

Link of evaluation results to actions to reshape the implementation accordingly

Other comments

Many of these tools facilitate creation of an action plan for improving care delivery processes since change will only happen if an auditing or organisational evaluation process is part of a planned, continuous improvement process.

DOCUMENT:

Organisational Skills Analysis Tool. Chronic disease Care (OSAT-CDC) by Gill + Willcox

www.gillandwillcox.com.au

Summary

The OSAT-CDC (2002) is an adaptation of the Department of Human Services (Public Health) *Health Promotion Skill Assessment Tool* for Organisations by Gill and Willcox. The chronic disease care adaptation was initially developed for type 2 diabetes and used the Australian Diabetes Educators Association *Best practice guidelines* as a key reference. It combines best practice in chronic disease care with indicators from department service coordination and health promotion policy. Feedback from agencies that have utilised the tool has also contributed to its development.

Organisations that have committed to improving their systems for chronic illness care often find an organisational audit of current practice to be a valuable process. Establishing a baseline helps develop an action plan to improve chronic care and also allows the effectiveness of the strategies implemented to be measured. The OSAT-CDC Tool is designed to assist agencies to recognise the skills they have in chronic disease care and identify opportunities and scope for further system and workforce development.

This tool is more specific in terms of skills and practices that are audited compared with the ACIC which is broader in its statements. It is designed to be implemented at an agency and direct client service level. It was designed for use in a multidisciplinary or cross sectorial groups to assess the workforce as a whole, not just skill or practice deficits of individual, practitioners or teams.

In addition to that, it outlines a number of indicators for best practice in chronic disease care and steps through a process that will assist the agency to reflect on the role it can play in promoting best practice within a community setting, the corresponding skills and infrastructure required for best practice. The agency's current skills and practices in chronic disease care and establish priorities for service and skill development is also reviewed.

The Tool has three sections with 16 overall questions: *Agency capacity and resources* (capacity to provide chronic care according to best practice recommendations), *provision of planned care based on best practice guidelines* (process of care delivery: how are planed, delivered and evaluated), and *Planning and provision of chronic disease services including health promotion and early intervention programs* (capacity to assess, plan and implement chronic disease services, health promotion and early intervention programs for people with, or at risk of developing a chronic disease).

Specific examples of good practice are provided under each component and these are relevant to a Victorian context, and subsequently assist in developing awareness of best practice in chronic illness care as well as improving the reliability of self-rating.

Contribution to CHRODIS GP assessment dimensions

Organisation capacity an resources

- The management team members responsible for planning, implementation and evaluation of chronic disease services is suitably qualified (team member roles are defined and clearly articulated and there is a clear leadership)
- The organisation develops co-operative working relationships with other organisations (the organisation involves key partners in the development of new services and/ or products)

- Chronic disease care services are provided by suitably qualified team members (provided by a multidisciplinary team, with appropriate qualifications, access to relevant professional development activities/resources)

Provision of planned care based on best practice guidelines

- Chronic care is provided according to the best practice standards incorporating current knowledge and research findings.
- The organisation has clear protocols for initial contact/needs identification (identify individuals at risk, eligibility for the service, referrals from other agencies)
- Comprehensive assessment of all individuals with chronic disease (medical, physical, social and psychological needs history) from an interdisciplinary team. It is also included risk assessment for complications and other co-morbidities associates
- The organisation provides information/education for all people with a chronic disease (factors involved in the development of the disease, treatment, prevention and services) in variety of formats, languages, learning styles etc.
- Team members support individuals self-management of the illness
- Clients are refer to other programmes to support maintained of lifestyles changes
- The organisation evaluates the effectiveness of its chronic disease service.
- The organisation collects and documents appropriate client data
- Team members are sensitive to cultural beliefs and the social economic of the individuals

Planning and provision of chronic disease services including health promotion and early intervention programs

- The organisation establish a relationship with key community networks and members/groups
- Community members are involved in identifying needs and setting priorities
- The organisation have planned social marketing activities (health message for effective audience reach)
- The organisation implements and monitored risk factor screening programs

Other comments

DOCUMENT: Highly Adoptable Improvement Assessment and Discussion Guide (Canada).

http://www.highlyadoptableqi.com/uploads/HAI_Guide.pdf

Synthesis

The Highly Adoptable Improvement model centralizes the recipients of change and emphasizes the constructs of workload/capacity balance and perceived value. This model is based on existing theories, models and input from key informants.

The design of any organisational intervention and the mechanisms by which it is implemented directly contribute to the balance between workload/capacity and perceived value. If the balance equates to more workload/less capacity and less perceived value then the results are more likely to favour burnout, cynicism and workarounds, and less likely to produce the intended results. This will create a negative feedback on the recipients of change and result in decreased perceived value and capacity that will create resistance to ongoing change. If the balance favours less workload/more capacity and higher perceived value, then the likelihood of adoption and incorporation is greater as is also the achievement of the intended outcomes. This creates positive feedback that increases perceived value and capacity and decreases resistance to further change.

The model is intended to be used by a quality improvement team (and those commissioning that team) to help guide the development and implementation of an improvement initiative.

The model states five domains with a range of degrees of adoptability aiming to assess the "risk" of losing the momentum to adopt and improvement within an organization. It is based on the participation of different levels within the organization, it includes sections to describe the reasoning behind the assessment and to record proposed action plans.

Contribution

Implementation Strategy:

- End-user participation
    - Is end-user staff involved in the change?

      Active participation of end-users in the design, testing, revising and implementation of change interventions increases the likelihood of higher perceived value and is more likely to produce a less intensive intervention workload, thus increases the chance of sustained adoption

- Alignment and planning
    - Does the change initiative align with the organizations and/or team’s values and goals and has the rollout been planned effectively?

      Change initiatives that are aligned with the goals, values and objectives and planned ahead of time to inform end-users and avoid project/priority conflicts are more likely to increase perceived value and sustained adoption

- Resource availability
    - Are the required resources (training, equipment, time, personnel) for the implementation of the change initiative known and will they be made available?

      Providing the necessary supports and resources to aid understanding and implementation of the change initiative increases the ability for end-users to adopt the changes into their existing workflow.

Intervention Design: - Workload o How much estimated workload (cognitive, physical, time) is associated with the intervention? - Complexity o How complex is the change intervention? - Efficacy o What degree of evidence and belief is there that the proposed intervention will lead to the intended outcome?
Other comments

2.2. Practice appraisal frameworks

a) EU Level

DOCUMENT: «BateraZainduz»: implementation of chronic disease management models in primary care, focused on the integration of assistance OSTEBA. Basque Government. November 2012

Summary

Within the strategy to address the challenge of chronicity in the Basque Country, it was proposed a research and action project that seeks to initiate chronic disease management models in a population with type 2 diabetes. The project involves professionals of Primary Care and a University Hospital.

The main objective of the project was the implementation of a management model of chronic patients oriented to care integration. It compared clinical and management outcomes of a group of patients that have been treated with chronic management models with a control group that have been treated conventionally.

The project duration was 2 years and 6 areas of the Chronic Care Model (CCM) have been implemented in two populations groups belonging to a Primary Health Centers. During the first semester, pre-intervention indicators were collected, and the target and control populations were selected. During the 2nd and 3rd semesters the interventions were carried out and during the last semester, post-intervention indicators have been collected and analysed.

To select the interventions to be implemented, a literature search was carried out to find interventions that showed evidence of efficacy. Subsequently, with the information obtained from the literature, a survey to the professionals was made to detect those interventions that they considered important to be implemented with swiftness. The interventions obtained were grouped within the CCM (Community, Self-management, Delivery system design, Decision support, Clinical Information System).

The results of this project indicated that regarding clinical outcomes, no major changes were detected between both groups as expected. However, in terms of the use of the health resources, there were significant differences about the use of Hospital Care resources. The intervened population group reduced the number of visits to Outpatient Department and the Accident and Emergency department while the control group increased them.

Contribution to CHRODIS GP assessment dimensions

1- *Community*
    - Agreements and coordination with different resources (main town halls, social services, pharmacies and local diabetics associations)

2- *Health system organization*
    - Leadership of the project by directive staff of the region,
    - Collaboration between Primary and Hospital Care

3- *Self-management support*
    - Design and execution of a structured education plan for patients and professionals
    - Creation of a share care plan

4- *Delivery system design*
    - Primary and Hospital Care integration,
    - Continuity of care

  - Risk stratification of complex patient cases

5- *Decision support*

  - Adoption of Guidelines

6- *Clinical information system*

  - Shared Electronic Health Record
  - Call Centre service to remind and reinforce treatment

Other comments

DOCUMENT: The King's Fund: Commissioning and contracting for integrated care. November 2014

http://www.kingsfund.org.uk/sites/files/kf/kings-fund-commissioning-contracting-integrated-care-nov14.pdf

Summary

Many clinical commissioning groups (CCGs) in England have started to develop novel contracting and commissioning tools to drive more transformational and sustainable service integration. Contracts are merely the 'scaffolding' for the integrated model and it is the terms of the contract that will act as a lever for collaboration*.

This report describes two contractual models (frameworks) that are currently being developed in five areas of England: prime contract and alliance contract.

In a prime contractor model, the CCG contracts with a single organisation (or consortium) which then takes responsibility for the day-to-day management of other providers that deliver care within the contracted scope or pathway. There is a variation on this model - the prime provider model - that stipulates that the contracted organisation also provides services directly. On the other hand, an alliance contract sees a set of separate providers enter into a single agreement with a CCG to deliver services, where the commissioner(s) and all providers within the alliance share risk and responsibility for meeting the terms of a single contract.

Across both models, there are three underpinning principles: outcomes, service integration and shifting costs.

Outcomes: Hold providers to account for outcomes (accountability). Outcomes should be few, clear, concise and readily communicated. Outcome-based contracting, shifts greater responsibility onto providers to design suitable care pathways to achieve these outcomes. Some outcome measures might relate directly to **clinical outcomes**, while others could focus specifically on **incentivising collaboration**. Making contract-holders accountable for achieving and improving outcomes seeks to mitigate concerns around ‘cream-skimming’ – where a contract-holder will do the bare minimum within the budget in order to maximise profit above all other considerations.

Integration of services: Hold providers to account for streamlining the delivery of patient care across the gaps between service providers to stimulate greater collaboration and integration of services. Providers can be incentivised to collectively develop innovative solutions **through a shared outcomes framework** that includes a combination of: 1) direct measures of organisational integration; 2) measures that focus specifically on the gaps between services; and 3) clinical measures that are most efficiently achieved in partnership.

Shift the flow of money between providers. Activity cannot be reallocated from acute providers until adequate provision is available within other (community) settings. Patients and providers will continue to use traditional referral routes and treatment options until viable alternatives are available. Payment mechanisms and incentives will need to be aligned across providers to avoid fragmentation in the delivery of care. Pooling budgets will allow for more efficient reallocation of funding across the system and also provide the opportunity to consider streamlining these currencies through a programme or capitated budget.

Authors suggest a cautious approach to implementing new contractual models. CCGs and other commissioners need to carefully consider whether a contractual solution is appropriate and proportionate for addressing the particular problem they want to solve. The costs associated with developing new contractual approaches are high and the process is difficult, time-consuming and resource-intensive, and likely to require dedicated teams or programmes to drive significant improvement. The cases explored in this paper demonstrate very early experiments to drive innovation through contracting, and it is unlikely that this approach will be sustainable or replicable across the country, despite the best intentions of commissioners. Nevertheless, change on this scale is vital to develop a service that meets the financial challenges and the needs of the population into the future.

Contribution to CHRODIS GP assessment dimensions

Account for outcomes: Outcomes should be few, clear, concise and readily communicated. Outcome-based contracting, shifts greater responsibility onto providers to design suitable care pathways to achieve these outcomes.

Shared outcomes framework among providers to stimulate greater collaboration and integration.

Adequate funding of new settings or programmes. Payment mechanisms and incentives will need to be aligned across providers to avoid fragmentation in the delivery of care. Pooling budgets will allow for more efficient reallocation of funding across the system

Engagement and communication: It is essential to continually engage and communicate with providers, patients and the wider community to define the problem and identify appropriate solutions.

Other comments

DOCUMENT: European Scaling-up Strategy in Active and Healthy Ageing EIP on AHA (November 2014)

Summary

Health and care services in Europe are undergoing changes to adapt systems to a growing demand caused by ageing and the expansion of chronic diseases. The multitude of good examples developed throughout the EU has led to a realisation that a comprehensive scaling-up strategy is needed at European level. For that reason, the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) which brings together key stakeholders in this policy area, and supports the good practices and References Sites developed by its partners, can act as a catalyst to foster scaling-up across regions and countries.

The several good examples developed throughout the EU has led to a realisation that a comprehensive scaling-up strategy is needed at European level. This paper presents five steps for setting up an effective European scaling up strategy. The first three constitute a "what to scale up" element, while the remaining two "how to scale up" part:

STEP 1 - BUILDING A DATABASE OF GOOD PRACTICES

The Partnership, through the work of the Action Groups and Reference Sites, developed a collection of examples of what needs to be done for ageing people to stay active, independent and healthy for as long as possible

STEP 2 - ASSESSMENT OF VIABILITY OF GOOD PRACTICES FOR SCALING UP

This strategy proposes to assess the viability for scaling up by using comparability frameworks rather than "classic" evidence, This approach helps not only to relate practices to each other, but also to identify the characteristics of each practice and system. Two examples of assessment frameworks, Definition and Endorsement of Criteria to Identify Priority Areas When Assessing the Performance of Health Systems, Opinion of the Expert Panel on Effective Ways of Investing in Health, February 2014 and MAST (MODEL FOR ASSESSMENT OF TELEMEDICINE APPLICATIONS) are stated in this report and thoroughly described in following documents

STEP 3 - CLASSIFICATION OF GOOD PRACTICES FOR REPLICATION

To enhance the potential for scaling up across borders and regions, the identified good practices need to contain elements that can be sufficiently generic to allow their transferability and adaptation to varying local circumstances and conditions. Therefore, good practices should be classified according to feasibility and contextual factors, as well as the characteristics of the system in which are they implemented. Both concepts, feasibility and contextual factors, are described in the Opinion of the Expert Panel on Effective Ways of Investing in Health.

STEP 4 - FACILITATING PARTNERSHIPS FOR SCALING UP

There are several proven ways of diffusing good practices, facilitating exchange and scaling up. INTERREG IVC has developed a reference model for exchange of good practices on inter-regional level20. According to their model these exchanges of experiences are in fact multidimensional and dynamic learning processes, geared towards achieving various forms of policy changes within the partner areas and beyond.

STEP 5 - IMPLEMENTATION - KEY SUCCESS FACTORS AND LESSONS LEARNT

Based on WHO / ExpandNet work and the Partnership’s work on the good practices catalogue and Reference Sites’ ‘How to guide’, the following framework for implementation of scaling up is proposed:

1. Planning the innovative service and setting up a system for change

2. Organisational process and design choices

3. Monitoring, evaluation and dissemination

Key elements of this framework are considered contributions to CHRODIS GP assessment dimensions and listed below

Contribution to CHRODIS GP assessment dimensions

1. Planning the innovative service and setting up a system for change

    - Good understanding of the context
    - Needs’ evaluation
    - Political endorsement
    - Engagement of relevant stakeholders
    - Strategy and roadmap
    - Cost assessment
    - Financial viability and business model

2. Organisational process and design choices
    - Investing in human capital: training and re-skilling the workforce
    - Integrating ICT solutions.
    - Service re-design and organisational changes

3. Monitoring, evaluation and dissemination
    - Assessment indicators: economic aspects and patient and caregiver perspective
    - Knowledge exchange and learning
    - Communicating to raise awareness and acceptance
    - “Different context at” scaling up at different levels

Other comments

DOCUMENT:

1º European innovation Partnership on Active and Healthy Ageing (EIP-AHA). Reference Sites. Excellent innovation for ageing. A European Guide (2013)

2º- European innovation Partnership on Active and Healthy Ageing (EIP-AHA). Reference Sites. Excellent innovation for ageing. How to Guide (2014)

Summary

The European Innovation Partnership on Active and Healthy Ageing (the Partnership) was initiated in October 2010 to tackle the common challenge of an ageing population in Europe. It brings together key stakeholders to develop new innovations, which can improve the quality of life of older people, whilst simultaneously creating market opportunities for businesses in this policy area. The focus of this Partnership is on linking together organisations, resources and expertise to produce short-term, demonstrable results which can encourage the uptake of innovation to improve older people's health and quality life in addition to enhance the sustainability and efficiency of care systems.

References Sites are regions, cities or integrated hospitals/care organisations, established in a geographical location in Europe that provide a comprehensive examples of innovation-based services with proved value to citizens and care system in EU regions. They provide concrete examples of existing and successful integrated solutions, based on evidence of their impact in practice.

The European innovation Partnerships on Active and Healthy Ageing. Reference Sites. Excellent innovation for ageing. A European Guide (2013) provides a snapshot of on-going developments. The aim is to take a tour of regions, cities and communities through Europe where there is innovation projects for active and healthy ageing in real life. The selection of the reference sites for this guide was based on key criteria such as EIP-AHA relevance, scale, and number of specific EIP actions to which they are committed, evidence and replication potential. They filled out questionnaires on their contribution to the different action areas of the *European Innovation Partnership on Active and Healthy Ageing* and on their overall strategy to tackle the demographic challenge in Europe. Then they were scored with a ranking from 1 to 3 stars and the results of the process were 32 Reference Sites from 12 Member States.

The 32 award-winners have implemented innovative technological, social or organisational solutions to enhance the efficiency of health and social care system and foster innovation and economic growth. All Reference Sites have committed to sharing their achievements with others and transferring knowledge across Europe.

The second edition of the Reference Sites. *European innovation Partnerships on Active and Healthy Ageing. Reference Sites. Excellent innovation for ageing. How to Guide (2014)* provides practical indications on how to scale up and transfer best elements of the Reference Sites experiences to other European contexts. This Guide is a follow-up to the first edition published in July 2013.

Contribution to CHRODIS GP assessment dimensions

- Political support on several levels: Including regional government, national healthcare management authorities and scientific societies
- Funding: structural funds from resources of project partners
- The organizational changes comply with the national healthcare system strategy
- Innovation in IT Tools: use of technological products, devices and services e-tools. infrastructures are being modified and rebuilt
- The synergy of local industry and technology
- Cross-agency approaches
- Community linkage
- A multi-stakeholder collaborative alliance of partners
- Involved all the actors in the innovation cycle (private and public sector and citizens)
- Robust performance monitoring and evaluation system
- Professional qualification and training
- Principles: interdisciplinary approach, professionalism, subsidiarity and regionalism
- Leadership

Other comments

two documents describe the programme implemented in their own country but it does not provide, which criteria or standard have been used to determine the quality of the programmes.

DOCUMENT: Dorling, H. et al. Developing a checklist for research proposals to helps describe health service interventions in UK research programmes: a mixed methods study. al. *Health Research Policy and Systems*. 2014. 12:12

Summary

One of the most common reasons for rejecting research proposals in the National Institute for Health Research (NIHR) Health Services and Delivery Research (HS&DR) Programme is the failure to adequately specify the intervention or context in research proposals.

There is a body of literature which discusses intervention, context, and the use of checklists. However, existing checklists do not have enough focus on areas relevant to complex health service interventions or consider research applications. Authors developed a checklist focusing on complex health services and delivery interventions and context. They used an iterative method, first assessing existing checklists in peer reviewed literature, which was the base to build another checklist. This list after being evaluated by two reviewers was again externally validated by eight researchers.

Small-scale iterative testing suggested it was acceptable and useful for researchers. Nevertheless, further validation is needed to demonstrate relevance to a wider range of researchers and funding bodies.

The final checklist includes six constructs:

- Organisation
- Location
- Patient group
- Workforce and Staff
- Intervention

Other important contextual information (leadership, cultures, costing).

Contribution to CHRODIS GP assessment dimensions

Organisation and location constructs are included in Practice’s design

Patient group construct is included within target group assessed

Workforce and staffing construct is included in the subdomain Stakeholders within Implementation domain and also in Capacity and resources (Implementation)

Intervention construct is included in the subdomains Aims and Objectives of the practice, and Practice’s design (Concept and Design) and Capacity and Resources (Implementation).

Other important contextual information construct takes into account concepts included in theory grounds of the practice, leadership, sustainability and scalability in terms of political endorsement and contextual aspects which may affect outcomes and scalability to other sites.

Other comments

DOCUMENT: Shepperd S, Lewin S, Straus S, Clarke M, Eccles MP, et al. (2009) Can We Systematically Review Studies That Evaluate Complex Interventions? PLoS Med 6(8): e1000086. doi:10.1371/journal.pmed.1000086

Summary

This article displays that it is challenging for researchers to systematically review complex interventions and, synthesize data from separate studies due to the difficulties in defining, developing, documenting, and reproducing complex interventions. The lack of consistent terminology and the inconsistent use of existing terminology to describe complex interventions mean that identifying potentially eligible studies can be difficult. Also, there are usually few data reporting the characteristics of complex interventions, and what data there are tend to be of poor quality.

Thus, in the article considers the challenges facing systematic reviewer and suggests several ways of addressing them:

- Solutions to improve the description and conceptual understanding of the content of a complex intervention include typologies to guide the classification of interventions and supplementary evidence, such as qualitative or descriptive data.
- Complex health interventions (CHIs) can be systematically reviewed, but only if a paradigm shift occurs in the way that these interventions are conceptualised. CHIs muss focus on the interactions between components of a CHI and the impact of human behaviour on the outcome of the intervention. In CHIs, the action of individuals under specific contexts results in outcomes, which are neither deterministic nor regular but can be explained and predicted. Systematically reviewing CHIs is only feasible when the review method takes into account these properties.
- The systematic reviewers should search for and include relevant theoretical and qualitative work, and they should also include data from a broader range of experimental study designs than is currently normally the case in most Cochrane systematic reviews. Theory-driven analysis, wherever possible, should also accompany the more conventional quantitative syntheses, the emphasis on the latter being downplayed.

Contribution to CHRODIS GP assessment dimensions

Case management:

- Integrated care pathway
- Liaison service
- Self-management care

Scaling-up of the interventions:

- Accessibility
- Risk of adverse events
- Cost-effectiveness
- Budget impact of interventions

Other comments

DOCUMENT:

Kidholm K et al. A model for assessment of telemedicine applications (MAST). International Journal of Technology Assessment in Health Care, 28:1 (January 2012), 44-51

Summary

The European Commission (EC) has expressed strong support for telemedicine as a solution to the challenges faced by healthcare systems with aging populations, increasing numbers of patients with chronic conditions and decreasing supply of human resources.

For that reason, in 2009, the EC initiated the MethoTelemed project (2009-2010), aiming to provide a structures framework for assessing the effectiveness and contribution to quality of care provided by telemedicine applications. The framework was to be based on the user's need for information for decision making on whether or not to use new telemedicine applications.

The basis for the development of the model was a literature reviews, a workshop 1 on Assessing users' needs (stakeholders in telemedicine), a workshop 2 to validate the framework and finally a review process.

The MAST model provides a structured framework for assessing the effectiveness and contribution to quality of care of telemedicine applications and covers three parts: preceding considerations before an assessment, a multidisciplinary assessment of the outcomes and an assessment of the transferability of results.

The purpose of the article is to present the MAST Model developed in the *MethoTelemed study* through user and stakeholder workshops and on the basis of a systematic literature review.

Contribution to CHRODIS GP assessment dimensions

Preceding considerations

- Purpose of the programme
- Its implementation accords with national and regional legislation
- Maturity or degree of development over time

Multidisciplinary assessment

- Health problem
- Safety (patient's and staff)
- Clinical effectiveness (effect on patients health: mortality, morbidity, QL)
- Patient's perspectives (issues related to perception of the patient about the programme)

- Economic evaluation
- Organizational aspects (resources that have to be mobilized and organized when implementing a new programme, and what kind of changes or consequences can produce in the organisation
- Socio-cultural, ethical and legal aspects

Transferability

- Cross-border /interoperability (degree of integration with other clinical or administrative systems)

Other comments

DOCUMENT: Expert panel on effective ways of investing in health (EXPH). Definition and Endorsement of Criteria to Identify Priority Areas. When Assessing the Performance of Health Systems. The EXPH adopted this opinion at its 4th plenary of 27 February 2014

Summary

Scientific advice is an essential requirement for the Commission to pursue modern, responsive and sustainable health systems. With this aim, the European Commission has set up a multidisciplinary and independent Expert Panel which provides advice on effective ways of investing in health (Commission Decision 2012/C 198/06).

The core element of the Expert Panel's mission is to provide the Commission with an independence advice in response to questions submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability.

The areas of competence of the Expert Panel include different settings such as primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities among others.

As part of this process and by mandate of the Council Working Party on Public Health at senior level, Sweden is co-ordinating a sub-group on measuring and monitoring the effectiveness of health investments.

The Sub-group of the Working Party on Public Health has developed a framework and set of criteria to identify priority areas when assessing the performance of health systems in Europe.

The Expert Panel provided its views on the framework prepared by the Working Party Sub-group (review the criteria used, identify weaknesses and make recommendations on ways to address them, identify additional elements which have not been taken into account or are not properly represented and make recommendations for their inclusion), and test the framework in real life situations at Member State and at EU level. In doing so, the Expert Panel should provide guidance on the methodologies and approaches which will need to be taken in order to test the framework.

Contribution to CHRODIS GP assessment dimensions

Criteria:

Impact:

- Which impact can it be expected from the implementation of the policies considering the context?
- Universality (coverage, "access to good quality care" dimension)
- Health equity (health recovery, maintenance and improvement)
- Solidarity (expenditure, financial protection, fair financing and distribution)
- Responsiveness (self-perceived acceptability of health system)
- Economic impact (economy, employability, productivity, social cohesion etc)
- High quality and safety services (services, safety, effectiveness…)

Feasibility

- Is the organisation feasible?
- Knowledge (evidence based interventions and policymaking)
- Reaction Time (effects/visibility: time needed to asses impact)

- Political Agenda (government program, European agenda…)
- Stewardship (leadership)
- Acceptability (public, professionals, industries, political parties, patient’s associations)
- Costs (affordability)
- Monitoring (measure and monitor achievements)

Prioritization:

Prioritization of areas or policies after comparing the cost and the effectiveness of different options

Evaluation:

National or regional indicators

Other comments

DOCUMENT: Spanish strategy on palliative care for the National Health System. Actualization 2010-2014.

Summary

The Palliative Care Strategy of the National Health System in Spain was approved by unanimity by the Interterritorial Council of the NHS on march 2007, validating the consensual work between the institutional representatives and the experts from various fields related to health care provision during the last stages of life. Seven examples of Good practices related to the strategy and selected amongst those submitted by the members of the Institutional Technical Committee, were presented in the first document.

Subsequently to this first document, a new update strategy for the period 2010-2014 document was published to consolidate the improvement of care that patients in advanced stages of the illness receive and their families.

For the update, there was a Monitoring and Evaluation Committee constituted by representatives of the Autonomous Communities, the National Institute of health management (INGESA), scientific societies, patient’s associations and experts in the field of this Strategy that established the methodology for the evaluation by consensus. A model questionnaire for the collection of specific information by the CCAA was developed and other information come from existing health information systems, the Institute of health information and the General direction of pharmacy.

It has also reviewed the best evidence published in national and international journals (up to May 2009). Taking into account the contributions of the evaluation and review of new evidence, the Monitoring and Evaluation Committee agreed upon the objectives for the strategy in palliative care for the National Health System 2010-2014, incorporating modifications in some of them as well as new recommendations.

In general, they considered that the vast majority of objectives were fully applicable and they need longer period to achieve. The objectives are preceded in each strategic line for a summary of the evaluation and a report of the new evidences. There are five strategy lines: integral care, Organization and Coordination, patient's autonomy, education and research.

Contribution to CHRODIS GP assessment dimensions

According to integral care aspects:

- Patient assessment, symptoms control and pain treatment
- Interdisciplinary care plan
- Clinical approach to patient safety
- Care coordination within units and the rest of the healthcare service provider network
- Provision of care to the patient family
- Established National Indicators
- Use of clinical guidelines
- Evidence based practice

According to Coordination and organizational aspects:

- Existence of a fluid communication circuit between primary care and hospital care
- Accessibility of the patient (and caregivers) to the healthcare service provider network
- Continuity of care
- Coordination at the different healthcare levels/teams involved (social and health care)
- Use of a "call centre" as core enabling proactive monitoring, problem solving and activation of health, social and/or community resources.
- Systematic monitoring, including the use of phone when a faster response is needed
- Incorporation of psychological/emotional support (to the patient and) main family caregivers in order to strengthen their adaptation to that role.

According to patient's autonomy aspects:

- Apply the bioethics aspects of care according to the legislation

According to <u>education </u>aspects:

- Establish educational programs for healthcare professionals in palliative care

According to <u>research</u> aspects:

- Promote multidisciplinary research

Other comments

DOCUMENT: Oslo Innovation Manual (OECD publishing 3rd Edition) Guidelines for Collecting and Interpreting Innovation Data .

Synthesis

The Oslo Manual, developed jointly by Eurostat and the OECD, devoted to the measurement and interpretation of data relating to science, technology and innovation.

The aim of the manual is to provide guidelines for the collection and interpretation of data on innovation. It is designed to accommodate the various uses of innovation data into a wider interpretation framework. One reason for collecting innovation data is to better understand innovation and its relation to economic growth. This requires both knowledge of innovation activities that have a direct impact on firm performance (for example through greater demand or costs reduction), and of the factors that affect their ability to innovate. Another purpose is to provide indicators for benchmarking national performance. It informs both, policy making and allows international comparison. There is a need of collecting new indicators but also a desire to maintain existing ones for comparisons over time. The Manual is designed to achieve a balance between these different needs.

Contribution

Innovation (domain):

- Research and experimental development
    - Basic research promotion and financing
    - Applied research promotion and financing
- Activities for product and process innovations (production, distribution, environmental/security impact)
- Activities for marketing and organisational innovations
- Acquisition of external knowledge and technology (training, ICT, management systems reorganization, software, …)

- Design
- Public-private partnership and collaboration
- Innovation barriers
    - Cost (high financial risk; high costs; lack of proper funding; lack of incentives)
    - Knowledge (innovation potential; lack of qualified personnel; information gaps; cooperation/partner absence)
    - Organizational (rigid organizational structures)
    - Market (lack of demand; too much competence)
    - Policy/Institutional (lack of infrastructure; liability of property/copy rights; excessive regulation and taxation)
    - Perception (is it needed?)

Innovation is measured using 5 criteria as indicators of validity:

1. Relevance
2. Advantage (among the alternatives)
3. Mobilisation of resources
4. Specificity (domain specific or target –user- specific)
5. Risk management (increased probability to reach the goals set)

Other comments

This Manual also provides a lot of definitions in the area of Innovation, included in the glossary.It is endorsed in some policy frameworks (e.g. Spain) for defining innovation or innovative developments/products.

DOCUMENT: Action Group B3 Integrated care. Maturity Model. B3-AA7-ICT Service (October 2014)

Summary

The European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) was established in 2012, with the objective to add, by 2020, two healthy life years (HLY)* to the average healthy life span of European citizens.

Six Action Groups work towards the clear deployment targets in each of the six Specific Actions of the Partnership's Strategic Implementation Plan.
Among them, B3 Action group objectives are replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level. The main targets of the group are:
To get their aim they are developing different tools, among them a Maturity matrix to assess the degree of maturity of chronic diseases care programmes. There is an agreement on the main dimensions for the Maturity Matrix:

- System integration
- Territorial integration
- Organisational integration
- Financial integration
- Service integration
- Personnel or professional integration
- ICT integration

These main dimensions have correlation with dimensions specific for organisational models, which have linked some maturity indicators that are detailed below

Contribution to CHRODIS GP assessment dimensions

Dimensions and linked maturity indicators in organisational models

- Readiness to Change: Public consultation, clear strategic goals and milestones, stakeholder engagement
- Structure & Governance (effective change management): Funded programmes, ICT competence centres, distributed leadership, communications
- eHealth/eServices (ICT integration): Unique citizen ID, linked records, scale teleservices
- Standardisation (simplification of infrastructure): Use of international standards, reduction in number applications, regional procurements, mandates
- Challenges (actions to remove legal, organisational, financial or skill barriers): Laws to enable data sharing, financial incentives, training
- Population approach: Risk stratification, range of care pathways, prevention, feedback
- Evaluation/Monitoring: Agencies - HTA, health impact, care cost/quality improvements
- Breadth of Ambition: fully integrated care services (health and social), citizen engagement
- Innovation management to get faster adoption of proven ideas: Outreach to regions, academic and industry relations, procurement
- Capacity Building (increasing technology skills, continuous improvement): Capturing bottom-up innovation, deployment skills

Other comments

DOCUMENT: Pharmaceutical Group of European Union (PGEU) Summary of Pharmacy Good Practices, Services and Initiatives in Europe.

Synthesis

This document summarise and provide examples of pharmacy lead solutions to tackle the burden of chronic diseases within the EU's healthcare systems, as well as initiatives in pilot phase which are earmarked for inclusion in health systems in the future.

Pharmacies are widely dispersed, both in rural and urban areas, thus constituting a key element for accessibility to healthcare for chronic patients which usually are intensive users. It is difficult to conceive that the risk of increased medication use as mentioned above can be effectively managed without the use of pharmacists' skills and training, making them and obvious resources for assistance and advice for patients who are seeking to manage their own health and health care.

While pharmacy maintains its key role in providing advice on medication, there appears to be a growing recognition that better use of the pharmacy interface can make a significant contribution to both improving medicines use, and the detection and management of chronic disease.

Contribution

- Patient (caregiver) Education
- Counselling
- Coordination with the rest of the healthcare system (entry point/referral to other healthcare professionals)
- Enhancement and development information systems (sharing information across all levels)
    - Drugs and other pharmacy products
    - Monitoring activities
    - Adherence
    - Adverse events
    - Patient entourage (functional patient or adequate caregiver)
- Communication channels with patients and caregivers
    - Notification, alerts, reminders or invitations to care related events
- mHealth/ICT health (telemedicine)
- Public health agent role
- Knowledge brokers role
- Adherence assessment
- Support role for patient self-management

Other comments

DOCUMENT: Stellefson M, Dipnarine K, Stopka C. The Chronic Care Model and Diabetes Management in US Primary Care Settings: A Systematic Review. Prev Chronic Dis 2013; 10:120180. http://www.cdc.gov/pcd/issues/2013/12_0180.htm
Summary
The Chronic Care Model (CCM) was developed to provide patients with self-management skills and tracking systems. The model represents a well-rounded approach to restructuring medical care through partnerships between health systems and communities. The objective of this documented was to describe how researchers (16 reported studies) had applied CCM in US primary care settings to provide care for people who have diabetes and to describe outcomes of CCM implementation. The studies focused primarily on people aged 50 to 70 years.
Contribution to CHRODIS GP assessment dimensions
Health system - organisation of healthcare - Support from health care leaders to stimulate organisational changes - Engage/implicate the governing boards of healthcare systems to support the institutionalisation of the CCM approach - Redefinition of team roles (e.g. nurses, instead of PCP's conducting foot examinations on diabetic patients) - Health system reorganisation for helping the establishment of self-management training programmes which enhance identification and intervention with patients at risk for developing complications Self-management support: - Provision to patients of self-management education on certain topics like medication, compliance, goal setting, self-care, interpretation of laboratory results. - Establishment of follow-up telephone calls in order to facilitate clinicians to monitor patient progress Decision support: - Provision of specialized decision support services via phone or email - Organisation of problem-based learning meetings - Establishment of telemedicine technology

- Training PCPs on evidence-based guidelines and methods for implementing CCM

Delivery system design:

- Implementation of a specific standards of care (which it may already exist or be designed)
- Implementation of clinical guidelines
- Integrate self-management education into primary care settings through addressing patient barriers to care such as accessibility to self-management education and availability of staff to assist with chronic conditions.

Clinical information systems:

- Establishment a widespread and collaborative use of clinical information systems using disease registries and electronic clinical/medical records
- Assimilating clinical information systems into user-friendly, portable digital technologies like smartphones or iPads, may enable patients and providers to view and respond to laboratory results more regularly.

Community resources and policies:

- Stimulate collaborations between community leaders and physicians
- Stimulate collaborations between pharmaceutical industry/companies and health plans
- Stimulate the development of public-private partnerships between providers and community organisations to address barriers to care and explore culturally appropriate community-based services for underserved populations and neighbourhoods (cooking classes, exercise programs, nutrition counselling, self-monitoring assessment, etc.)

Other comments

Besides, they report:

- The importance to determine the combination of components that will likely produce optimal patient and provider outcomes.

- Changing staff roles and responsibilities to more efficient treatment was the first strategy that produced clinical benefits.

- Reorganized care can also support better training programmes for patients to help them self-manage their illness.

- Determine whether provider training delivered through telecommunication and distance learning technologies can provide ample decision-support training to specialists.

- Self-management Education improves psychosocial and clinical outcomes.

DOCUMENT: Integrated Community Care Management Benchmarks framework (ICCM). http://ccmcentral.com/wp-content/uploads/2014/01/CCM-Benchmarks-and-Indicators-chart.pdf

Summary

The iCCM Benchmark Framework is meant to be a tool for program planners and managers to systematically design and implement iCCM programs from the early phases through to expansion and scale-up. Key activities or steps that should be completed are specified for each component and for each phase of implementation. The intent is that benchmarks in one phase should be addressed before progressing to the next phase, although it is recognized that such a linear progression is not always possible. By spanning components ranging from coordination and policy setting to human resources and supervision and quality assurance and covering introduction to expansion, the iCCM benchmarks help planners and implementers chart their way towards implementing a comprehensive iCCM program at scale.[1]

So, the proposed benchmarks are being grouped into the three phases of program evolution: Advocacy & Planning, Pilot & Early Implementation and Expansion & Scale-up wherein eight health systems components are being identified:

1. Coordination and Policy Setting
2. Costing and Financing
3. Human Resources
4. Supply Chain Management
5. Service Delivery and Referral
6. Communication and Social Mobilization
7. Supervision and Performance Quality Assurance
8. Monitoring & Evaluation, and Health Information Systems

1-McGorman, Laura, et al. “A Health Systems Approach to Integrated Community Case Management of Childhood Illness: Methods and Tools.” American Journal of Tropical Medicine and Hygiene 87.5 (2012): 69-76

Contribution to CHRODIS GP assessment dimensions

First phase (General Domain): Advocacy & Planning

- Coordination and Policy Settings:

mapping of partners (responsibility) and definition of the leadership of the action/practice
assessment and situation analysis
review of national policies, and international guidelines

- Costing and Financing:

Costs estimation undertaken based on all services, medicines, and other type of supply delivery requirements

- Human Resources:

Definition/redefinition of professional roles
Definition and establishment of the criteria for professional recruitment
Well defined plan for comprehensive training and refresher training (modules, training of trainers, monitoring and evaluation)
Strategy focused to maintain community health workers incentives/motivation

- Supply Chain Management:

Medicines and other healthcare products supply consistent with national policies Qualifications assessment for needed medicines and/or other type of healthcare products

Development of an inventory control plan and resupply logistic system

- Service Delivery and Referral:

Development of Strategies or plans

- Communication and Social Mobilization:

Development of communication strategies

Definition of materials and messages of iCCM targeting the community and other groups

Development of community and social actions like training materials, job aids, etc.

- Supervision and Performance Quality Assurance:

Development of appropriate supervision checklists and other tools

Establishment of a supervision plan (number. of visits, supportive supervision roles, etc.)

Establishment of the figure and function of “supervisor trained in supervision”

- Monitoring & Evaluation and Health Information System:

Development of a monitoring framework for all components of iCCM

Identification of sources of information

Development of standardized registers and reported documents

Definition of indicators and standards for health management information system (HMIS) and iCCM surveys

Documentation and circulation of research agenda for iCCM

Second phase (General Domain): Pilot & Early Implementation

- Coordination and Policy Settings:

Establishment of Ministry of Health (MOH) leadership to manage unified iCCM

Completing discussions regarding ongoing policy change, where necessary

- Costing and Financing:

Financing gap analysis

Ministry of Health invest in funding iCCM program

- Human Resources:

Clarifying to community and referral service providers the roles and expectations for Community Health worker (CHW)

Trained CHW, with community and facility participation

Establishment and MOH support of strategies to retain CHW (Implementation of incentive/motivation plans)

- Supply Chain Management:

Consistency in procuring medicines and supplies for iCCM with national policies and plans

Implementation of a logistic system to maintain quality, and quality of products for iCCM

- Service Delivery and Referral:

Assessment of CHWs rationally use of medicines and diagnostics

Revision and modification of guidelines based on pilot

Implementation of referral and counter referral system

Clarification of community information on location of referral facility

Clarification of health personnel on their referral roles

- Communication and Social Mobilization:

Implementation of a communication and social mobilization plan

Availability of materials and messages to aide CHWs

Establishment of dialogue channels for CHW to dialogue with parents and community members about iCCM

- Supervision and Performance Quality Assurance:

Monitoring data and report reviewing of supervision visits (every 1-3 months)

Supervisor visiting homes, community and providing skills coaching CHWs

CHW supervisor’s performance review (includes iCCM supervision)

- Monitoring & Evaluation and Health Information System:

Monitoring framework tested and modified accordingly

Revision of registers and reporting documents

CHWs, supervisors and M&E staff training on the new framework, its components and use of data

Third phase (General Domain): Expansion/Scale-up

- Coordination and Policy Settings:

Institutionalisation of MOH leadership to ensure sustainability

Hold routine stakeholders meetings to ensure coordination of iCCM partners

- Costing and Financing:

Development of a long-term strategy for sustainability and financial viability

Sustain of the MOH investment in iCCM

- Human Resources:

Process establishment for update and discussion of CHW role/expectations

Provide ongoing training to update CHW on new skills and reinforce initial training

Review of CHW retention strategies

Facilitate advancement, promotion and/or retirement to CHWs who express desire to

- Supply Chain Management:

Motorisation of stocks of medicines and supplies at all levels of the system (through routine information system and/or supervision)

Implementation of inventory control and resupply logistics system for iCCM and adaptation based on results of pilot, with no substantial stock-out periods

- Service Delivery and Referral:

Timely deliverable of appropriate diagnosis and treatment by the CHWs

Regular revision and modification (when needed) of guidelines

CHWs referral and counter referral with patient compliance as a routine

- Communication and Social Mobilization:

Establishment of communication and social mobilisation plans

Implementation reviewed and refined based on monitoring and evaluation

- Supervision and Performance Quality Assurance:

CHW Routinely assessment/supervision for quality assurance and performance

Use of reports’ data and community feed-back for problem-solving and coaching

Yearly evaluation of individual performance, coverage or monitoring data

- Monitoring & Evaluation and Health Information System:

Monitoring and evaluation through Health management information system (HMIS) to sustain program impact

Performance of research and external evaluation of iCCM to inform scale-up and sustainability

Other comments

2.3 Documents from Chrodis collaborators and associated partners

DOCUMENT:

de Bruin SR, et al. Comprehensive care programs for patients with multiple chronic conditions: A systematic literature review. Health Policy (2012)

Hopman, EPC, de Bruin SR, Forjaz J, Rodriguez Blazquez C, Tonnara G, Lemmens LC, Onder G, Rijken PM. Comprehensive care programs for patients with multiple chronic conditions and/or frailty: A systematic literature review (update of the article de Bruin SR et al. 2012).

Summary

The first article (de Bruin et al.) provides insight into the characteristics of comprehensive care programs for patients with multiple chronic conditions and their impact on patient's informal caregivers, and professional caregivers. They conducted a systematic review of the literature published between January 1995 and January 2011 and a manual search on the internet using the chronic care model (CCM) to define comprehensive care. After inclusion, the methodological quality of each study was assessed and a best-evidence synthesis was applied to draw conclusions. Forty-two publications were selected describing thirty-three studies evaluating twenty-eight comprehensive care programs for multimorbid patients.

The authors conclude that most of the literature focuses on comprehensive care programs for people with a single disease and its effectiveness remains inconsistent. The majority of comprehensive care programs incorporated interventions related to three or more CCM components. They also conclude that the diversity in the effects of comprehensive care programs may also be related to whether the programs were correctly implemented, whether the program components were integrated, and whether they were fully adopted by the patients and the caregivers involved.

The second article (Hopman et al.) is an update of de Bruin et al. (2012), which overview of existing comprehensive care programs for multimorbid and/or frail patients and gain insight into their characteristics and effectiveness. They performed a systematic literature search in multiple electronic databases published between January 2011 and March 2014. Twenty publications/studies were selected evaluating nineteen comprehensive care programs for multimorbid patients.

They concluded that again, there is a broad array of comprehensive care programs available to multimorbid patients, but because of the heterogeneity of the programs, it is as yet too early to draw firm conclusions regarding their effectiveness. In line with the former literature review [de Bruin et al., 2012], the majority of comprehensive care programs reviewed incorporated interventions related to three or more CCM components.

Contribution to CHRODIS GP assessment dimensions

- Multidisciplinary team work

- Individualized care plans
- implementing evidence-based guidelines
- self-management
- Establishing access to community resources and partnerships with local community service centres
- Involvement and coordination of different disciplines and levels of care (primary and hospitalisation)
- Electronic patients records
- Risk stratification patients to enhance who will benefit most from integrated care programmes
- Integrated care programmes should be patient centred
- Importance of caregivers and/or case managers
- Include care pathways
- Programmes should address poly-pharmacy and patient adherence
- Evaluation of programmes:
    - Patient outcomes: Mental, physical and social status or functioning
        Quality of life
        Satisfaction with received care
    - Healthcare utilisation
        Hospital care
        Community care
        Primary care
        Institutional long-term care
    - Healthcare Costs

Other comments

All comprehensive care programs in both studies included interventions related to the CCM component

DOCUMENT:

Smith SM, Soubhi H, Fortin M, Hudon C, O'Dowd T. Managing patients with multimorbidity: systematic review of interventions in primary care and community settings BMJ 2012;345:e5205 doi: 10.1136/bmj.e5205 (3 September 2012)

Summary

This article tries to determine the effectiveness of interventions designed to improve outcomes in patients with multimorbidity in primary care and community settings. The authors conducted a systematic review of the literature published in different databases from 1990 till April 2011. The types of studies considered eligible for inclusion were randomised controlled trials, controlled clinical trials, controlled before and after studies and interrupted time series analyses and in all languages.

Overall, this study suggests that although the interventions identified all multiple components, they are divided into two mains groups: organisational interventions and predominantly patient oriented.

Organisational interventions targeted at the management of specific risk factors or focused on areas where patients have difficulties, such as with functional ability or the management of medicines; appear more likely to be effective. On the other hand, organisational interventions that have a broader focus, such as case management or changes in delivery of care, seem less effective.

The patient oriented interventions that were not linked to healthcare delivery or specific functional difficulties were also less effective.

The evidence on the care of patients with multimorbidity is limited, despite the prevalence and its impact on patients and healthcare systems. In general the results of this study were mixed and inconclusive. However, the review also indicates that interventions targeted either at specific combinations of common conditions or at specific problems for patients with multiple conditions, may be more effective.

Contribution to CHRODIS GP assessment dimensions

* Two main interventions:

- Patient oriented interventions
- Organisational interventions
    - Case management
    - Coordination of Care
    - Enhancement of skill mix in multidisciplinary teams
    - focusing on specific risk factor management

* Costs

* Acceptability of services

* Drug adherence

* Functional health outcomes

* Utilisation of health services

3. Delphi-m in Patient’s empowerment Interventions with chronic conditions

3.1. Practice appraisal tools

DOCUMENT: SUCCEED. A quality Improvement Tool for HIV Prevention Projects

Summary

Succeed is a tool designed to help HIV prevention projects, assess their objectives, and analyse their ability to meet them with sound, high quality activities.

The SUCCEED tool allows project personnel, and important stakeholders, to review their own work and improve it while its implementation. Succeed is based on scientific research about success factors in the field of health promotion. It has been specifically adapted for its use in HIV prevention. It can be used to review existing interventions or a draft of a new one, using a straightforward questionnaire to capture critical data points about the quality of the project.

The questionnaire broadly addresses three widely-recognized work aspects on quality improvement: Structure, Process and Results. Each part has several sections in which one can choose the questions that apply to the project in order to be assessed. At the end of each section, you can develop and document your own recommendations and actions for improvement.

The SUCCEED tool has been conceived primarily as a self-diagnostic approach to quality improvement.

Contribution to CHRODIS GP assessment dimensions

Two new domains were added from this tool:

Ethical implications of the project
Sustainability of the project. (*This item will be stated from the result of the programme assessment)*
It also contributes to the reinforcement of the following “criteria”:

Theory grounds (well specified and measurable main goal and sub-goals)
Expected size of the effect
Time Schedule
Leadership (and responsibility)
Key population and target population
Community linkages
Financing and sources of funding
Participation and commitment
Mapping of relevant stakeholders
Impact of the implementation in current organization
Specific knowledge transfer strategies planned or already in place
Regularity of monitoring reports and consequences derived from assessment
Evaluation framework assessing process and outcomes
Regarding participation:

Do you know if the stakeholders feel they are active participants in the project?
Does the project track the extent of stakeholder participation?
Have stakeholders made formal commitments about their participation in the project?

If yes, can you list the commitments made by the various stakeholders?
Are there contracts or agreements between the project sponsor and the stakeholders (e.g. between the project sponsor and an implementing partner)?
Are there regular mechanisms for communicating with stakeholders?
Has the project analyzed potential obstacles and/or opponents to its work?

Other comments

Although the SUCCEED tool has been specifically adapted for its use on HIV prevention programs implementation, it is usually considered as a good self-assessment framework for organizations with the intention of implementing broader promotion and prevention programs.

DOCUMENT: European Quality Instrument for Health Promotion (EQUIHP)

Summary

The EQUIHP has been developed as a European consensus tool, facilitating the assessment and improvement of quality in health promotion. It is based on the review of existing tools and European consensus. EQUIHP consists of two components: a Scoring Form (checklist) and a User manual (guideline).

The criteria are clustered into four topics, identifying the areas that are considered essential to achieve quality for effective health promotion: (I) the framework of health promotion principles, (II) aspects regarding project development and implementation, (III) aspects regarding project management, and (IV) sustainability. For each of these areas or ‘clusters’, a number of criteria have been formulated, as well as indicators to measure these criteria.

It is a tool for quality development and assurance of health promotion projects. It can be used throughout the process of planning, implementing and/or assessing a project.

The aim is to obtain more uniformity in quality indices and to facilitate cross-national comparisons and collaboration in enhancing quality in health promotion projects.

This approach embraces the principles of health promotion, including a positive and comprehensive approach to health, attention for the broad determinants of health, participation, empowerment, equity and equality.

Contribution to CHRODIS GP assessment dimensions

This document provided us with the theoretical framework (health promotion principles) used for structuring the general domains of analysis into a comprehensive map of areas and assessment criteria. Domains and subdomains of analysis were arranged to meet this working frame.

The 4 areas mentioned above, and most of the criteria configured in those 'clusters' were matched with the domains previously identified, positioning them into a broader context.

The final structure of the questionnaire includes:

I - Framework of health promotion principles

II - Project development & implementation

Analysis
Aims & objectives
Target group(s)
Intervention (strategies and methods) // Implementation strategy
Evaluation

III - Project management

Leadership
Capacity and resources
Participation & commitment
Dissemination // Knowledge transfer
Integration or interaction with the healthcare system

) Community linkages // Networks
) Ethical implications
IV- Sustainability

Participation & commitment

The ways in which various parties will be involved and committed to the project is clearly outlined. The following indicators will help you to determine the level of participation and commitment:

1. Has the way in which collaboration and synergy (networking) will be obtained been clearly specified?

2. Have the internal and external partners been identified who are required for adequate support and commitment at each stage of the project?

3. Will working methods be used that take into account the different perspectives and contributions of different partners?

4. Is the participation foreseen in the organisation of the project (e.g., steering/advisory committee)?

5. Have the potential opponents and obstacles of the project been identified?

6. Will participation of internal and external partners be formalised via agreements?

Other comments

The user manual includes a Glossary of terms as an annex which we used to complement our own glossary of terms.

Besides, as a part of the Scoring Form (checklist), we found the scale used to evaluate each indicator as ‘achieved’, ‘partially achieved’ and ‘not achieved’, appealing.

DOCUMENT: A compilation of Good Practices Replicating and Tutoring Integrated Care for Chronic Diseases, Including Remote Monitoring at Regional Level.http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/gp_b3.pdf#view=fit&pagemode=none

Summary

Good Practices following the integrated care model (an European adaptation of the Chronic Care Model) https://webgate.ec.europa.eu/eipaha/infographics/B3.jpg

Contribution to CHRODIS GP assessment dimensions

Best practices that included patient empowerment

Apps where patients introduce their medical data and they receive tailored healthy living advices.
Training programmes to support patients and carers and develop support tools for self-management and patient involvement
continuity of care projects changing work processes or integrating information of different providers sometimes including patients
care outside the hospital for chronic patients with all or some of the following elements:
care coordination: to ensure attention to patient needs, plan and brig data to the clinical team
Tele-monitoring: can be preventive or for acute periods.
In some cases consists in periodical calls to patients to collect basic vitals (that have been measured at home), survey data about health and lifestyle and receiving advice to promote autonomy
In some others, call centre for specific conditions where patients can call with doubts or seeking help in acute episodes
some require monitorization technology as portable electrocardiograms
Access to Personal Health Records for self- monitorization, linked to tailored learning resources and remote assistance
Community care: mainly in care homes

DOCUMENT: Assessment of Chronic Illness Care (ACIC): A Practical Tool to Measure Quality Improvement - MacColl Institute for Healthcare Innovation (USA)

Summary

The content of the ACIC was derived from specific evidence-based interventions for the six components of the Chronic Care Model (community resources, health organization, self-management support, delivery system design, decision support and clinical information systems). Like the Chronic Care Model, the ACIC addresses the basic elements for improving chronic illness care at the community, organization, practice and patient level.

The ACIC provides subscale scores corresponding to each of the Chronic Care Model elements, as well as an overall score.

Contribution to CHRODIS GP assessment dimensions

From this tool, new domains or specifications have been added:

Community linkage between the health delivery system (or providers) and the Community (Linking Patients to Outside Resources, Partnerships with Community Organizations
Self-Management Support. Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness and reduce complications and symptoms.
Patient's participation in the programme and to consider their empowerment as a final aim of the programme
The need of evidence based resources available for professionals and patient's
Assessment and Documentation of Self-Management Needs and Activities
Self-Management Support
Addressing Concerns of Patients and Families
Effective Behaviour Change Interventions and Peer Support
Decision Support: Informing Patients about Evidence based Guidelines
Delivery System Design. Evidence suggests that effective chronic illness management involves more than simply adding additional interventions to a current system focused on acute care: appointment system, follow up, Planned Visits for Chronic Illness Care, continuity of care.

DOCUMENT: PACIC-tool: Patient assessment of chronic illness care. (PACIC-tool PLUS)

Synthesis

PACIC survey is a patient-centered instrument for evaluating the quality and patient-centeredness of chronic illness care received according to the Chronic Care Model paradigm.

In defining six aims for transforming healthcare in America, the Institute of Medicine Quality Chasm Report declared "patient centeredness" a central feature of quality, along with safety, promptness, effectiveness, efficiency and equity. Patient centeredness may be a first principle that can provide a lens to focus action, and as such can be used as the guide for achieving all six aims.

Historically, patient centeredness has been regarded as the assessment of needs and preferences to consider social and cultural factors affecting the clinical encounter or compliance with treatment. There is a growing consensus that patients have a more active role to play in defining and reforming healthcare, particularly in chronic disease management, where patients provide the majority of care in day-to-day management of their illness.

The revised documents correspond to the 20- and the 26-item version of the PACIC. They measure specific actions or qualities of care, congruent with the CCM, that patient's report they have experienced in the delivery system. The survey should be sufficiently brief to use in many settings. When paired with the ACIC, these tools can provide complementary consumer and provider assessments of important aspects of care for chronic illness patients.

Available from the Improving Chronic Illness Care webpage through the following link: http://www.improvingchroniccare.org/downloads/pacic.pdf

Contribution

Patient Activation (items 1-3)

- Empowerment (governance participation, social involvement, etc.)
- Self-management
- Quality of life

Delivery System Design/Decision Support (items 4-6)

- Bidirectional Communication
- Assistance at home (primary care, palliative care)

Goal Setting (items 7-11)

- Planification of care takes patient's plans into account

Problem-solving/Contextual Counselling (items 12-15)

- Education
- Integration in the patients community (NGO, support groups)
- Counselling (decision support (tools and personal assistance)

Follow-up/Coordination (items 16-20)

- Multidisciplinary, across levels coordination
- Monitoring, emergency care rapid response
- Telephone follow-up after contact with the healthcare system

Other comments

DOCUMENT: CDC Program Performance and Evaluation Office (PPEO) – Program Evaluation Steps

Summary

This CDC evaluation framework gives public health professionals a starting point for evaluating public health programs. The evaluation includes six ordered steps that can be used as a starting point to tailor an evaluation for a particular public health effort, at a particular point in time. In general, the earlier steps provide the foundation for subsequent progress.

7. Engage stakeholders, including those involved in program operation; those served or affected by the program; and primary key users of the evaluation.
8. Describe the program, including the need, expected effects, activities, resources, stage, context and logic model.
9. Focus the evaluation design to assess the issues of greatest concern to stakeholders while using time and resources as efficiently as possible. Considering the purpose, users, uses, questions, methods and agreements.
10. Gather credible evidence to strengthen evaluation judgements and the recommendations that follow. These aspects of evidence gathering typically affect perceptions of credibility: indicators, sources, quality, quantity and logistics.
11. Justify conclusions by linking them to the evidence gathered and judging them against agreed-upon values or standards set by the stakeholders. Justify conclusions on the basis of evidence using these five elements: standards, analysis/synthesis, interpretation, judgement and recommendations.
12. Ensure use and share lessons learned with these steps: design, preparation, feedback, follow-up and dissemination.

Attached to this, there is a document of evaluation standards (CDC), setting 30 standards assessing the quality of evaluation activities determining whether a set of evaluative activities are well-designed and working to their potential. These standards, adopted from the Joint Committee on Standards for Educational Evaluation, answer the question, "Will this evaluation be effective?"

The 30 standards are organized into the following four groups:

3 Utility standards, ensuring that an evaluation will serve the information needs of intended users.

4 Feasibility standards, ensuring that an evaluation will be realistic, prudent, diplomatic and frugal.

5 Proprietary standards, ensuring that an evaluation will be conducted legally, ethically and with due regard for the welfare of those involved in the evaluation, as well as those affected by its results.

6 Accuracy standards, ensuring that an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated.

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following “criteria”:

- Quality Management // Evaluation of the program (project):
    - Consulting insiders and outsiders
    - Taking special effort to promote the inclusion of less powerful groups or individuals
    - Coordinating and including stakeholder input throughout the evaluation design, operation and use
    - Identification of the purpose of evaluation (who and how the evaluation results are to be used)
- Intervention & Implementation strategy:
    - Characterizing the set of needs addressed
    - Listing specific expectations as goals with explicit criteria of success
    - Clarifying by an explicit logic model the relationships between program elements and expected changes
    - Assessing the program’s maturity or stage of development
    - Integration of the program (project) with other ongoing efforts
- Integrated action concept and networking: systematic networking to exchange information, mutual support and cooperation
- Quality management: framework to be tested on a regular basis for potential improvements:
    - Choosing indicators that meaningfully address evaluation questions
    - Description of practical methods for sampling, data collection, data analysis, interpretation and judgement
    - Existence of written protocols or agreements that summarize the evaluation procedures
    - Existence of clear roles and responsibilities for change management of the program (project) when critical circumstances change
    - Safeguarding the confidentiality of information and information sources
    - Using appropriate methods of analysis and synthesis to summarize findings
    - Interpreting the significance of results for deciding what the findings mean
    - Considering alternative ways to compare results with program objectives (comparison groups, past performances)

    - Recommending actions or decisions that are consistent with the conclusions and limiting conclusions to situations, time periods, persons, contexts, and purposes for which findings are applicable

- Dissemination and knowledge transfer:
    - Providing continuous feedback to stakeholders regarding interim findings, provisional interpretations and decisions to be made that might affect likelihood of use
    - Scheduling follow-up meetings with intended users to facilitate the transfer of evaluation conclusions into appropriate actions or decisions
    - Disseminating both the procedures used and the lessons learned from the evaluation to stakeholders, using tailored communication strategies that meet their particular needs

Other comments

gh it is framed into the context of a meta-evaluation of the assessment process; this document also includes a reference to a ‘Checklist for ensuring effective evaluation reports’ adapted from *Worthen BR, Sanders JR, Fitzpatrick JL. Program evaluation: alternative approaches and practical guidelines. 2nd ed. New York, NY: Addison, Wesley Logman, Inc. 1997*.

ecklist has been also reviewed in order to address our evaluation model to some of those recommendations.

DOCUMENT: Quint-essenz: Swiss quality criteria for health promotion and prevention programmes www.quint-essenz.ch

Summary

Quality system Quint-essenz (www.quint-essenz.ch) has been funded and developed by Health Promotion Switzerland. Part of their work has been developing a set of criteria for systematic project quality assessment, specifically for intervention projects in health promotion and prevention. It has been developed in partnership with scientists and practitioners.

Its objectives are:

- To systematically reflect and evaluate intervention projects during their different phases.
- To identify strengths and potential for improvement.
- To determine priority areas where improvement in the project is necessary.
- To set goals for quality and to define measures for improvement

The core of the system constitutes 24 quality criteria that are corroborated in terms of indicators which identify strengths and weaknesses, determine priority areas and define measures for improvement and make project's qualities visible.

An initial assessment is needed to determine which criteria and indicators are the most relevant for a project at specific point in time (project design, implementation or valorisation). To assess each phase-specific indicator on a scale from minus to maximum.

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following "criteria":

- Equity approach: considerations of gender, social status, cultural and linguistic diversity. Quint essenz includes this criteria in project design, implementation and evaluation
- Target population empowerment: reinforcing individual resources
- Participation and commitment of stakeholders and/or target groups:
  - The principal actors in each setting are involved in the planning and implementation of the project.
  - The project's structure is adequate and comprehensible for all concerned.
  - The project leaders and all others involved in the project are adequately qualified to accomplish their tasks.
- Evidence of the health problem addressed and need of the programme
- Practice shows alignment with broader health programmes or national strategies.
- Contextual conditions as part of the systematic analysis of the health problem addressed.
- Potential for conflicts of interest in the project environment
- Project's objectives state clearly the desired effect on the various target groups

- Intervention strategies and methods:
  - Justification for proposed procedures
  - Time Schedule
  - Availability of necessary resources
  - All the resources needed for the programme are in the budget
- Community linkages/Network: The project is making the most of possible networking opportunities in order to achieve its objectives.
- Evaluation:
  - The project is managed by periodical target-performance comparisons.
  - The evaluation contributes to the best possible management of the project and allows a conclusive assessment of the project.
  - The project's objectives have been reviewed and they have been attained.
- Dissemination, scaling up and knowledge transfer:
  - All the important aspects of the project have been documented in a comprehensible manner.
  - Sustainability: The project aims at long-term changes.
  - Results and experiences from the project are disseminated and made available in a purposeful manner.

Other comments

map of dimensions these criteria have not been considered:

- Attribution of indicators to specific project phases: Project Design (PD), Implementation (IM), Valorisation (VA).
- The communication processes within the project structure are adequate. The project management and the team are motivated to work in the best possible way.

3.2. Practice appraisal frameworks

DOCUMENT: Expert panel on effective ways of investing in health (EXPH). Definition and Endorsement of Criteria to Identify Priority Areas. When Assessing the Performance of Health Systems. The EXPH adopted this opinion at its 4th plenary of 27 February 2014

Summary

Scientific advice is an essential requirement for the Commission to pursue modern, responsive and sustainable health systems. With this aim, the European Commission has set up a multidisciplinary and independent Expert Panel which provides advice on effective ways of investing in health (Commission Decision 2012/C 198/06).

The core element of the Expert Panel's mission is to provide the Commission with independent advice in response to questions submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability.

The areas of competence of the Expert Panel include different settings such as primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities among others.

As part of this process and by mandate of the Council Working Party on Public Health at senior level, Sweden is co-ordinating a sub-group on measuring and monitoring the effectiveness of health investments.

The Sub-group of the Working Party on Public Health has developed a framework and set of criteria to identify priority areas when assessing the performance of health systems in Europe.

The Expert Panel provided its views on the framework prepared by the Working Party Sub-group (review the criteria used, identify weaknesses and make recommendations on ways to address them, identify additional elements which have not been taken into account or are not properly represented and make recommendations for their inclusion), and test the framework in real life situations at Member State and at EU level. In doing so, the Expert Panel should provide guidance on the methodologies and approaches which will need to be taken in order to test the framework.

Contribution to CHRODIS GP assessment dimensions

Criteria:

Impact:

- Which impact can it be expected from the implementation of the policies considering the context?
- Universality (coverage, "access to good quality care" dimension)
- Health equity (health recovery, maintenance and improvement)
- Solidarity (expenditure, financial protection, fair financing and distribution)
- Responsiveness (self-perceived acceptability of health system)
- Economic impact (economy, employability, productivity, social cohesion etc)

- High quality and safety services (services, safety, effectiveness…)

Feasibility

- Is the organisation feasible?
- Knowledge (evidence based interventions and policymaking)
- Reaction Time (effects/visibility: time needed to asses impact)
- Political Agenda (government program, European agenda…)
- Stewardship (leadership)
- Acceptability (public, professionals, industries, political parties, patient’s associations)
- Costs (affordability)
- Monitoring (measure and monitor achievements)

Prioritization:

Prioritization of areas or policies after comparing the cost and the effectiveness of different options

Evaluation:

National or regional indicators

Other comments

DOCUMENT: ▪ Patient Empowerment in the European Health services: The Health Systems and Policy Monitor http://www.hspm.org/

Summary

The HSPM collects information on European NHS in different areas. The information on patient empowerment has been reviewed. It mainly focuses on patient’s rights regarding information, choice, public participation, compensation.

Some patient driven interventions have been implemented at national level

<u>Information</u>

Telephonic Information for patients (UK) or carers (Austria)

Health information online (Austria)

Integrated Patient Handbook contains information about patient's right to health care services, treatments, provided health care services and other benefits, prescribed medicines and on the financing of the treatment.

Right to refuse to be informed

Right to inspect or copy patient file

Right to be informed of diagnosis, prognosis, treatment (some include treatment alternatives) (some countries oral and written)

Transparency portals, waiting list information

Patient offices (Denmark) for information on the system, counselling, complains

Choice: mainly choosing GP

Public participation

Patient Associations are consulted by the Gov. Health Department

Patient inclusion in administration boards (hospitals, elders' homes). (Belgium, France)

Umbrella patient association www.leciss.org (France) Danish Patient (Denmark)

National/local Patient forums

NSUE http://www.nsue.ie/ users participate in the redefinition of mental health services (Ireland)

Contribution to CHRODIS GP assessment dimensions

DOCUMENT: Empathy Empowering patients in the management of chronic diseases

Summary

EMPATHiE Project has analysed patient empowerment (PE) for patients with chronic diseases. The results of this project include a catalogue of best practices in PE, that has found four types of promising strategies established effective practices (such self-management support and patient education); recent innovative practices (such as virtual interactive platforms and tele-monitoring through smart-phones); shared decision making practices and systemic changes regarding the model of care (such as the chronic care model).

Contribution to CHRODIS GP assessment dimensions

Interventions

self-management
education or health literacy
multidimensional interventions

SDM

Outcomes

Patient Empowerment related measurements
Patient perception/satisfaction
Professional perception/satisfaction
Quality of life
Clinical outcomes
Use of health services (ER, Cost, time…)
Patient-provider relationships

Settings

clinical encounter
web-based, paper
Local, institutional, national, international
Primary care

Multimorbidity /co-morbidity

Continuity of care (a proper coordination between levels of care) workflows include multiplicity of scenarios, the participation of different professional groups and the sequential nature of the proceedings, in order to address health care processes integrally.
Care pathways for multimorbid patients
Adapting evidence for individual comorbidity cases
Facilitators/Barriers for co-morbid patient empowerment better motivation to change lifestyle; professional fragmentation; different conditions are treated separately; teamwork professionals

Patient centred care/ Patient Empowerment Dimensions

considering patient needs and preferences
Support autonomy
Support ownership
Create strengths and resources (salutogenetic approach (?)
Access to information and health literacy covering all aspects of health, including prevention, treatment options, evidence-base for different treatments, and lifestyle advice.
ensuring that health professionals have the right skills, knowledge and attitudes to practice patient-centred healthcare
Self-management supported by technology
Transparent quality data for patient choice

Other Comments

DOCUMENT: Canadian best practice portal (http://cbpp-pcpe.phac-aspc.gc.ca/)

Summary

The Canadian Best Practices portal was originally launched in 2006 and supported by the Centre for Chronic Disease Prevention (CCDP) within the Public Health Agency of Canada. The portal includes a searchable list of Best Practice Interventions relevant to chronic disease prevention and health promotion.

The aim of the Best Practices Intervention Section is to provide decision-makers with access to published information about proven best practices.

The Best Practice Interventions include interventions, programs/services, strategies, or policies which have demonstrated desired changes through the use of appropriate well documented research or evaluation methodologies and have the ability to be replicated and the potential to be adapted and transferred.

For the practice to be included in the portal and be considered a Best Practice must satisfy five required criteria:

- The Type of intervention is appropriate
- Evaluation of the intervention
- Impact
- Replicability and adaptability
- Source

Contribution to CHRODIS GP assessment dimensions

Reinforcement of the following “criteria”:

- Ethical implications
    - Interventions must have been developed free of commercial interests that may compromise integrity
- Analysis: the practice is based on a systematic analysis of the health problem and its determinants
    - Addresses health determinants
    - Focuses on a population health
- Evaluation framework assessing process and outcomes

Other comments

DOCUMENT: Preventing and Managing Chronic Disease: Ontario’s Framework

Contribution to CHRODIS GP assessment dimensions

Productive interactions and relationships
Informed, activated individuals & families
Activated communities & prepared, proactive community partners
Self-management Supports
Clients are part of care team and engaged in shared decision making
Individuals empowered to be self-managers
Self-management support services organized for clients
Shared clinical guidelines
Follow-up
Innovative Patient Interactions : regular group-classes (vs 15 min. visits)
Telephone contact has been found to be effective, and is low-cost
Managing and preventing chronic disease successfully requires regular, ongoing contact with clients
Care Planning, Care Paths and Care Management:
Periodic planned visits between clients and their care team that focus solely on clients’ chronic conditions, have been found to improve health outcomes and reduce the number of specialty and acute care visits.
Patient-centred care plan tailored to the client’s specific needs, capacities, circumstances and wishes.
Enhanced Health Promotion and Prevention
Outreach, Population Needs-Based Care and Cultural Sensitivity : culture and Social Determinants of Health
Sharing access to Electronic Medical Records with clients has also been shown to increase clients’ ability to self-manage chronic conditions and take charge of their health.
Public Participation Strengthening community action also involves mobilizing individuals and families to participate in organized community action.
Enhancing Local knowledge, Skills and Resources

Other Comments

DOCUMENT: Centers for Disease Control and Prevention (CDC): Program Evaluation in Public Health, steps and standards.

http://thecommunityguide.org/toolbox/assess-and-evaluate.html

Summary

This CDC evaluation framework gives public health professionals a starting point for evaluating public health programs. The evaluation includes six ordered steps that can be used as a starting point to tailor an evaluation for a particular public health effort, at a particular point in time. In general, the earlier steps provide the foundation for subsequent progress.

13. Engage stakeholders, including those involved in program operation; those served or affected by the program; and primary key users of the evaluation.
14. Describe the program, including the need, expected effects, activities, resources, stage, context and logic model.
15. Focus the evaluation design to assess the issues of greatest concern to stakeholders while using time and resources as efficiently as possible. Considering the purpose, users, uses, questions, methods and agreements.
16. Gather credible evidence to strengthen evaluation judgements and the recommendations that follow. These aspects of evidence gathering typically affect perceptions of credibility: indicators, sources, quality, quantity and logistics.
17. Justify conclusions by linking them to the evidence gathered and judging them against agreed-upon values or standards set by the stakeholders. Justify conclusions on the basis of evidence using these five elements: standards, analysis/synthesis, interpretation, judgement and recommendations.
18. Ensure use and share lessons learned with these steps: design, preparation, feedback, follow-up and dissemination.

Attached to this, there is a document of evaluation standards (CDC), setting 30 standards assessing the quality of evaluation activities determining whether a set of evaluative activities are well-designed and working to their potential. These standards, adopted from the Joint Committee on Standards for Educational Evaluation, answer the question, "Will this evaluation be effective?"

The 30 standards are organized into the following four groups:

5. Utility standards, ensuring that an evaluation will serve the information needs of intended users.
6. Feasibility standards, ensuring that an evaluation will be realistic, prudent, diplomatic and frugal.
7. Proprietary standards, ensuring that an evaluation will be conducted legally, ethically and with due regard for the welfare of those involved in the evaluation, as well as those affected by its results.
8. Accuracy standards, ensuring that an evaluation will reveal and convey technically adequate information about the features that determine worth or merit of the program being evaluated.

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following "criteria":

- Quality Management // Evaluation of the program (project):
  - Consulting insiders and outsiders
  - Taking special effort to promote the inclusion of less powerful groups or individuals
  - Coordinating and including stakeholder input throughout the evaluation design, operation and use
  - Identification of the purpose of evaluation (who and how the evaluation results are to be used)
- Intervention & Implementation strategy:
  - Characterizing the set of needs addressed
  - Listing specific expectations as goals with explicit criteria of success
  - Clarifying by an explicit logic model the relationships between program elements and expected changes
  - Assessing the program's maturity or stage of development
  - Integration of the program (project) with other ongoing efforts
- Integrated action concept and networking: systematic networking to exchange information, mutual support and cooperation
- Quality management: framework to be tested on a regular basis for potential improvements:
  - Choosing indicators that meaningfully address evaluation questions
  - Description of practical methods for sampling, data collection, data analysis, interpretation and judgement
  - Existence of written protocols or agreements that summarize the evaluation procedures
  - Existence of clear roles and responsibilities for change management of the program (project) when critical circumstances change
  - Safeguarding the confidentiality of information and information sources
  - Using appropriate methods of analysis and synthesis to summarize findings
  - Interpreting the significance of results for deciding what the findings mean
  - Considering alternative ways to compare results with program objectives (comparison groups, past performances)
  - Recommending actions or decisions that are consistent with the conclusions and limiting conclusions to situations, time periods, persons, contexts, and purposes for which findings are applicable
- Dissemination and knowledge transfer:
  - Providing continuous feedback to stakeholders regarding interim findings, provisional interpretations and decisions to be made that might affect likelihood of use
  - Scheduling follow-up meetings with intended users to facilitate the transfer of evaluation conclusions into appropriate actions or decisions

- Disseminating both the procedures used and the lessons learned from the evaluation to stakeholders, using tailored communication strategies that meet their particular needs

Other comments

gh there is framed into the context of a meta-evaluation of the assessment process; this document also includes a reference to a ‘Checklist for ensuring effective evaluation reports’ adapted from *Worthen BR, Sanders JR, Fitzpatrick JL. Program evaluation: alternative approaches and practical guidelines. 2nd ed. New York, NY: Addison, Wesley Logman, Inc. 1997*.

ecklist has been also reviewed in order to address in our evaluation model to some of those recommendations.

3.3. World Health Organization (WHO) documents

DOCUMENT: Coulter A, Parsons S and Askham J. Where are the patients in decision-making about their own care? World Health Organization and World Health Organization, on behalf of the European Observatory on Health Systems and Policies. (2008)

Summary

Strategies for promoting an active role for patients should pay attention to health literacy, shared decision-making and self-management. A number of interventions have been shown to be effective in building health literacy, promoting patient involvement in treatment decisions and educating patients to play an active role in self-management of chronic conditions. These interventions include:

- written information that supplements clinical consultations
- web sites and other electronic information sources
- personalized computer-based information and virtual support
- training for health professionals in communication skills
- coaching and question prompts for patients
- decision aids for patients
- Self-management education programmes.

It focuses on strategies to improve:

- health literacy
- treatment decision-making
- Self-management of chronic conditions.

The Chronic Care Model developed by Ed Wagner and his colleagues in the United States has been highly influential internationally (10).

Contribution to CHRODIS GP assessment dimensions

Educating patients about self-management can improve their knowledge and understanding of their condition, coping behaviour, adherence to treatment recommendations, and sense of self-efficacy and symptom levels. Computer-based self-management education and support help to increase a patient’s knowledge and self-care ability and help improve social support, leading to better health behaviour and a better outcome. Self-management initiatives appear to work better when integrated into the healthcare system, instead of being organized separately. The role of health professionals in guiding patients through the process is critical to successfully implementing these initiatives.

Implementation: it requires a whole-system approach Governments, health authorities or payers looking for ways to inform and empower patients need to agree on clear goals and a coherent strategy, with actions targeted at macro (national), meso (regional) and micro (organizational) levels. This coherent strategy requires a whole-system approach, in which support for patient involvement is built into the following types of initiatives:

• patients’ rights or charters;

• regulatory requirements for provider organizations, including financial incentives and contracts;

• procedures for professional regulation, including patient feedback on interpersonal skills and quality of care;

• provision of health information materials, websites and portals;

• training health professionals in communication skills; • self-care education and support integrated into all levels of health delivery; and • specific aids and techniques to help patients play a more active role

The goal of self-management support is to enable patients to perform three sets of tasks (11): 1. Managing their illness medically – for example, taking medication or adhering to a special diet; 2. Carrying out normal roles and activities; and 3. Managing the emotional effect of their illness.

DOCUMENT: Global Status Report on Non Communicable Diseases (2010)

https://apps.who.int/iris/bitstream/handle/10665/44579/9789240686458_eng.pdf;jsessionid=33653B889F0FA802A1C612AEFFC23F52?sequence=1

Summary

This report was prepared by the WHO Secretariat under Objective 6 of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs. It focuses on the current global status of NCDs and will be followed by another report to assess progress in 2013.

Contribution to CHRODIS GP assessment dimensions

Self-care programmes are seen as a vital form of prevention in those at high risk and in improving outcomes in people with NCDs. They have also been shown to reduce demand on health services and thereby cut costs of care (44). Self-care is defined by WHO as including “activities that individuals, families, and communities undertake with the intention of enhancing health, preventing disease, limiting illness and restoring health”. Techniques and approaches used in self-care programmes include the “patient as the expert” approach, nurse-led programmes, home self-monitoring techniques and programmes using new information technologies, such as mobile phones, computer networks, web-based tools and telemedicine. In general, self-care programmes aim to increase the interest and involvement of people in their own care, and by doing so, empower them to manage their condition. They use educational or self-management interventions to improve patients’ management of their conditions. These interventions are designed to impart knowledge and skills to enable patients to participate in decision-making, to monitor and control the disease and to change behaviour. Published literature demonstrates that patient education for self-care can provide benefits in terms of knowledge, self-efficacy and health status (45). Although the amount of scientific c enquiry into the direct associations between increased health literacy and improved health outcomes on NCD-related health outcomes is scant, the impact of health education, an important component of self-care, is known (46), particularly in smoking cessation interventions directed towards individual smokers through individual and group counselling and mass education (47, 48). The effectiveness of individual patient education in the management of diabetes has also been reported to be positive (49) but it is not yet supported by quality evidence (50).

DOCUMENT: Draft comprehensive global monitoring framework and targets for the prevention and control of NCD 2013

https://apps.who.int/iris/handle/10665/105633

Summary

The review of this report did not add any additional information.

3.4 Documents from Chrodis collaborators and associated partners

DOCUMENT: WP5-Task 1. Questionnaire on “Good Practice in the Field of Health Promotion and Chronic Disease Prevention”

Summary

The objective of CHRODIS WP 5 (Objective Nº 2 in CHRODIS work programme) is to promote the exchange, scaling up, and transfers of highly promising, cost-effective and innovative health promotion and primary prevention practices.

In order to achieve this aim, WP5 developed the questionnaire on “Good practice in the field of health promotion and primary prevention” to get an overview of existing mechanisms and policies and to identify where good practice exists and where needs lie in the participating EU countries.

Responses to this questionnaire have constituted WP5 partners Country Reviews and describe how health promotion and primary prevention is currently being delivered in different countries and also set the stage to help partners identify promising practices being applied in their own countries.

Evidence extracted from the specific country responses are separately analysed in the following items

Contribution to CHRODIS GP assessment dimensions

From this questionnaire, a new domain have been added:

- Integration and/or interaction with Health delivery system and Community linkages Plus… Development or reinforcement of the following “criteria”:
- Estimated size of effect, effectiveness and economic analysis within section Analysis
- Dissemination, scaling up and knowledge transfer
- Equity approach in target population
- Definition of Integration and/or interaction with Health delivery system

- Capacity and resources: data collection systems, personal training, financing and Budget impact
- Leadership
- Evaluation

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Bulgaria

Summary

Bulgaria implemented a comprehensive national health strategy which entails different policies and guidelines in the field of CVD, stroke and Diabetes:

- National Program for Prevention of Chronic Non-communicable Diseases 2014-2020
- Better Healthcare Concept
- Health Strategy for Disadvantaged Ethnic Minorities
- National Strategy for Physical Education and Sports Development of Republic of Bulgaria 2012 - 2022
- National Strategy for Demographic Development in Republic of Bulgaria - update (2012-2030)
- National Strategy for Poverty Reduction and Social Inclusion Promotion 2020
- The National Strategy of the Republic of Bulgaria on Roma Integration (2012 - 2020)
- National Strategy for Long-term Care
- National Plan to Promote Active Aging among Elderly in Bulgaria (2012-2030)

The above-stated policies include monitoring and evaluation frameworks, timeframes for implementation and target indicators.

Health inequalities and the socio-economic gradient are addressed in the following policies - National Strategy for Poverty Reduction and Social Inclusion Promotion 2020 and National Strategy of the Republic of Bulgaria on Roma Integration (2012 - 2020).

The target group of the older population (65 and over) is specifically addressed in the updated version of the National Strategy for Demographic Development in the Republic of Bulgaria (2012-2030), National Plan to Promote Active Aging among Elderly (2012-2030), and National Strategy for Long-term Care.

Contribution to CHRODIS GP assessment dimensions

Criteria reflected in the Bulgarian health strategy:

- Comprehensiveness
    - Alignment with other strategies
- Aims & Objectives (Bulgaria's approach follows a clear structure
- Multi-stakeholder approach
- Empowerment (e.g. "enhancing the capacity of the community in the health field")
- Indicator "community linkage" ("Improving the network in support of health formed by local institutions, NGOs and individuals.")
- Equity approach (Commitments and strategies addressing health inequities and supporting socially vulnerable populations)

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Cyprus

Summary

Cyprus implemented a national health framework through the MoH which entails a strategic plan on Diabetes, currently under revision.

Policy development included the participation of stakeholders who were able to set specific goals and describe the mechanisms to facilitate the implementation of the strategy. These stakeholders are also responsible to implement the strategy.

Contribution to CHRODIS GP assessment dimensions

Criteria reflected by the Cypriotic approach:

- Comprehensiveness (e.g. through Health in all policies)
- Multi-Stakeholder Approach / Inter-sectoral work
- Equity
- Evidence / Context analysis

  Indicators:

    - Health Impact Assessment
    - Theoretical basis of the programme

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Estonia

Summary

Estonia has electronic database for health-promoting activities (Created by the National Institute for Health Development 2010) http://www.terviseinfo.ee/et/toeoevahendid/toovahendid/tervist-toetavate-tegevuste-andmebaas

(Before that electronic database Institute published annually a book with some of the selected best practices).

Prevention activities should be described by the target, location, and time. Activities can be searched by keyword or filter field.

All inserted activities are revised by health promotion specialist, to evaluate evidence base, and whether the action is justified by the need and methodology.

There is a need to develop special criteria to evaluate the “best practices” in that database. It has no proper assessment tool. At the moment there exists only a possibility to “like” the activities to signal either you like it or not.

Contribution to CHRODIS GP assessment dimensions

The following categories are applied in the database and included in the template (criteria/indicators in italic)

- Target group
    - Main target group
    - Main target group stratification
    - Main target age
    - Main target gender
    - Planned target area:
    - Actual presence of how many target persons
- Description
    - Objectives
- Methodology
- Evidence
- Evaluation of performance
- Reporting on results
- Final recommendation for the practice

- Budget and partners

Other comments

DOCUMENT: Questionnaire WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Germany

Summary

Information provided through Work Package 5 partner BZgA, Germany.

The cooperation network “Equity in Health” is a nation-wide strategy to tackle health inequities with a database for “Best Practice” Interventions as the core of the activities.

The presented concept follows the overarching aim to identify good practices in health promotion especially among socially disadvantaged and/or vulnerable groups.

Contribution to CHRODIS GP assessment dimensions

The following criteria have been taken into account:

- Target Group Orientation
- Innovation and Sustainability (this is a joint criteria in the German concept. The criteria were separately included in the template)
- Low Threshold
- Participation
- Empowerment
- Integrated Action Concept and Networking
- Documentation and Evaluation

Included but in different context:

- Concept and Statement of Purpose (dissolved within the dimension “Concept and Design -> Criteria Aims and Objectives”)
- Intermediary Concept (indicator of criteria “Scalability)
- Setting Approach (indicator under criteria “target group”)
- Quality Management (subsumed in “Evaluation”)
- Cost-Benefit Ratio (used as indicator, not a criteria on its own)

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Greece

Summary

There is no national mechanism or criteria to identify good practice and no good practice databases in Greece.

The Centre for Health Services Research at the University of Athens uses and advocates for the European Quality Instrument for Health Promotion (EQUIHP) - however it has not been adopted yet at a central level for the evaluation processes of the funded projects.

Contribution to CHRODIS GP assessment dimensions

See SoE on EQUIHP

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Iceland

Summary

Iceland implemented a national health strategy which is implemented through the development and provision of guidelines.

Icelands public health guidelines follows a life cycle perspective and provides guidelines and information on selected topics for different steps in the life cycle, e.g. healthy ageing.

Topics for public health practices for older people include

Health and wellbeing

- Alcohol and drug abuse and older people
- Mental health and older people
- Health of older people
- Exercise and older people

- Nutrition and older people
- Violence and the prevention of accidents and elderly people
- Dental care and older people
- Nursing and residential - numbers

In addition to domestic research and experiences, health promotion and primary prevention practice initiated by the health sector is usually based on guidance and recommendations published by e.g. WHO, EU and the Nordic council of ministers.

Contribution to CHRODIS GP assessment dimensions

The Public Health Fund of Iceland defines criteria for the funding of public health programmes (http://lydheilsusjodur.sidan.is/content/files/public/uthlutunarreglur.pdf – translation below through Google Translate).

Criteria which were included in the criteria template *(Criteria and Indicators in italic)*:

- Projects that are consistent with the policies and programs of the government in public health (*Alignment/Comprehensiveness)*.
- The value and importance of the project for public health (*Relevance*)
- Gender and residence distribution. (*Equity: Gender, Rural&urban*)
- Applications for funding for projects must be professionally processed and based on the results of research or equivalent professional data (*Evidence base*).
- Projects must have clear objectives and the projected results (*Aims and Objectives*).
- Provision of a manner in which performance will be assessed *(Evaluation, Effectiveness)*

Furthermore the following funding priorities of the City of Reykjavik prevention fund have been taken into account in the template:

(http://reykjavik.is/sites/default/files/2013_reglur_forvarnarsjods.pdf **)**

- Strengthening social capital in neighborhoods in the city *(Empowerment)*
- Systematic collaboration of residents, organizations and businesses for the benefit of preventive and social capital *(Scalability: Community linkages/Networks)*
- Projects that meet the goals set by the City Council, such as the prevention strategy goals of the City *(Concept and Design: Comprehensiveness)*

Other comments

Further funding criteria which were not included in the template because they are too specific for funding mechanisms rather than related to actual good practice identification:

- Applications must be accompanied by budget.
- Grants are generally awarded to companies, organizations and public authorities.
- Individuals are normally only awarded grants for research projects.
- normally does not exceed the amount allocated to the project by the local or institutions than their own contribution.

- If the applicant has previously received a grant for a project must be submitted for the final report, if continuing work involved shall be available for a progress report on implementation of the project.
- allowances are higher than 500.000kr. are normally paid in two installments and subsequent
- things only from progress reports and other requested data.
- Do supports the general management of institutions or organizations or to purchase furniture or other furnishings.
- No grants are given to conferences.
- No grants are given to projects that are profit applicant.
- Application and supporting documents should be sent within the period mentioned in the ad.
- Applications received after the scheduled deadline are not taken into consideration.

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Ireland

Summary

Ireland developed and implemented a comprehensive policy framework for health promotion and primary prevention which is aligned with the basic principles of the Ottawa charter.

Policies include

- Healthy Ireland (HI) framework
    - Tobacco control
    - Special Action Group on Obesity (SAGO)
    - Physical activity
- National strategies, e.g.

    - Building Healthier Hearts

    - Changing Cardiovascular Health

    - National positive ageing strategy

On the implementation level this entails approaches like

- The Health Promoting School Initiative

- The Health Promoting Health Services

- The Healthy Cities Project

Currently there is no systematic approach to collating and evaluating good practice on a national level in Ireland. However, in 2013/2014 the HSE undertook an auditing exercise to collect information on all ongoing projects directly funded by the HSE relevant to health promotion and disease prevention. It is intended that this audit will inform a more systematic approach to good practice review in Ireland in the future'.

Contribution to CHRODIS GP assessment dimensions

A special focus from the Irish partners was put on the Gender aspects in health care and health promotion.

Further basic principles and rules of action from the Irish approach considered in the template entail

- *Setting approach*
- *Indentifying and addressing the social determinants of health*
- *Equity*
    - *Gender*
- *Comprehensiveness*

Other comments

DOCUMENT

Questionnaire WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II-Italy

Summary

Information provided by ISS (Istituto Superiore di Sanita) and MINSAL (Ministrry of Health)

Good Practice Criteria provided through a proprietary evaluation framework "Pro.Sa"[2]

"Pro.sa" is grounded on the theories of evidence and best practices translation and exchange (knowledge translation and exchange), among different actors (practitioners on health promotion and prevention, stakeholders, decision makers). Through Pro.Sa database the project manager can submit his project to be evaluated as Good Practice. Two independent readers, properly trained in the use of the assessment tool and experts in the field of health promotion, read the project and give it a scaled score. The focus on good practices aims at:

- highlighting strength factors for the effectiveness of an intervention;
- promoting sustainability and transferability in other settings or contexts;

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[2] http://www.retepromozionesalute.it; http://www.guadagnaresalute.it/progetto/progettoProsa.asp

- building a professional network (community of practice) in the field of health promotion and prevention

Contribution to CHRODIS GP assessment dimensions

The following Good Practice criteria from ProSa were taken into account for the template (Criteria/Indicator):

19. Working group (multidisciplinary, multi-sector, including representatives of target groups) Multi-Stakeholder Approach
20. Equity in health
21. Empowerment
22. Involvement/Participation
23. Setting
24. Theoretical models and theories of design and behaviour change
25. Evidence of effectiveness and good practice examples
26. Context analysis
27. Determinants analysis
28. Resources, time and limits
29. Partnership and alliances
30. Objectives
31. Process evaluation
32. Interventions/activities description
33. Output and outcome evaluation
34. Sustainability
35. Communication
36. Documentation

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Lithuania

Summary

Lithuania follows a comprehensive policy approach in public health. The basic principles have been outlined in the Health System Law (1994), Lithuanian Health Programme (1998–2010) and the National Public Health Strategy (2006–2013). In 2002, the parliament adopted the Public Health Law and the Public Health Monitoring Law. Other relevant legal documents regulating public health service activities include the Law on Alcohol Control (1995), the Law on Tobacco Control (1995), the Law on Food (2000)

Implementation follows action plans as issued by the Ministry of Health through Ministerial orders, e.g.

- Action plan for healthy aging protection in Lithuania 2014-2023
- Action plan approval for reducing health inequalities in Lithuania 2014-2023
- Screening and prevention program funding approval for people attributable to high-risk cardiovascular diseases
- Procedure for the reimbursement of diabetes medicines
- Stroke control and prevention programme 2006-2008

The main national health policy in Lithuania is the "Resolution for Lithuanian health program approval 2014-2025". It aims to achieve that the population is healthier and lives longer, improves population health and reduces health inequalities by 2025.

It entails the following purposes and tasks:

- To create a safer social environment, reduce health inequalities
    - To reduce poverty and unemployment
    - To reduce socio, economic population differentiation at country and community levels
- To create healthy occupational and living environment
    - To create safe and healthy working conditions, increase the safety of consumers
    - To create favorable conditions for leisure
    - To reduce road accidents and injuries
    - To reduce pollution of air, water, soil and noise
- Formation of healthy lifestyle and its culture
    - To reduce alcohol and tobacco use, prevent diversion of drug and psychotropic substances use and their accessibility
    - To promote habits of healthy nutrition
    - To develop habits of physical activity
- To ensure high quality and efficient health care needs of the population
    - To ensure the sustainability and quality of the health system by developing evidence-based health technologies
    - To develop the health infrastructure and improve the quality of healthcare, safety, accessibility and to patient-centered care
    - To improve maternal and child health
    - To strengthen chronic non-communicable diseases prevention and control
    - To develop Lithuanian electronic health system
    - To maintain the health care during the crisis and emergency situations

Contribution to CHRODIS GP assessment dimensions

Principles related to Good Practice criteria in the template:

- *Comprehensiveness*
    - *Alignment*
- *Context and determinants analysis*
- *Aims and Objectives*
- *Equity*
    - *Socioeconomic status*
    - *Education level*
    - *Vulnerable social groups*

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- the Netherlands

Summary

The RIVM (National Institute for Public Health and the Environment) Centre for Healthy Living (CGL) supports the delivery of efficient and effective local health promotion by clearly presenting available interventions, planning instruments, communication materials and links to relevant Dutch knowledge and support organizations on the portal Loketgezondleven.nl. This portal also presents information on the quality, effectiveness and feasibility of health promotion interventions.

Database with life style interventions

Organizations working in the field of health promotion interventions can request for including their intervention in de database with health promotion (lifestyle) interventions. Every organization with a grant for research or implementation of a lifestyle intervention needs to enter their intervention in the database of Loketgezondleven.nl.

Procedure for selecting best practices

To identify and select best practices, the Centre for Healthy Living developed an assessment system for interventions, i.e. the Dutch recognition system. The aim of the recognition system is to gain a better view into the quality and effectiveness of health promotion interventions and to increase the quality of professional practice in health promotion. Organizations are supported to submit an intervention using a standard submission form.

The registration desk of the Centre for Healthy Living checks the criteria for inclusion, the completeness and quality of the submitted forms provides and give initial feedback to improve the submission if necessary. They also check the relevance of the intervention. Then there are two types of assessment possible:

3. an assessment of the description of the objective, target group, approach and boundary conditions by professional practitioners or other experts from the sector concerned. This happens in the form of a peer review by practice panels. Based on this, interventions can receive the assessment **'Well Described'.**

4. an assessment of the theoretical basis and/or effectiveness of the intervention by an independent expert committee. Interventions that are assessed as good by the Recognition Committee receive a recognition **'Theoretically Sound' or 'Effective'** There are several subcommittees for different types of interventions, for example youth health care and health promotion for adults and elderly.

For both types of assessment, an evaluation for **Feasibility** is also possible, i.e. strong and weak features with respect to the feasibility of the interventions. Interventions that are assessed to be feasible are easy to adapt to another context.

Contribution to CHRODIS GP assessment dimensions

The Dutch system includes the following criteria (criteria/indicator in template)

- Manual of intervention available (Documentation)
- Process evaluation
- Two way assessment:
  - Description of the project / ‚well described'
  - Theoretical basis of the project
- Transferability (‚Feasability')
- Effectiveness
- Relevance

Other comments

Criteria not included in the template:

- Material for the next 2 years available
- Contact person

  too specific for the purpose of the template

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Norway

Summary

Norway developed and implemented a comprehensive policy framework with a Public Health Act from 2012 at its core.
The purpose of this act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental living conditions, and contribute to the prevention of mental and somatic illnesses, disorders and injuries. The act establishes a new foundation for strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. It also provides a broad basis for the coordination of public health work across various sectors and actors and between authorities at local, regional and national level.

A dedicated Good Practice Database does not exist. However, basic criteria within the existing policy and implementation framework were identified and included in the Good Practice template.

Contribution to CHRODIS GP assessment dimensions

The following principles of the Norwegian approach were reflected in the criteria of the template:

- Comprehensiveness
    - Health in all policies
    - Alignment
- Equity
    - Gender
    - Socioeconomic status
- Multiple stakeholders
- Sustainable development
- Participation

Principles not reflected in criteria

Precautionary principle ("do no harm")

Diametral to the purpose to identify good practice

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Portugal

Summary

Information in the questionnaire through Work Package 5 partners from Portugal:

- *Direcção - Geral de Saúde (DGS)*
- *Instituto Nacional de Saúde (INSA)*

Portugal implemented a national health plan, which is specified through nine national health programs and in particular for cardiovascular disease and stroke, a National Programme for Cardio-Cerebrovascular Diseases exists.

Criteria to identify good practices are used for the assignment of funding mechanisms.

Contribution to CHRODIS GP assessment dimensions

The following criteria have been taken into consideration:

- Project area facing health strategies and objectives (Alignment)
- Quality of methods proposed
- Post-funding sustainability of the project
- Potential for translation of the intervention or project
- Participative methodology with involvement of several stakeholders and or target groups
- Budget appropriateness in the face of expected work to be done and results

Other comments

Criteria not taken into consideration:

- Expected situation improvement in a before-after evaluation with adequate methodology

  Because: Lack of feasibility and applicability to health promotion programmes

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DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- Spain

Summary

Information in the questionnaire provided by Spanish partners in WP 5:

- Consejería de Sanidad y Servicios Sociales, Comunidad Autónoma de Cantabria
- Consejería de Salud y Bienestar Social de la Junta de Andalucia
- Fundación Progreso y Salud
- Instituto de Salud Carlos III
- Ministerio de Sanidad, Servicios Sociales e Igualdad

Spain established a structured procedure to identify good practices across the National Health System (NHS). The procedure is embedded within different “Health Strategies of the NHS”.

The procedure entails inclusion criteria for programmes/practices:

- Adequacy (it covers the factors and issues considered in the Strategy)
- Relevance (its objectives correspond with the needs and characteristics of the population at which are aimed at or a regulatory rule)
- based on the best evidence available (efficacy proven)
- potential evaluation possible (registry systems in place)
- sustainability (being implemented for at least one year and funding in place).

Contribution to CHRODIS GP assessment dimensions

Prioritization criteria entailed in the approach include:

- Evaluation/ Effectiveness
- Efficiency: economic evaluation performed.
- Equity: it is evaluated the existence of an equity approach incorporated in the situation analysis and in the formulation of the different actions taking into account the different needs of population groups. Participation of the target population on different stages and intersectoral work are also considered here.
- Feasibility: it is suitable for transferability.
- Strategic adequacy: it is aligned with the main national and international strategies on the field.
- Comprehensiveness: it takes action on two or more risk factors/health determinants.
- Ethical issues: potential conflicts of interest of the different actors involved are being considered.

Other comments

DOCUMENT: WP5 Questionnaire on Good practice in the field of health promotion and primary prevention. Question II- the United Kingdom

Summary

In the United Kingdom, health promotion and chronic diseases overarching policy development for the four constituent home countries (England, Scotland, Wales and Northern Ireland) takes place within the Departments (Ministries-equivalent) of Health for each country. As a result there are variations from home country to home country. Policies are initiated, developed and approved centrally, with input from regional and local health authorities/boards and from patient groups such as Diabetes UK and from clinicians and academics with an interest in the areas concerned.

Implementation is at a regional and local level. Recently, In England, local government has become involved with public health, including prevention of diseases. The delivery of prevention policies is made by clinicians, social workers and others.

PHE is therefore the national-level body setting the policy and strategic direction of public health and promotion, while, the delivery became a legal duty of local authorities in April 2013. Overall, public health is the duty of local authorities, while it used to be a combination of local health bodies and local authorities.

The UK developed an extensive range of clinical and best practice guidelines through the national body "NICE" on topics like

- Lifestyle and wellbeing[2]
- Diabetes and other endocrinal, nutritional and metabolic conditions[3]
- Cardiovascular conditions[4]
- Health inequalities[5]
- Value for money[6]

Contribution to CHRODIS GP assessment dimensions

The following principles of the UK's system have been adopted for the template on Good Practice criteria:

- Comprehensiveness
    - Alignment
    - Several risk factors addressed at the same time
- Evaluation
- Cost effectiveness
- Risk assessment
- Multi-/Intersectoral approach
- Partnerships and alliances
- Equity
- Documentation
- Evidence base
    - Theoretical model
    - Health Impact Assessment
- Aims and Objectives
- Community linkage /Networks
- Sustainability

References

[2] https://www.nice.org.uk/GuidanceMenu/Lifestyle-and-wellbeingC
[3] https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions
[4] https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Cardiovascular-conditions
[5] https://www.nice.org.uk/advice/LGB4/chapter/introduction
[6] https://www.nice.org.uk/advice/LGB10B/chapter/introduction

3.5 Documents related to Innovation

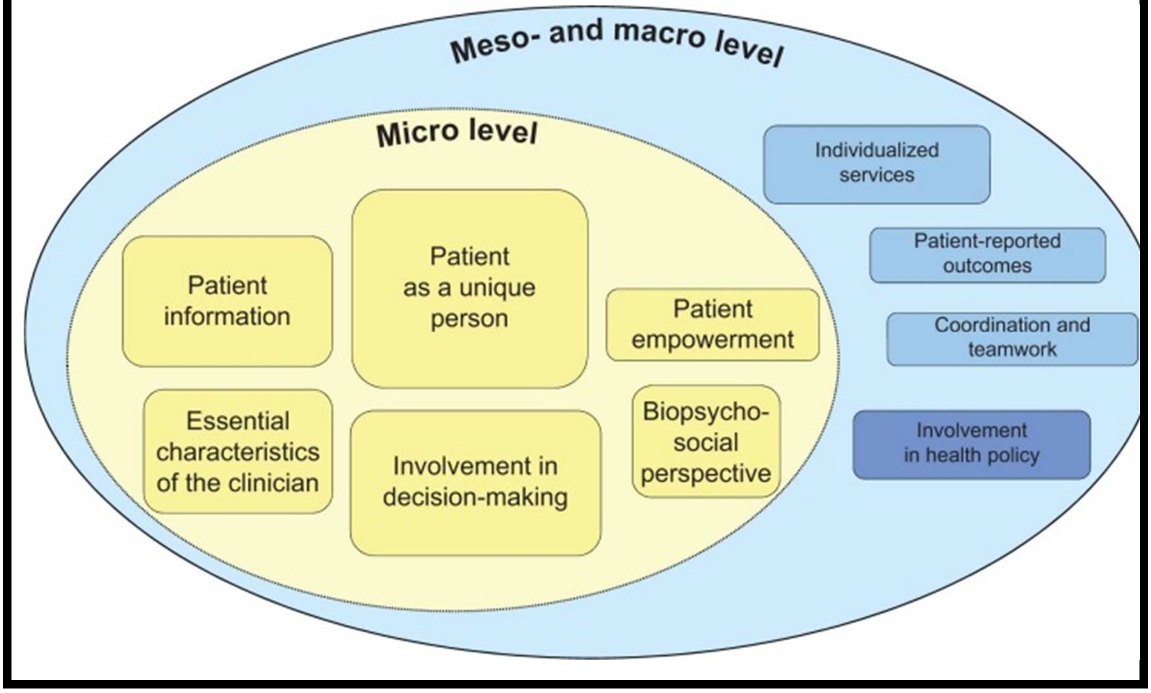
DOCUMENT: Scholl, I., Zill, J. M., Härter, M., & Dirmaier, J. (2014). How do health services researchers understand the concept of patient-centeredness? Results from an expert survey. *Patient Preference and Adherence*, *8*, 1153–1160. doi:10.2147/PPA.S64051

Summary

The concept of patient-centeredness has gained in importance over recent decades, including its growing importance on a health policy level. However, many different definitions and frameworks exist. This renders both research and implementation into clinical practice difficult. This study aimed at assessing how German researchers conceptualize patient-centeredness, how they translate the German equivalent into English, and what they consider the most important references on the topic.

Contribution to CHRODIS GP assessment dimensions

see table below



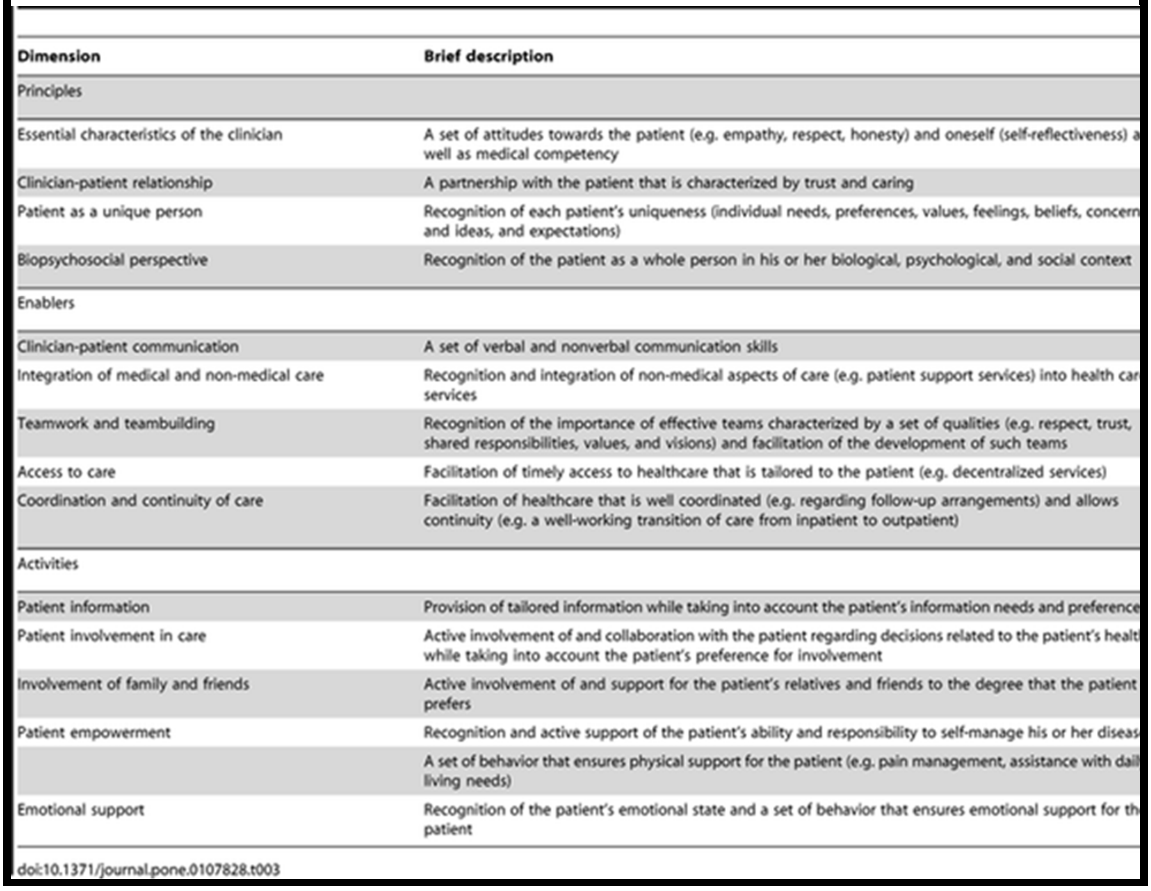
DOCUMENT: Scholl I, Zill JM, Härter M, Dirmaier J (2014) An Integrative Model of Patient-Centeredness – A Systematic Review and Concept Analysis. PLoS ONE 9(9): e107828. doi:10.1371/journal.pone.0107828 http://127.0.0.1:8081/plosone/article?id=info:doi/10.1371/journal.pone.0107828

Summary

Existing models of patient-centeredness reveal a lack of conceptual clarity. This results in a heterogeneous use of the term, unclear measurement dimensions, inconsistent results regarding the effectiveness of patient-centered interventions, and finally in difficulties in implementing patient-centered care. The aim of this systematic review was to identify the different dimensions of patient-centeredness described in the literature and to propose an integrative model of patient-centeredness based on these results.

Contribution to CHRODIS GP assessment dimensions

see table below



Dimension	Brief description
Principles	
Essential characteristics of the clinician	A set of attitudes towards the patient (e.g. empathy, respect, honesty) and oneself (self-reflectiveness) a well as medical competency
Clinician-patient relationship	A partnership with the patient that is characterized by trust and caring
Patient as a unique person	Recognition of each patient's uniqueness (individual needs, preferences, values, feelings, beliefs, concern and ideas, and expectations)
Biopsychosocial perspective	Recognition of the patient as a whole person in his or her biological, psychological, and social context
Enablers	
Clinician-patient communication	A set of verbal and nonverbal communication skills
Integration of medical and non-medical care	Recognition and integration of non-medical aspects of care (e.g. patient support services) into health car services
Teamwork and teambuilding	Recognition of the importance of effective teams characterized by a set of qualities (e.g. respect, trust, shared responsibilities, values, and visions) and facilitation of the development of such teams
Access to care	Facilitation of timely access to healthcare that is tailored to the patient (e.g. decentralized services)
Coordination and continuity of care	Facilitation of healthcare that is well coordinated (e.g. regarding follow-up arrangements) and allows continuity (e.g. a well-working transition of care from inpatient to outpatient)
Activities	
Patient information	Provision of tailored information while taking into account the patient's information needs and preference
Patient involvement in care	Active involvement of and collaboration with the patient regarding decisions related to the patient's healt while taking into account the patient's preference for involvement
Involvement of family and friends	Active involvement of and support for the patient's relatives and friends to the degree that the patient prefers
Patient empowerment	Recognition and active support of the patient's ability and responsibility to self-manage his or her diseas
	A set of behavior that ensures physical support for the patient (e.g. pain management, assistance with dail living needs)
Emotional support	Recognition of the patient's emotional state and a set of behavior that ensures emotional support for th patient

doi:10.1371/journal.pone.0107828.t003

DOCUMENT: Coulter, A., Entwistle, V. A., Eccles, A., Ryan, S., Shepperd, S., & Perera, R. (2015). Personalised care planning for adults with chronic or long-term health conditions. The Cochrane Database Of Systematic Reviews, 3CD010523. doi:10.1002/14651858.CD010523.pub2

Summary

Intervention review

Personalised care planning is a collaborative process used in chronic condition management in which patients and clinicians identify and discuss problems caused by or related to the patient's condition, and develop a plan for tackling these. In essence it is a conversation, or series of conversations, in which they jointly agree goals and actions for managing the patient's condition.

19 studies involving a total of 10,856 participants.: diabetes (12), mental health (3), one on heart failure, one on end-stage renal disease, one on asthma, and one on various chronic conditions.

Contribution to CHRODIS GP assessment dimensions

Patient-focused interventions:

- information materials or decision aids for patients (Protheroe 2010)
- computer-based interventions to help patients identify and achieve behavioural goals (Glasgow 2004)
- suggested lists of questions the patient can ask to prompt the clinician to involve them more actively in decisions about their care (Shepherd 2011)
- health coaching and motivational support to help patients clarify objectives, solve problems and achieve behavioural goals (Frosch 2011)
- patient-held records for summarising personal goals and test results (Dijkstra 2005)

Clinician-focused interventions:

- specific training programmes in shared decision making, care planning and/or motivational interviewing (Kennedy 2005)
- guidelines and feedback emphasising the need to elicit patients' preferences during care-planning consultations (Wensing 2003)
- algorithms embedded in clinical record systems to guide the care-planning process (Ell 2010)

Interventions designed to influence the behaviour of both clinicians and patients:

- brief tools for use within care-planning consultations to guide the discussion about options and agreed actions (Elwyn 2012a)
- an electronic or printed template for documenting jointly- agreed actions for use in monitoring and follow-up (Ross 2004).

Primary outcomes

1. Changes in health and well-being, including each of the following three dimensions measured separately: i) physical health ii) psychological health iii) subjective health status.

2. Changes in patients' self-management capabilities or indicators relevant to those capabilities

Secondary outcomes

1. Changes in health-related behaviours: diet, exercise, smoking, use of relaxation techniques, self-management actions, condition-relevant self-monitoring, adherence to treatment recommendations, and attainment of personal goals.

2. Changes in use of formal health services: number and length of hospital admissions, number of outpatient, emergency department, or primary care visits, and, where recorded, effects on the costs of care.

DOCUMENT: Grover, A., & Joshi, A. (2014). An overview of chronic disease models: a systematic literature review. Global Journal Of Health Science, 7(2), 210-227. doi:10.5539/gjhs.v7n2p210

Summary

The objective of our study was to examine various existing chronic disease models, their elements and their role in the management of Diabetes, Chronic Obstructive Pulmonary Disease (COPD), and Cardiovascular diseases (CVD).

Contribution to CHRODIS GP assessment dimensions

Chronic Care Model (CCM) (20 articles), Improving Chronic Illness Care (ICIC) (1), and

Innovative Care for Chronic Conditions (ICCC) (4), Stanford Model (SM) (1) and Community based Transition Model (CBTM) (1).

CCM : patient driven elements

core themes

Self-management support: Emphasizes patient's role in managing health. Established self-management techniques such as mutual goal setting and action planning have focused on various methods of teaching such as group classes, skill development, and various lifestyle behaviors.

Community Involves linking and using community resources that support healthcare effort by clinicians. The use of church-based support groups, local community health programs, clinic based support groups and internet are acceptable community interventions.

Additional themes

Cultural competency

Improving health of people with chronic illness requires transformation of a system to one that is proactive instead of reactive. Roles need to be defined and tasks need to be distributed among team members. Interactions need to be planned to support evidence-based care. More complex patients may need more intensive management for a period of time to optimize clinic care and self-management. Health literacy and cultural sensitivity are two important features and providers are increasingly being called upon to respond effectively to the diverse cultural and linguistic needs of patients (Wielawski,2011).

ICCC: patient driven elements

Care centered in patients and their families: Management of chronic conditions requires life style and daily behavior change. Focusing on the patient in this way constitutes an important shift in current clinical practice. The present scenario has a patient role as a passive recipient of care, missing the opportunity to leverage what he or she can do to promote personal health. Health care for chronic conditions must be re-oriented around the patient and family.

Support patients in their communities: Patients and families need services and support from their communities. Communities can also fill crucial gap in health services that are not provided by organized.

The other 2 models are not resumed.

How has Self-Management Support been implemented?: It emphasizes patient's role in managing health. Established self-management techniques such as mutual goal setting and action planning have focused on various methods of teaching such as group classes, skill development, and various lifestyle behaviors (Wagner et al., 1996a, 1996b, 2001, 2002). Personalized healthcare plan, medications, action plan, lifestyle goals and feedback for the providers to deliver tailored feedback have been studied (Pearson et al., 2005; Nuttin g et al., 2007; Tracey & Bramley, 2003; Chin et al., 2004; Sperl-Hillen et al., 2004; Ciccone, 2010; Glasgow et al., 2004). Incentives have been offered to increase patients' participation for self-management programs (Siminerio et al., 2004) Patient education, patient activation/ psychological support (Piatt et al., 2011; Piatt et al., 2010; Siminerio et al., 2006; Piatt et al., 2006; Vargas et al., 2007; Nutting et al., 2007; Schmittdiel et al., 2006; Smith et al., 2008), access to self-management resources and tools (Vargas et al., 2007; Wellingham et al., 2003; Ciccone, 2010; Schmittdiel et al., 2008; Askew, Jackson, Ware & Russell, 2010) and collaborative decision making are some of the other common components of self-management support element of CCM(Pearson et al., 2005). Individuals with chronic diseases are provided with training to improve their skills for blood glucose monitoring (Frei et al., 2010; Schmittdiel et al.,2006), adjusting insulin, and modifying diet and exercise (Schmittdiel et al., 2006), review medical charts (Schmittdiel et al., 2006) and track self- management behavior (Sperl-Hillen et al., 2004) are some of the techniques employed to improve self-management in these individuals. Only one study used Stanford model to improve self-management in chronic disease individuals (Franks, Chapman, Duberstein & Jerant, 2009).

Evidence suggests that the application of CCM principles to health care systems lead to better outcomes for patients with chronic illnesses (Schmittdiel et al., 2006). The principles include (i) first contact (primary care physicians should be patient's first contact), (ii) continuity includes relationship between the primary care physician and patient should be long term and consistent over time, (iii) comprehensiveness should provide a wide range of preventive and acute care services to meet a large proportion of patient medical records, (v) coordination involves primary care systems to coordinate care across physicians, ideally using electronic information systems and (v) accountability includes primary care physicians to be responsible for patient's overall health and medical outcomes (Schmittdiel et al., 2008).

DOCUMENT: Chouvarda, I. G., Goulis, D. G., Lambrinoudaki, I., & Maglaveras, N. (2015). Review: Connected health and integrated care: Toward new models for chronic disease management. Maturitas, doi:10.1016/j.maturitas.2015.03.015

Summary

A patient centered e-health management model can improve communication between patient, healthcare professionals in primary care and hospital, can facilitate decision making.

A central concept is personal health system for the patient/citizen and three main application areas are identified. The connected health ecosystem is making progress, already shows benefits in (a) new biosensors, (b) data management, (c) data analytics, integration and feedback.

Contribution to CHRODIS GP assessment dimensions

Future: people will be accessing and controlling their healthcare information

Direct communication with healthcare professionals in timely and contextualized decisions (no SDM)

Life style, prevention, rehabilitation
Enable disease management at home and prevent hospitalization

Ambient assisted living: This category of applications addresses the need for independent living and quality of life among elder population, via multifaceted approaches that include monitoring of activity and vital signs, physical and cognitive training, self-assessment, services for daily life facilitation (e.g. for shopping needs) and social support.

Personal Health Systems; 2 types:

- Portable or wearable
- Intelligent information processing of existent data
- Active feedback to patients from data or healthcare professionals

Such systems can involve the personal health records (PHRs), mobile health and medical apps for patient interaction, decision support for the patient and professional [16], communication tools and social networks [17],

Sensors: devices include a great variety of sensors for measurements

Data management: from personal health record, sensors, patient generated

This includes longitudinal data on symptoms, vital signs and signals, treatment history, lifestyle and behaviour along with contextual and environmental data recorded or inferred by patients and care providers, which can be integrated with the clinical or even molecular data.

Data analytics

Data analysis can produce:

- Represented in status and trends of the patient conditions: intuitive representations for patients.
- Predictive models and decision support systems
- Especially interesting for comorbidity.

DOCUMENT: Chouvarda, I. G., Goulis, D. G., Lambrinoudaki, I., & Maglaveras, N. (2015). Review: Connected health and integrated care: Toward new models for chronic disease management. Maturitas, doi:10.1016/j.maturitas.2015.03.015

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DOCUMENT: WHO Innovative Care for Chronic Conditions: Building blocks for action 2012

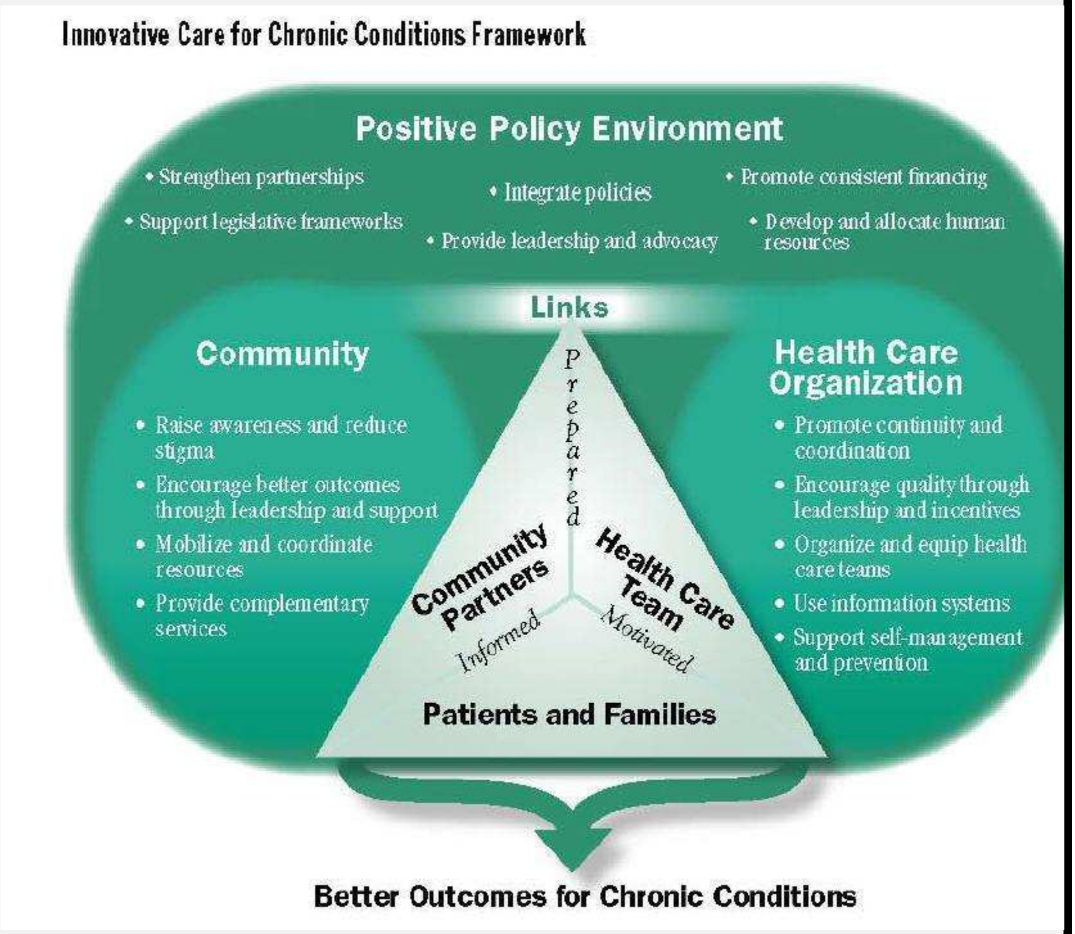
Summary

The World Health Organization created this document to alert decision-makers throughout the world about important changes in global health, and to present health care solutions for managing the rising burden. It establish the eight essential elements for taking action as:

1. Support a Paradigm Shift (from acute episodic model to chronic integrated care model)
2. Manage the Political Environment
3. Building Integrated Health Care
4. Align Sectorial Policies for Health
5. Use Health Care Personnel more Effectively
6. Centre Care on the Patient and Family
7. Support Patients in their Communities
8. Emphasize Prevention

This document describes the '*Innovative Care of Chronic Conditions Framework'* aimed to lead the pathway through innovative ways of addressing the chronic conditions care adapting health policies, systems and models.

It focuses on: Evidence-based decision making, population focus, prevention, quality, integration of care, flexibility and adaptability.



Innovative Care for Chronic Conditions Framework

Contribution to CHRODIS GP assessment dimensions

This document provides us with a framework for innovative care for chronic conditions introducing or developing domains such as:

· Innovative Care

· Community Linkages

· Leadership and advocacy

· Self-management and prevention

· Sustainability

Other comments

The proposed framework was used to build up and organize the specific sub-domains included in the Innovation domain.

DOCUMENT: PAHO Innovative Care for Chronic conditions: Organizing and Delivering High Quality Care for Chronic Non communicable Diseases in the Americas 2013-Eng

Summary

The document concludes that the Chronic Care Model should be implemented in its entirety since its components have synergistic effects, where the whole is greater than the sum of the parts. Policy reforms and universal access to care are critical elements leading to better outcomes and reducing disparities in chronic disease care. It is critical to integrate PHC-based chronic care into existing services and programs. Chronic diseases should not be considered in isolation but rather as one part of the health status of the individual, who may be susceptible to many other health risks. A patient-centred care system benefits all patients, regardless of their health conditions or whether his/her condition is communicable or non-communicable. A care system based on the Chronic Care Model is better care for all, not only for those with chronic conditions.

Primary care has a central role to play as a coordination hub, but must be complemented by more specialized and intensive care settings, such as diagnostic labs, specialty care clinics, hospitals, and rehabilitation centres. Finally the ten recommendations for the improvement of quality of care for chronic conditions are:

1. Implement the Chronic Care Model in its entirety.

2. Ensure a patient centred approach.

3. Create (or review existing) multisector policies for CNCD management including universal access to care, aligning payment systems to support best practice.

4. Create (or improve existing) clinical information system including monitoring, evaluation and quality improvement strategies as integral parts of the health system.

5. Introduce systematic patient self-management support.

6. Orient care toward preventive and population care, reinforced by health promotion strategies and community participation.

7. Change (or maintain) health system structures to better support CNCD management and control.

8. Create PHC-led networks of care supporting continuity of care.

9. Reorient health services creating a chronic care culture including evidence-based proactive care and quality improvement strategies.

10. Reconfigure health workers into multidisciplinary teams, ensuring continuous training in CNCD management

Contribution to CHRODIS GP assessment dimensions

This document provided us with further insights into the development of the Chronic Care Model.

It also enhances the attention to several domains such as:

Theory grounds (well specified and measurable main goal and sub-goals)
Key population and target population
Community linkages
Patient Participation and commitment
Mapping of relevant stakeholders
Impact of the implementation in current organization
Regularity of monitoring reports and consequences derived from assessment
Development of integrated health information systems
Evaluation framework assessing process and outcomes

KEY ACTIONS FOR SELF-MANAGEMENT SUPPORT

Ensure patient participation in the process of care;
Promote the use of lay or peer educators;
Use group visits;
Develop patient self-regulatory skills (i.e., managing health, role and emotions related to chronic conditions);
Promote patient communication skills (especially with regard to interactions with health professionals and the broader health system);
Negotiate with patient goals for specific and moderately challenging health behaviour change;
Stimulate patient self-monitoring (keeping track of behaviours);
Promote environmental modification (creating a context to maximize success);
Ensure self-reward (reinforcing one's behaviour with immediate, personal, and desirable rewards);
Arrange social support (gaining the support of others);
Use the 5As approach during routine clinical encounters (Asses, advise, agree, assist, arrange)

EXAMPLES OF EFFECTIVE INTERVENTIONS

Group based self-management support for people with type 2 diabetes (50)
Self-monitoring of blood pressure specially adjunct to care (51)
Patient educational intervention for the management of cancer pain alongside traditional analgesic approaches (52)
Patient educational intervention using the 5 As for reducing smoking, harmful use of alcohol and weight management (53)
Training for better control blood glucose and dietary habits for people with type 2 diabetes (54)
Lay educator led self-management program for people with chronic conditions, including arthritis, diabetes, asthma and COPD, heart disease and stroke (55-57)
Self-management support that involves a written action plan, self-monitoring and regular medical review for adults with asthma (58)
Self-management support for people with heart failure to reduce hospital readmission (59)
Patient oriented interventions such as those focused on education or adherence to treatment (60)

Other comments

This document fully endorses the Chronic Care Model committing to its development for structuring a new healthcare system addressing the care of chronic conditions.

DOCUMENT:

1º European innovation Partnership on Active and Healthy Ageing (EIP-AHA). Reference Sites. Excellent innovation for ageing. A European Guide (2013)

2º- European innovation Partnership on Active and Healthy Ageing (EIP-AHA). Reference Sites. Excellent innovation for ageing. How to Guide (2014)

Summary

The European Innovation Partnership on Active and Healthy Ageing (the Partnership) was initiated in October 2010 to tackle the common challenge of an ageing population in Europe. It brings together key stakeholders to develop new innovations, which can improve the quality of life of older people, whilst simultaneously creating market opportunities for businesses in this policy area. The focus of this Partnership is on linking together organisations, resources and expertise to produce short-term, demonstrable results which can encourage the uptake of innovation to improve older people's health and quality life in addition to enhance the sustainability and efficiency of care systems.

References Sites are regions, cities or integrated hospitals/care organisations, established in a geographical location in Europe that provide a comprehensive examples of innovation-based services with proved value to citizens and care system in EU regions. They provide concrete examples of existing and successful integrated solutions, based on evidence of their impact in practice.

The European innovation Partnerships on Active and Healthy Ageing. Reference Sites. Excellent innovation for ageing. A European Guide (2013) provides a snapshot of on-going developments. The aim is to take a tour of regions, cities and communities through Europe where there is innovation projects for active and healthy ageing in real life. The selection of the reference sites for this guide was based on key criteria such as EIP-AHA relevance, scale, and number of specific EIP actions to which they are committed, evidence and replication potential. They filled out questionnaires on their contribution to the different action areas of the *European Innovation Partnership on Active and Healthy Ageing* and on their overall strategy to tackle the demographic challenge in Europe. Then they were scored with a ranking from 1 to 3 stars and the results of the process were 32 Reference Sites from 12 Member States.

The 32 award-winners have implemented innovative technological, social or organisational solutions to enhance the efficiency of health and social care system and foster innovation and economic growth. All Reference Sites have committed to sharing their achievements with others and transferring knowledge across Europe.

The second edition of the Reference Sites. *European innovation Partnerships on Active and Healthy Ageing. Reference Sites. Excellent innovation for ageing. How to Guide (2014)* provides practical indications on how to scale up and transfer best elements of the Reference Sites experiences to other European contexts. This Guide is a follow-up to the first edition published in July 2013.

Contribution to CHRODIS GP assessment dimensions

- Political support on several levels: Including regional government, national healthcare management authorities and scientific societies
- Funding: structural funds from resources of project partners
- The organizational changes comply with the national healthcare system strategy
- Innovation in IT Tools: use of technological products, devices and services e-tools. infrastructures are being modified and rebuilt
- The synergy of local industry and technology
- Cross-agency approaches
- Community linkage
- A multi-stakeholder collaborative alliance of partners
- Involved all the actors in the innovation cycle (private and public sector and citizens)
- Robust performance monitoring and evaluation system
- Professional qualification and training
- Principles: interdisciplinary approach, professionalism, subsidiarity and regionalism
- Leadership

Other comments

two documents describe the programme implemented in their own country but it does not provide, which criteria or standard have been used to determine the quality of the programmes.

DOCUMENT: Burguess J POSITION PAPER Innovation and efficiency in health care: does anyone really know what they mean? Health Systems (2012) 1, 7–12

Summary

Contribution to CHRODIS GP assessment dimensions

What do we mean by quality and what does it really mean to hold all this quality fixed? A particularly attractive definition for thinking about this is from the Institute of Medicine, which defines quality as multidimensional and characterized by care that is safe, timely, effective, efficient, equitable, and patient-centred (recently, this last term of patient-centred has begun to be viewed as too oriented toward sickness as opposed to wellness, so in a spirit of loss aversion is turning toward person-centred).

DOCUMENT: García-Goñi et al Pathways towards chronic care-focused healthcare systems: Evidence from Spain Health Policy 108 (2012) 236– 245

Summary

Contribution to CHRODIS GP assessment dimensions

Ten characteristics of a high-performing chronic care system (1) Ensuring universal coverage (2) Provision of care that is free at the point of use (3) Delivery system should focus on the prevention of ill health (4) Priority is given to patients to self-manage their conditions with support from carers and families (5) Priority is given to primary healthcare (6) Population management is emphasised through the use of tools to stratify people with chronic diseases according to their risk and offering support commensurate with this risk (7) Care should be integrated to enable primary healthcare teams to access specialist advice and support when needed (8) The need to exploit the potential benefits of information technology in improving chronic care (9) Care is effectively coordinated (10) Link these nine characteristics into a coherent whole as part of a strategic approach to change Source: Ham [10]

DOCUMENT: Margolis et al Collaborative Chronic Care Networks (C3Ns) to Transform Chronic Illness Care. Paediatrics 2013;131;S219

Summary

Contribution to CHRODIS GP assessment dimensions

Collaborative Chronic care Networks

All participants in health care (patients and families, caregivers, clinicians, and researchers) care deeply about improving health. What is missing is a system to harness this motivation and focus participants' collective intelligence toward transforming care and outcomes. What if we could harness the collective intelligence of patients, clinicians, and researchers to create such a system? Wikipedia (the Web-based, collaborative encyclopaedia project), Linux (the open-source computer software operating system), and the open, rapid sharing of data that occurred in advance of publication in the human genome project are just 3 examples of how the production of knowledge, information, and know-how can be distributed over large groups of people, dramatically accelerating the discovery process. These models are transforming how individuals connect, exchange information, and produce knowledge, enabling previously unimaginably large groups of people to join together to make real their shared vision of the future. These models have rapidly achieved unprecedented innovation and performance, in part because they have built systems that allow inherent motivation of like-minded individuals to flourish through a culture of cooperation.4 This form of production has been termed network-based or "social" production.5

Network-based production is particularly suited to complex systems such as health care, precisely because the knowledge, skills, and tools necessary to develop and implement real change are often beyond the capacity of 1 place, person, or organization because the stakeholders in the process (in this case, patients, clinicians, and researchers) are motivated and have skills that can be devoted to the task, and finally because the scientific questions about how to accomplish improvements in health and health care require a multidisciplinary complex systems science perspective. A C3N is a network-based production system for health and health care.

Building community starts with communicating a compelling vision; for the C3N Project, it is improving the health of all patients affected by a chronic illness. The project's core leadership team of patients, clinicians, and researchers share responsibility for defining this vision and purpose, communicating it, and creating strategies for implementation. Sharing stories is a powerful way to motivate action. A short film about Improve CareNow's work was created by renowned filmmaker Jesse Dylan, and a diverse group of participants, supporters, and collaborators (including Improve CareNow clinicians and staff, patients and family members, researchers, quality improvement experts, and health care innovators) post their personal stories regularly on LOOP, the official blog of Improve CareNow (http://improvecarenowblog.org/).

http://c3nproject.org/about-c3n-project#challenge

http://c3nproject.org/patients

DOCUMENT: Paulus et al. Continuous Innovation In Health Care: Implications Of The Geisinger Experience. Health Affairs, 27, no.5 (2008):1235-1245

Summary

Contribution to CHRODIS GP assessment dimensions

Adoption of integrated electronic health systems is the beginning of a long care-transformation journey.

Personal Health Navigator. EJEMPLO: Geisinger's "patient-centred medical home" initiative is designed to deliver value by improving care coordination and optimizing health status for each individual. Components designed to create a functional "Personal Health Navigator" for consumers include round-the-clock primary and specialty care access; a GHP-funded nurse care coordinator in each practice site; predictive analytics to identify risk trends; virtual care-management support; a person, called a personal care navigator, to respond to consumers' inquiries; and a focus on proactive, evidence-based care to reduce hospitalizations, promote health, and optimize management of chronic disease. Other features include home-based monitoring, interactive voice-response surveillance, and support for end-of-life care decisions.

Electronic Health Record access: EHR access is provided to all participants, including physicians, care managers, and consumers. Consumer EHR features include Internet-based lab results display and results trending over time, clinical reminders, self-scheduling, secure e-mail with providers, prescription refills, and educational content

Other comments

DOCUMENT: OECD Innovation strategy 2010.

http://www.oecd.org/sti/the-oecd-innovation-strategy-9789264083479-en.htm

Summary

It is centred on how to measure Innovation on every different area of progress.

It provides an extensive analysis of the situation of the innovation, measured by proxy indicators across the OECD countries and sectors, addressing the need of more research and measurement in how innovation is implemented and how can we promote it to reach new levels of development.

It proposes a framework for measuring innovation through their derivative products. Also it promotes people participation and addresses the main challenges to tackle in next years.

Contribution to CHRODIS GP assessment dimensions

This document provided us with a main framework for measuring innovation and develops this domain expanding the domains of:

· Innovation

· Sustainability

· Research Implementation

· Innovation measurement as a method to assess its impact on the healthcare systems

Other comments

3.6. Documents related to scalability

DOCUMENT: Scaling up: a framework and lessons for development effectiveness from literature and practice. Hartman and Linn. Wolfensohn Center for Development Working Paper 5, 2008

Summary

The document is focused on development interventions, though the lessons drawn seem more generally applicable to other types of interventions and projects with a vocation to expand and stay in place (such as health promotion and primary interventions in European Member States).

The authors explore the possible approaches and paths to scaling up, the drivers of expansion and of replication, the space that has to be created for interventions to grow, and the role of evaluation and of careful planning and implementation.

They draw a number of lessons for the development analyst and practitioner. More than anything else, scaling up is about political and organizational leadership, about vision, values and mind-set, and about incentives and accountability—all oriented to make scaling up a central element of individual, institutional, national and international development efforts. The paper concludes by highlighting some implications for aid and aid donors.

Contribution to CHRODIS GP assessment dimensions

The Domain Scalability has drawn on this document incorporating 3 criteria:

- Size of the population targeted if scaled up
- Analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators
- Systematic networking efforts to foster the exchange of information, mutual support and cooperation with other community resources

3.7. Documents related to implementation of practices

DOCUMENT: Elwyn Glyn, Laitner Steve, Coulter Angela, WalkerEmma, Watson Paul, Thomson Richard et al. Implementing shared decision making in the NHS*BMJ* 2010; 341 :c5146 http://www.bmj.com/content/341/bmj.c5146

Summary

Despite considerable interest in shared decision making, implementation has proved difficult and slow. At least three conditions must be in place for shared decision making to become part of mainstream clinical practice: ready access to evidence based information about treatment options; guidance on how to weigh up the pros and cons of different options; and a supportive clinical culture that facilitates patient engagement. This article outlines some options for creating a sustainable decision support platform for patients that may facilitate a wider adoption of shared decision making in clinical practice.

Contribution to CHRODIS GP assessment dimensions

Successful Implementation will require

- available evidence
- adapted into accessible tools (decision aids) both to patients and clinicians
- introduce in the referral care pathway
- a more favourable organizational culture and healthcare professionals
- strong strategic leadership, commissioning high quality content, sustainable funding

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DOCUMENT: Taylor SJC, Pinnock H, Epiphaniou E, et al. A rapid synthesis of the evidence on interventions supporting self-management for people with long-term conditions: PRISMS – Practical systematic Review of Self-Management Support for long-term conditions. Southampton (UK): NIHR Journals Library; 2014 Dec. (Health Services and Delivery Research, No. 2.53.)Available from: http://www.ncbi.nlm.nih.gov/books/NBK263840/

Summary

Self-management is 'the tasks . . . individuals must undertake to live with one or more chronic conditions . . . [including] . . . having the confidence to deal with medical management, role management and emotional management of their conditions'. We convened an expert workshop and identified characteristics of LTCs potentially of relevance to self-management and 14 diverse exemplar LTCs (stroke, asthma, type 2 diabetes mellitus, depression, chronic obstructive pulmonary disease, chronic kidney disease, dementia, epilepsy, hypertension, inflammatory arthropathies, irritable bowel syndrome, low back pain, progressive neurological disorders and type 1 diabetes mellitus). For each LTC we conducted systematic overviews of systematic reviews of randomised controlled trials (RCTs) of self-management support interventions (‘quantitative meta-reviews’); and systematic overviews of systematic reviews of qualitative studies of patients’ experiences relating to self-management (‘qualitative meta-reviews’). We also conducted an original systematic review of implementation studies of self-management support in the LTCs. We synthesised all our data considering the different characteristics of LTCs. In parallel, we developed taxonomy of the potential components of self-management support.

We concluded that supporting good self-management is inseparable from the high-quality care all people with LTCs should receive. Supporting self-management is not a substitute for care from doctors and nurses but a hallmark of good care. Providers of services for people with LTCs should consider how they can actively support self-management.

Effective self-management support interventions are multifaceted, should be tailored to the individual, their culture and beliefs, a specific LTC and position on the disease trajectory, and underpinned by a collaborative/communicative relationship between the patient and health-care professional (HCP) within the context of a health-care organisation that actively promotes self-management. Self-management support is a complex intervention and although many components were described and trialled in the studies no single component stood out as more important than any other. Core components include

(1) provision of education about the LTC, recognising the importance of understanding patients’ pre-existing knowledge and beliefs about their LTC;

(2) psychological strategies to support adjustment to life with a LTC;

(3) strategies specifically to support adherence to treatments;

(4) practical support tailored to the specific LTC, including support around activities of daily living for disabling conditions, action plans in conditions subject to marked exacerbations, intensive disease-specific training to enable self-management of specific clinical tasks; and

(5) social support as appropriate.

Implementation requires a whole-systems approach which intervenes at the level of the patient, the HCP and the organisation. The health-care organisation is responsible for providing the means (both training and time/material resources) to enable HCPs to implement, and patients to benefit from, self-management support, regularly evaluating self-management processes and clinical outcomes. More widely there is a societal need to address public understanding of LTCs. The lack of public story for many conditions impacted on patient help-seeking behaviour and public perceptions of need.

Contribution to CHRODIS GP assessment dimensions

Self-management support interventions dimensions:

2. Recipients: patients, carers, HCPs, organisations.
3. Components: education, information about resources, specific action plans and/or rescue medication, equipment, safety netting, regular clinical review, training to communicate with HCPs, training for activities of daily living (ADL), training in

psychological strategies, training for practical self-management activities, social support, monitoring with feedback to the patient, practical support with adherence, lifestyle advice and support.
4. Modes of delivery.
5. Personnel delivering the support.

Despite intense interest in supporting good self-management among people with long-term conditions (LTCs), it can be difficult for commissioners to identify what works. In addition, although there is a plethora of evidence concerning self-management for some LTCs, many lack a tradition of research explicitly on self-management and, consequently, some patient groups may be overlooked.

We have adopted the definition of self-management proposed by the US Institute of Medicine: Self-management is defined as the tasks that individuals must undertake to live with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management and emotional management of their condition. Phase 1: To agree in discussion with an Expert Advisory Group:

- Characteristics of LTCs of relevance to self-management
- Components of self-management support interventions to inform a taxonomy
- The selection of exemplar LTCs for detailed investigation in phase 2.

Phase 2: To undertake meta-syntheses of the evidence around interventions for self-management support in each of the exemplar LTCs from:

- Published systematic reviews of randomised controlled trials (RCTs) (‘quantitative meta-reviews’)
- Published syntheses of qualitative studies (‘qualitative meta-reviews’).

To conduct an original systematic review of primary studies concerned with the implementation of self-management support interventions in populations with the exemplar LTCs (i.e. Phase IV implementation trials).

To synthesise the resulting meta-reviews and systematic review in an overarching narrative synthesis, to determine what is known about the likely effectiveness of self-management support interventions with respect to health service resource use, health outcomes [including quality of life (QoL), symptoms, biological markers of disease and equity].

Phase 3: To organise a multidisciplinary workshop as a result of the work undertaken in phases 1 and 2 in order to:

- Discuss our findings, and
- Help develop practical recommendations for health service commissioners.

To identify research gaps for future primary research or research synthesis.

Supporting self-management is inseparable from high-quality care for people with long-term conditions

The key theme from all our meta-reviews and the implementation systematic review was that supporting self-management is inseparable from the high-quality care of people with LTCs.

Commissioners and providers of services for people with LTCs should consider how they can promote a culture of actively supporting self-management as a normal, expected aspect of the provision of care.

In our reviews self-management was not a substitute for professional care. Far from feeling abandoned and left to look after themselves, supported self-management empowered patients to access best care and support, though potentially (and paradoxically) reducing health-care resource use, especially in asthma and COPD.

Supported self-management must be tailored to the individual, their culture and beliefs, and the time point in the condition

A recurring theme from the meta-analyses was the importance of tailoring the self-management support to the individual and their condition. There was abundant evidence from the qualitative meta-reviews suggesting that individuals' existing health beliefs frame their understanding of their condition, and they will tailor medical regimes and self-management strategies to fit into their own lives and beliefs. Quantitative meta-reviews in both T2DM and asthma identified the benefits of providing culturally specific interventions. The nature of the LTC also emerged as an important factor in determining the self-management priorities.

Communication: a common theme in most of the qualitative meta-reviews was the importance of enhancing communication between HCPs and patients.
Organizational support is needed.
Long-term condition characteristic-specific self-management components must be taken into account
The implementation systematic review suggested that effective interventions were multifaceted and multidisciplinary.

DOCUMENT:

Framtpton, S. et al. (2008) Patient Centered Care Improvement Guide. Picker Institute http://www.hqontario.ca/portals/0/Modals/qi/en/processmap_pdfs/tools/Patient-Centered%20Care%20Improvement%20Guide.pdf

Summary

A practical resource for organizations striving to become more patient-centered (in hospitals) with a Self-Assessment Tool to identify and prioritize opportunities for introducing patient centered approaches most frequently cited barriers to implementation of patient-centered care, the foundation for successful implementation.

Contribution to CHRODIS GP assessment dimensions

Patient centred care needs organizational culture change

Need to overcome myths about patient centred care including: PCC is costly, there is no evidence, can be unsafe….

Leaders determine, guide and communicate the vision of any organization, and as such, leadership engagement in any organizational culture change initiative is crucial. In their own behaviours and values, leaders set the tone for implementation of patient-centred care.

Walking the talk means communicating openly, soliciting and responding to input from staff, patients, families and others, and ensuring staff members have the resources and flexibility they need to provide patient-centred care.

Physicians must be involved

Board members

Families and patients

Use implementation tools

open and responsive communication

personalization of care

culturally adapted care

continuity of care (patient navigators, patient advocates,

community care

Technology: data is not enough. Patient centred care technology must: enhance effective communication, promote continuity of care.

DOCUMENT: King, E. et al. (2013) The MAGIC programme: evaluation An independent evaluation of the MAGIC (Making good decisions in collaboration) improvement programme. The Health Foundation. http://www.health.org.uk/sites/default/files/TheMagicProgrammeEvaluation.pdf

Summary

The Health Foundation's MAGIC (Making good decisions in collaboration) improvement programme began in August 2010 and will run until October 2013. It aims to support clinical teams in primary and secondary care to embed shared decision making (SDM) with patients in their everyday practice. This evaluation covers the first phase of the programme.

The aims of the MAGIC programme are:

- Demonstrate that shared decision making (SDM) can feasibly, affordably and sustainably become a core characteristic of routine clinical care, both within primary and secondary care and at large scale
- Build practical and transferable knowledge about how this can be achieved and what the conditions for success are.

The programme was delivered through activities including:

- skills development and engagement, such as introductory and advanced skills development workshops for participating clinicians
- guidance on developing, adapting and implementing decision support tools
- facilitation and peer support for clinical teams
- Support in involving patients, including setting up patient forums and implementing a campaign – Ask 3 Questions – to 'activate' patients (increase their awareness of SDM).

Results:

The evaluation found evidence that the programme has succeeded in building participants' understanding and awareness of SDM, and developing their skills and confidence to apply the approach in practice. However, it proved difficult to successfully engage a small number of stakeholders, particularly senior clinicians.

Success was more likely where SDM was aligned with broader objectives such as developing more patient-centred care.

There was widespread use and positive feedback on many of the tools piloted within the programme. This is especially true of brief in-consultation decision support materials (Option Grids, Brief Decision Aids BDAs)), which were widely reported as being simple to use, effective in promoting consistent practice across clinical teams, and easy for patients to engage with.

Changes likely to produce a solid foundation for the implementation of SDM include:

- stronger and more widespread efforts to raise patients' awareness of and capacity to engage with SDM (including support to patient representative groups)

- the creation of mapping tools to enable service managers and commissioners to understand how care pathways can support SDM and where the decision points lie
- the development of national measures that can enable NHS managers to monitor and track patient experiences of SDM and outcomes
- provision of training and development programmes to support SDM, available to clinicians at all levels in the system
- the re-development of NHS and local authority information systems such as GP and NHS trust software systems so that SDM tools and information are readily available to clinicians and to patients, through patient records.

It was exceptional for clinical teams to have started the process of redesigning care pathways or wider systems to support the embedding of SDM prior to the MAGIC programme's involvement.

Patient awareness and involvement was low when the programme started

Evaluation participants reported that a key barrier to clinicians taking part in the MAGIC programme was the perception that they were already making shared decisions with their patients and so did not see the need to improve their practice.

The Health Foundation's recent evidence review notes,14 that initiatives that focus on 'passive' information-giving to patients are less likely to be effective than those which seek to actively engage patients with SDM. Raising awareness and changing expectations (described by some participants in the evaluation as the 'activation' of patients) was therefore a critical focus of the MAGIC programme.

Contribution to CHRODIS GP assessment dimensions

The evaluation found that assessing the baseline or 'starting point' of local teams, including their motivation and readiness to engage with SDM, may result in more tailored and therefore more effective approaches to implementation.

Specifically, we looked at the position of teams entering the programme in relation to the following dimensions:

- Attitudes, knowledge and awareness of shared decision making (SDM)
- Readiness of teams to engage in SDM
- Practical experience of using SDM tools, such as decision aids
- Clinical pathways and systems.

DOCUMENT: Wildevuur SE, Simonse LW Information and Communication Technology–Enabled Person-Centered Care for the "Big Five" Chronic Conditions: Scoping Review. J Med Internet Res 2015;17(3):e77 URL: http://www.jmir.org/2015/3/e77

Summary

The objective of this paper was to review the literature and to scope the field with respect to 2 questions: (1) which ICT interventions have been used to support patients and health care professionals in PCC management of the big 5 chronic diseases? and (2) what is the impact of these interventions, such as on health-related quality of life and cost efficiency?

This scoping review outlined ICT-enabled PCC in chronic disease management. Persons with a chronic disease could benefit from an ICT-enabled PCC approach, but ICT-PCC also yields organizational paybacks. It could lead to an increase in health care usage, as reported in some studies. Few interventions could be regarded as "fully" addressing PCC. This review will be especially helpful to those deciding on areas where further development of research or implementation of ICT-enabled PCC may be warranted.

Contribution to CHRODIS GP assessment dimensions

This document does not add anything additional.

DOCUMENT: Grumbach, K. et al. (2009) The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies. https://pcmh.ahrq.gov/sites/default/files/attachments/The%20Outcomes%20of%20Implementing%20Patient-Centered%20Medical%20Home%20Interventions.pdf

Summary

This summary provides a review of recent PCMH evaluations. The initial section of the summary provides a concise view of the key data on cost outcomes. The subsequent section provides more information about each PCMH model and includes data on quality and access in addition to costs, as well as reference citations.

Contribution to CHRODIS GP assessment dimensions

This document does not add anything additional.

4. Delphi-m in Diabetes

The contributions to construct the questionnaire for the Delphi-m in Diabetes were the three previous Delphi-m. For the summary of evidence, please refer the Summary of evidence of the previous Delphi-m.

Annex 5. Glossary of terms

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GLOSSARY

Accountability:

In ethics and governance, accountability is answerability, blameworthiness, liability, and the expectation of account-giving. In leadership roles, accountability is the acknowledgment and assumption of responsibility for actions, products, decisions, and policies including the administration, governance, and implementation within the scope of the role and encompassing the obligation to report, explain and be answerable for resulting consequences.

Affordability:

The extent to which something is affordable, as measured by its cost relative to the amount that the purchaser is able to pay.

Capacity building:

Capacity building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities.

Caregiver – Carers:

Persons, often relatives, who provide assistance (in activities and interaction within the environment) to those who are dependent on others for such assistance.

Care Plans:

Plans for the management of patient care that set goals for patients and provide the sequence of interventions that physicians, nurses and other professionals should carry out in order to reach the desired goals in a given time period.

Case Management:

Provision of continuous care across different services through the integration and coordination of needs and resources around the patient. The fundamental difference with disease management is that it focuses more on individual patients and their families than on the population of patients with a certain disease. This type of management is targeted at people with a high level of risk requiring expensive care, people who are vulnerable, or have complex social and health needs. The case manager coordinates patient care throughout the entire continuum of care.

Chronic care practice:

CHRODIS takes practice in a broad sense, referring to interventions at micro level (clinical practice), meso level (management interventions, providers funding schemes, implementation of a clinical guideline in several providers, etc.) or macro level (health plans, insurance policies, etc.)

Community of Practice:

A community of practice (CoP) is, according to cognitive anthropologist Etienne Wenger, a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact on a regular basis. The group can evolve naturally because of the members' common interest in a particular domain or area, or it can be created specifically with the goal of gaining knowledge related to their field. It is through the process of sharing information and experiences with the group that the members learn from each other, and have an opportunity to develop themselves personally and professionally.

Comorbidity:

Any distinct additional entity that has existed or may occur during the clinical course of a patient who has the index disease under study.

Cost effective:

Effective or productive in relation to its cost. Cost-effectiveness analysis is a decision-making assistance tool. It identifies the economically most efficient way to fulfil an objective. In evaluation, the tool can *be used to discuss the economic efficiency of a programme or a project.*

Coverage:

The extent to which an intervention (*see below*) is applied in terms of context, care-setting, target population, etc.

Delphi consultation

A Delphi consultation is a consensus technique widely used in health services and health policies research, particularly useful when evidence is uncertain (i.e. discretionary decisions are the rule) and stakeholders involved are heterogeneous.

It has been frequently used to decide on the appropriateness of the use of a diagnostic technique or a surgical procedure. CHRODIS opts for a modified technique with a two-round on-line consultation process and a face-to-face consensus meeting at the end of the two rounds.

Educational diabetes programs:

A structured patient education is an international accepted and vital intervention for people with diabetes with an evident effect on the therapy and prognosis of diabetes. Therefore it is labelled as education and care programs with a targeted structure of education. Usually, it means that the core contents, goals, methods and didactics are described in a curriculum and materials or tools for the educators and participants are provided.

Educational strategies and interventions are considered in educational diabetes programs. Patient education is described as a complex intervention with special requirements on evidence and transparency regarding its rationale, methodology, performance and outcome representation. Appropriate educational interventions and self-management support strategies were defined as a standard.

Efficacy:

The extent to which an intervention produces a beneficial result under ideal conditions.

Efficiency:

A measure of how economically the resources/inputs (funds, expertise, time, etc) are converted into results.

Effectiveness:

The extent to which the intervention's objectives were achieved, or are expected to be achieved, in real conditions, taking into account their relative importance (In contrast to efficiency, effectiveness is determined without reference to resources deployed or costs).

Empowerment:

It is a process that helps people gain control over their own lives and increases their capacity to act on issues that they themselves define as important.

Equity in health:

Means fairness. Equity in health means that people's needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life.

Evaluation:

The systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results. The aim is to determine the relevance and fulfilment of objectives, implementation efficiency, effectiveness, impact and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision–making process.

Evidence-based health promotion:

The use of information derived from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations.

Good practices:

A good practice would ideally refer to a practice able to improve quality of life efficiently (particularly from a societal perspective) while preserving the values of the patient and the society where the practice is implemented. The difficulty is on objectively measuring those elements.

CHRODIS opts for a definition of good practice built upon the use of a set of criteria previously agreed in a consensus process with experts on chronic care. Consensus becomes a surrogate when making positive statement is difficult, and normative (subjective) arguments might take place.

Grey literature:

It is the kind of material that is not published in easily accessible journals or databases. It includes things like conference proceedings that include the abstracts of the research presented at conferences, unpublished theses, and so on.

Guidelines:

Clinical practice guidelines (‘guidelines’) are systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. In addition, guidelines can play an important role in health policy formation and have evolved to cover topics across the health care continuum (e.g., health promotion, screening, diagnosis).

Health indicator: A health indicator is a characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time). Health indicators can be used to define public health problems at a particular point in time, to indicate change over time in the level of the health of a population or individual, to define differences in the health of populations, and to assess the extent to which the objectives of a programme are being reached.

Health inequalities:

Differences in health status or in the distribution of health determinants between different population groups. For example, differences in mobility between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequality in health and inequity. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health.

Health literacy:

Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course.

Health promotion:

The process of enabling people to increase control over, and to improve, their health.

Healthy aging:

The process of optimizing opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality life

Impact:

Intended or unintended change due directly or indirectly to an intervention (Related terms: results, outcome. The change can be positive and negative, primary and secondary).

Indicator:

Indicators in the context of evaluation are simply one-dimensional measures that help to measure, to express, or at least to reflect and to simplify the more complex formulation of the objectives.

Information need:

Information need is recognition that your knowledge is inadequate to satisfy a goal that you have, within the context situation that you find yourself at a specific point in the time

Innovation:

Those interventions which practice new solutions for certain problems and challenges or specific needs through the application of new ideas, concepts, process, and techniques are innovative.

Intersectorial collaboration:

A recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone.

Intervention:

May refer to policies, programmes as well as processes and practices

Low threshold approach:

Refers to purposeful ways to connect with disadvantaged target group(s), e.g. facilitating access to services, providing non-stigmatizing offers, including mediators in certain setting approaches (e.g. different languages-speaking dieticians in schools).

Meta-analysis:

The use of statistical techniques in a systematic review to integrate the results of included studies. Sometimes misused as a synonym for systematic reviews, where the review includes a meta-analysis.

Monitoring:

A continuing function that uses systematic collection of data on specified indicators to provide management, and the main stakeholders of an ongoing intervention, with indications of the extent of progress, and achievement of objectives and progress in the use of allocated funds.

Multimorbidity:

Co-occurrence of two or more conditions in the same patient without identifying an index disease.

National diabetic plan:

Any systematic and coordinated approach to improving the organization, accessibility, and quality of diabetes prevention and care.

Needs assessment:

A systematic procedure for determining the nature and extent of health needs in a population, the causes and contributing factors to those needs and the human, organizational and community resources which are available to respond to these.

Older person:

Ageing is multidimensional. Most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or older person. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits. At the moment, there is no United Nations standard numerical criterion, but the UN agreed cutoff is 60+ years to refer to the older population. For the purposes of this work, older people refer to those 65 and above.

Outcome:

An immediate or direct effect of a programme. Outcomes are frequently stated, for example: by a specified date, there will be a change (increase or decrease) in the target's behaviour, among the target population.

Outcome indicators:

It relates the results of a project in the target group to its specific objectives (and the underlying working hypothesis).

Ownership:

The state, relation or facts of considering yourself as owner of an intervention in which, you participate somehow.

Partners:

The individuals and/or organizations that collaborate to achieve mutually agreed upon objectives. The concept of partnership connotes shared goals, common responsibility for outcomes, distinct accountabilities and reciprocal obligations. Partners may include governments, civil society, non-governmental organizations, universities, professional and business associations, multilateral organizations, private companies, etc.

Patient centred care:

It is commonly understood as focusing on the individual seeking care—the patient. Care that is respectful of and responsive to individual patient preferences, need, and values, and ensuring that patient values guide all clinical decisions.

Patient’s preferences:

Appraisal of an individual who is informed and knowledgeable about the probabilities and severity of the effects and risks of interventions, and about process and outcome aspects of healthcare.

Patient’s strengths:

Patients’ characteristics that could potentially lead to successful outcomes like: motivation, self-direction, readiness for change, social and family support, etc.

Performance:

The degree to which a development intervention or a development partner operates according to specific criteria/standards/guidelines or achieves results in accordance with stated goals or plans.

Performance monitoring:

A continuous process of collecting and analyzing data to compare how well a project, program, or policy is being implemented against expected results.

Policy:

A Policy is a principle or protocol to guide decisions and achieve rational outcomes. A policy is a statement of intent, and is implemented as a procedure or protocol. Policies are generally adopted by a senior governance body or Board within an organization whereas procedures or protocols would be developed and adopted by senior executive officers. The term may apply to government, private sector organizations and groups, and individuals. Presidential executive orders, parliamentary rules of order and corporate privacy policies are all examples of policy. Policy differs from rules or law. While law can compel or prohibit behaviours (e.g. a law requiring the payment of taxes on income), policy merely guides actions toward those that are most likely to achieve a desired outcome.

Poly-pharmacy:

The use of multiple medications by a patient, generally older adults (those aged over 65 years). It is often defines as the use of five or more regular medication, but different cut-points have been proposed (including 8 or 10 medications.).

Prevention:

Prevention can be defined as an ‘action to reduce or eliminate the onset, causes, complications or recurrence of disease’. In general, the concept of prevention is characterised by activities that are designed to reduce the likelihood that something harmful will occur or to minimise that harm if it does occur.

There are several ways of categorising preventive measures, according to the stage in the natural history of disease at which they are introduced; the determinants of disease which are being addressed; the target groups to which they are applied; and the setting or level of delivery of preventive measures.

Primary prevention:

Measures and interventions directed towards preventing the initial occurrence of a disorder. It reduces both the incidence and prevalence of a disease.

Programme:

A plan of things that are done to achieve a specific result.

Public health:

Public health is the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals.

Quality of life:

Quality of life is defined as individual's perceptions of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment.

Relevance:

The extent to which the objectives of a development intervention are consistent with beneficiaries' requirements, local needs and global priorities and policies.

Responsiveness:

The ability of the health system to meet the population's legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth.

Review:

A review article in the medical literature which summarises a number of different studies and may draw conclusions about a particular intervention. Review articles are often not systematic. Review articles are also sometimes called overviews.

Risk factors:

This is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury. A small set of common risk factors are responsible for most of the main chronic diseases. These risk factors are: unhealthy diet, physical inactivity and tobacco use. In the context of this questionnaire the modifiable behavioural and social risk factors includes unhealthy diets, physical inactivity and tobacco use and the underlying socio-economic, cultural, political and environmental determinants of chronic diseases (including globalisation, urbanisation and population ageing). The majority of cardiovascular disease (CVD) for example, is caused by risk factors that can be controlled, treated or modified, such as high blood pressure, cholesterol, overweight/obesity, tobacco use, lack of physical activity and diabetes. However, there are also some major CVD risk factors that cannot be controlled (age and heredity). In terms of attributable deaths, the leading CVD risk factor is raised blood pressure (to which 13 per cent of global deaths is attributed), followed by tobacco use (9 per cent), raised blood glucose (6 per cent), physical inactivity (6 per cent) and overweight and obesity (5 per cent).

Risk factors for diabetes depend on the type of diabetes. Weight (obesity and overweight, often linked to a diet over-reliant on processed foods) and inactivity are major risk factors for diabetes 2.

Socioeconomic status (SES) is associated with chronic disease in large part through modifiable risk factors such as obesity, tobacco use, and sedentary lifestyle. Several recent studies have explored the association between neighbourhood deprivation and risk factors and chronic disease incidence and mortality. Whereas prevention efforts that focus on individual characteristics that control behaviour are important, environmental and social elements also affect personal choices, are modifiable risk factors, and deserve attention.

Risk-profiling (risk-stratification):

A formal estimate of the probability of a person's succumbing to a disease or benefiting from a treatment for that disease.

Salutogenic-approach:

The term describes an approach focusing on factors that support human health and well-being, rather than on factors that cause disease. More specifically, the "salutogenic model" is concerned with the relationship between health, stress, and coping.

Secondary prevention:

Secondary prevention aims to reduce progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention. Secondary prevention of diabetes relies on early detection of diabetes (e.g. throughscreening) and application of intervention strategies and disease management, respectively to prevent progression of the disease. Therefore all (primary) preventions of the secondary diseases (e.g. diabetes specific complications and co-morbidities) of type 2 diabetes are involved.

Systematic review:

A review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review. Statistical methods (meta-analysis) may or may not be used to analyse and summarise the results of the included studies.

Self-management:

The activities and skills (e.g., goal setting, decision making, self-monitoring) and individual learns and uses to improve their quality of life with one or more chronic conditions. Education and support from healthcare or other providers can enhance an individual’s self-confidence and self-management skills.

Self-management support:

An endeavor in which the healthcare team partners with patients to improve their ability to manage their conditions day to day.

Social support:

That assistance available to individuals and groups from within communities which can provide a buffer against adverse life events and living conditions, and can provide a positive resource for enhancing the quality of life.

Sustainability:

Sustainable interventions are those that can maintain their benefits for communities and populations beyond their initial stage of implementation. Sustainable actions can continue to be delivered within the limits of finances, expertise, infrastructure, natural resources and participation by stakeholders.

Scalability:

Deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis

Shared decision-making:

It is a collaborative process between patients and their providers whereby health care decisions are made together using both the best available scientific evidence and incorporation of patient's values and preferences.

SMART:

(Acronym) Specific/Measurable/Acceptable/Realistic/Time framed.

Stakeholders:

Agencies, organisations, groups or individuals who have a direct or indirect interest in the intervention or its evaluation

Target group:

The specific individuals, groups or organizations for whose benefit the intervention is undertaken.

Tertiary prevention:

The goal of tertiary prevention is to improve function and includes minimisation of the impact of established disease, and prevention or delay of complications and subsequent events through effective management and rehabilitation.

Transferability:

The quality of being transferable to other context or exchangeable among different contexts.

Trialability:

The quality or degree of being tested or verified by means of a trial.

Value concordance:

It is defined as the association between patients' preferences concerning health outcomes and/or medical treatments, and treatment intention or treatment undergone.

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Annex 6. First and second rounds results tables for the Delphi-m in Health Promotion and Primary Prevention of Chronic Conditions

List and affiliation of the expert panel involved in the Delphi -m

Name	Family Name	Organisation	Country
Teresa	Bennett	Health Service Executive	Ireland
Olga	Cleary	Institute of Public Health	Ireland
Elena	Coffano	Local Health Authority, Turin	Italy
Caroline	Costongs	Eurohealthnet	Netherlands
Maeve	Cusack	Cancer Control Health Service	Ireland
Plamen	Dimitrov	The National Center of Public Health and Analyses	Bulgaria
Tijana	Djurdjevic		Serbia
João	Filipe Raposo	Portuguese Diabetes Association	Portugal
Guido	Iaccarino	University of Salerno	Italy
Siobhan	Jennings	Health Service Executive	Ireland
Lotte	Kaba-Schoenstein	University of Applied Sciences, Esslingen	Germany
Sveinbjörn	Kristjánsson	The Directorate of Health	Iceland
Frank	Lehmann	Federal Centre for Health Education, Cologne	Germany
Krystiine	Liiv	National Institute for Health Development	Estonia
Christos	Lionis	University of Crete	Greece
Susanne	Løgstrup	Europena Heart Network	Denmark
Helen	McAvoy	Institute of Public Health	Ireland
Elizabeth	Mitchell	Institute of Public Health	Ireland
Michal	Molcho	National University of Ireland Galway	Ireland
Ioannis	Tountas	University of Crete	Greece
Hedinn	Unnsteinsson	Government of Iceland	Iceland
Djoeke	van Dale	Centre for Healthy Living of the National institute of Public Health and the Environment	Netherlands
Matthijs	van den Berg	National Institute for Public Health and the Environment	Netherlands
Richard	Watt	University College London	United Kingdom
Lars	Weinehall	Umeå University	Sweden
Simone	Weyers	University of Duesseldorf	Germany
Jamie	Wilkinson	Pharmaceutical Group of the European Union	Belgium

First Round Tables (Online) – Relevance Assessment

Table 2. Relevant criteria and categories for interventions' assessment obtained in the first round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
2	Comprehensiveness of the intervention	2	The intervention is aligned with a comprehensive approach to health promotion.	7	1	22	4	0
		4	The intervention is aligned with a policy plan at the local, national, institutional or international level.	8	1	20	6	0
3	Context and Determinants analysis / Evidence	5	Empirical data has been collected regarding the nature, size and distribution of the problem	8	1	21	5	0
4	Aims & Objectives	13	The concept includes a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed).	8	2	25	1	0
5	Description of intervention strategies and methods of implementation	14	The design is theoretically justified and addresses the sequence, frequency, intensity, duration, recruitment method and location of the intervention.	8	1	23	3	0
		15	The method of the intervention is thoroughly described in concrete activities including time frame or chronograms.	8	1	23	3	0
6	Equity	16	Different dimensions of equity are taken into consideration and are targeted (i.e. gender, socioeconomic status, education level, ethnicity, rural-urban area, vulnerable groups).	8	1	24	2	0
		17	Efforts are made to facilitate vulnerable group's access to relevant services ("low threshold" approach).	8	1	25	1	0
7	Target population	18	Target population/s is defined on the basis of needs assessment.	8	1	23	3	0
		20	Methods used for selection of target population/s are documented.	7	1	21	5	0
		21	The intervention aims to create a health promoting environment through a "setting approach".	7	1	21	5	0

		22	There is a communication strategy which includes intermediaries/multipliers addressing stakeholders that are of relevance to promote the use of /participation in the intervention (e.g. community doctors and local school teachers are made aware of the existence of a community counselling service).	8	1	21	5	0
8	Empowerment and Participation	23	The intervention aims to support the target population(s) in an autonomy-developing process.	7	1	22	3	0
		24	The intervention has been designed in consultation with the target population.	8	1	25	1	0
		25	The intervention creates ownership among the target population and stakeholders.	8	1	23	3	0
		26	Strengths and resources of the target population are developed (salutogenetic approach).	7	1	22	4	0
9	Multi-Stakeholder Approach	27	Different dimensions of a multi-stakeholder approach are taken into consideration (i.e multidisciplinary, multi-/ inter-sector, partnerships and alliances).	7	1	22	4	0
10	Ethical Considerations	29	Potential burdens of the intervention for the target population are addressed.	7	1	20	6	0
		30	Benefits and burdens of the intervention are fairly balanced.	7	1	21	5	0
		31	The intervention is implemented equitably, following the principle of proportional universalism: universal provision with a scale and intensity that is proportional to needs.	8	1	20	6	0
		32	The intervention's objectives and strategy are transparent to all individuals and stakeholders involved.	8	1	24	2	0
11	Adequacy, capacity and resources	33	The concept includes an adequate estimation of the human resources, material, non-material and budget requirements [in clear relation with committed tasks?].	8	1	24	2	0
		34	Sources of funding are specified in regards to stability and commitment.	7	1	22	4	0
12	Participation and structural commitment	35	Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	7	1	24	2	0
		36	Human resource needs assessed, defined and in clear relation with committed tasks.	7	0	23	3	0

13	Evaluation	37	Defined evaluation framework assessing structure, process and outcome.	8	1	25	1	0
		38	Use of validated evaluation methods and/or tools.	8	0	26	0	0
		39	Information /monitoring systems are in place to deliver data aligned with evaluation and reporting needs.	8	1	26	0	0
		40	Regularity of monitoring reports.	7	1	21	4	0
		41	Evaluation results are linked to the stated goals and objectives at each stage of the implementation process.	8	1	25	1	0
		42	The results of evaluation are linked to actions to reshape the implementation accordingly.	8	0	25	1	0
		43	The intervention is assessed for efficiency.	8	1	22	4	0
		44	The intervention is assessed for impact (i.e. health impact and in a broader sense, any consequences derived from the implementation of the intervention such as raising specific taboos among certain groups, unforeseen resistances in the implementation, etc.).	8	2	25	1	0
14	Sustainability	45	There is broad support for the intervention amongst those who implement it.	8	1	24	2	0
		46	There is broad support for the intervention amongst the intended target populations.	8	1	25	1	0
		48	The continuation of the project is ensured e.g. through ownership, structural continuity and/or institutional anchoring.	8	1	23	3	0
15	Scalability	49	Intervention scalability is assessed in terms of potential size of the population targeted if scaled up.	7	0	21	5	0
		50	Intervention scalability is assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators.	7	1	20	6	0
		51	Intervention scalability is assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring).	7	1	23	2	0
		52	There are specific knowledge transfer strategies in place (evidence into practice).	8	1	23	3	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 3. Discarded criteria and categories for interventions' assessment obtained in the first round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
1	Length of experience threshold	1	The intervention must have been implemented for a minimum length of time (n years) to be eligible for assessment as good practice	6	2	7	16	3
3	Context and determinants analysis	7	A comparison to existing alternatives has been carried out and includes economic analysis (e.g. cost effectiveness analysis, cost minimisation analysis, cost utility analysis)	6	2	9	16	1
		8	A comparison to existing alternatives has been carried out and includes Health Impact Assessment (HIA)	6	2	11	15	0
16	Innovation	55	The intervention implements new ways of funding coordination across key separate institutional and community instances/resources	6	1	10	16	0
		56	The intervention implements new ways of coordination for information systems involving key separate institutional and community instances/resources	6	1	8	18	0
		57	The intervention includes new (as yet un-trialled) ideas and approaches to resolve known problems	6	1	10	16	

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 4. No consensus criteria and categories among the experts for interventions' assessment obtained in the first round.

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)

2	Comprehensiveness of the intervention	3	The intervention addresses several risk factors or determinants of health at the same time	7	3	15	11	0
3	Context and Determinants analysis / Evidence	6	A systematic review has been conducted to collect evidence on the determinants of health (i.e. Social and economic environment, Physical environment, target population and persons' individual characteristics and behaviours)	8	2	19	6	1
		9	There is an analysis of the budget impact of implementing the intervention (BIA)	7	2	15	11	0
		10	Theoretical basis of the intervention are provided: description of the chain of causation	7	2	19	8	0
		11	Theoretical basis of the intervention are provided: description of interactions between key stakeholders	7	1	16	10	0
		12	Theoretical basis of the intervention are provided: description of interactions between processes	7	1	14	12	0
7	Target population	19	Specific characteristics and strengths of target population/s are documented	7	2	19	7	0
10	Ethical Considerations	28	Analysis of conflict of interests among stakeholders and individuals involved	7	2	14	12	0
14	Sustainability	47	The continuation of the project is ensured through follow-up funding and human resources	7	2	19	7	0
15	Scalability	53	There are systematic networking efforts to foster the exchange of information, mutual support and cooperation with other community resources.	7	2	18	8	0
16	Innovation	54	The intervention implements new ways of coordination for decision making involving key separate institutional and community instances/resources	7	1	13	13	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Second Round Tables (Online) – Relevance Assessment and Prioritization

Table 5. Criteria and categories (no reached agreement in the first round) assessed as relevant for interventions' assessment obtained in the second round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
3	Context and Determinants analysis / Evidence	10	Theoretical basis of the intervention are provided: description of the chain of causation	7	1	14	9	0
7	Target Population	7	Specific characteristics and strengths of target population/s are documented	7	1	14	9	0
14	Sustainability	47	The continuation of the project is ensured through follow-up funding and human resources	8	0	23	0	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 6. Criteria and categories (no reached agreement in the first round) discarded for interventions' assessment obtained in the second round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
1	Comprehensiveness of the intervention	3	The intervention addresses several risk factors or determinants of health at the same time	6	2	7	15	1
2	Context and Determinants analysis / Evidence	6	A systematic review has been conducted to collect evidence on the determinants of health (i.e. Social and economic environment, Physical environment, target population and persons' individual characteristics and behaviours)	6	2	11	12	0
		9	There is an analysis of the budget impact of implementing the intervention (BIA)	6	2	8	15	0
		11	Theoretical basis of the intervention are provided: description of interactions between key stakeholders	6	1	9	14	0
		12	Theoretical basis of the intervention are provided: description of interactions between processes	6	1	8	15	0

9	Ethical Considerations	28	Analysis of conflict of interests among stakeholders and individuals involved	6	1	7	15	0
14	Scalability	53	There are systematic networking efforts to foster the exchange of information, mutual support and cooperation with other community resources	7	1	13	10	0
15	Innovation	54	The intervention implements new ways of coordination for decision making involving key separate institutional and community instances/resources	6	1	9	14	0

Vote distribution*:

R- Relevant
NCR-No clear relevance
IR-Irrelevant

Table 7. Relevant criteria and categories for intervention's assessment ordered by their average priority scores

Note: Categories coloured in blue correspond to no consensus categories obtained in round one and subsequently selected as relevant in the second round.

Criterion-ID	Criterion	Item-ID	Item	Priority-Weight	
6	Equity	16	Different dimensions of equity are taken into consideration and are targeted (i.e. gender, socioeconomic status, education level, ethnicity, rural-urban area, vulnerable groups)	**183**	**181.5**
		17	Efforts are made to facilitate vulnerable group's access to relevant services ("low threshold" approach)	**180**	
4	Aims & Objectives	13	The concept includes a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed)	**179**	**179**
5	Description of intervention strategies and methods of implementation	14	The design is theoretically justified and addresses the sequence, frequency, intensity, duration, recruitment method and location of the intervention	**178**	**176.5**
		15	The method of the intervention is thoroughly described in concrete activities including time frame or chronograms	**175**	
13	Evaluation	41	Evaluation results are linked to the stated goals and objectives at each stage of implementation process	**182**	**176.13**
		42	The results of evaluation are linked to actions to reshape the implementation accordingly	**180**	
		39	Information /monitoring systems are in place to deliver data aligned with evaluation and reporting needs	**178**	
		38	Use of validated evaluation methods and/or tools	**178**	
		44	The intervention is assessed for impact (i.e. health impact and in a broader sense, any consequences derived from the implementation of the intervention such as raising specific taboos among certain groups, unforeseen resistances in the implementation, etc.)	**176**	
		37	Defined evaluation framework assessing structure, process and outcome	**176**	
		43	The intervention is assessed for efficiency	**172**	
		40	Regularity of monitoring reports	**167**	

14	Sustainability	48	The continuation of the project is ensured e.g. through ownership, structural continuity and/or institutional anchoring	**182**	**175,3**
		45	There is broad support for the intervention amongst those who implement it	**179**	
		46	There is broad support for the intervention amongst the intended target populations	**177**	
		47	The continuation of the project is ensured through follow-up funding and human resources	**163**	
8	Empowerment and Participation	24	The intervention has been designed in consultation with the target population	**177**	**175**
		23	The intervention aims to support the target population(s) in an autonomy-developing process	**175**	
		25	The intervention creates ownership among the target population and stakeholders	**175**	
		26	Strengths and resources of the target population are developed (salutogenetic approach)	**173**	
9	Multi-Stakeholder Approach	27	Different dimensions of a multi-stakeholder approach are taken into consideration (i.e. multidisciplinary, multi-/ inter-sector, partnerships and alliances)	**173**	**173**
10	Ethical Considerations	32	The intervention's objectives and strategy are transparent to all individuals and stakeholders involved	**180**	**170**
		31	The intervention is implemented equitably, following the principle of proportional universalism: universal provision with a scale and intensity that is proportional to needs	**169**	
		30	Benefits and burdens of the intervention are fairly balanced	**166**	
		29	Potential burdens of the intervention for the target population are addressed	**165**	
2	Comprehensiveness of the intervention	2	The intervention is aligned with a comprehensive approach to health promotion	**171**	**170**
		4	The intervention is aligned with a policy plan at the local, national, institutional or international level	**169**	
7	Target population	18	Target population/s are defined on the basis of needs assessment	**176**	
		20	Methods used for selection of target population/s are documented	**174**	

		22	There is a communication strategy which includes intermediaries/multipliers addressing stakeholders that are of relevance to promote the use of /participation in the intervention (e.g. community doctors and local school teachers are made aware of the existence of a community counselling service)	**172**	**168,4**
		21	The intervention aims to create a health promoting environment through a "setting approach"	**166**	
		7	Specific characteristics and strengths of target population/s are documented	**154**	
11	Adequacy, capacity and resources	33	The concept includes an adequate estimation of the human resources, material, non-material and budget requirements	**177**	**169.5**
		34	Sources of funding are specified in regards to stability and commitment	**162**	
12	Participation and structural commitment	35	Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities)	**171**	**169**
		36	Human resource needs assessed, defined and in clear relation with committed tasks	**167**	
3	Context and Determinants analysis / Evidence	5	Empirical data has been collected regarding the nature, size and distribution of the problem	**170**	**166,5**
		10	Theoretical basis of the intervention are provided: description of the chain of causation	**163**	
15	Scalability	52	There are specific knowledge transfer strategies in place (evidence into practice)	**171**	**162**
		51	Intervention scalability is assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring)	**160**	
		49	Intervention scalability is assessed in terms of potential size of the population targeted if scaled up	**159**	
		50	Intervention scalability is assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators	**158**	

Experts’ Comments during the first and second rounds with regard to relevance and priority

Experts' comments with regard to relevance:

- The assumption that, the feasibility of a good practice in health promotion and prevention came determined by each country's specific health policy framework, to the point that a practice will be a "good practice" depending on the country's policy rather than the practice *per se:*

  ["*We always have to see that the biggest effects are coming from political decisions*"]

  ["*It is very difficult to discriminate "best practice" when the countries' policies are very different among them and they depend on a specific national policy*"]

- This reliance on health policy as the main drive for good practice and impact led some experts to underplay the need for further evidence about interventions' effectiveness:

  [*"Prevention and Health Promotion need to be political decisions; ……… if we do more and more science into Public Health we are occupied by research and documentation and loose time and power for Action;, "………….. Research has to be the second priority and politics has to be the first priority"]*

- The potential for transferability was also regarded more as matter of national policy than dictated by the intervention requirements of resources or organisational features:

  [*"…..the policies of the different countries can differ largely. It is difficult to disseminate a best practice which is very dependent of a specific national policy*"]

- Another concern expressed had to do with assessing a practice by the adequacy of capacity and resources allocated to it. In some experts' view, funding was an ex-ante condition, extrinsic to the quality and expected impact of the practice itself, though closely linked to the success and continuation of an intervention:

  ["*Funds are very relevant but differ between countries. So it is difficult to implement this part of the intervention*"]

  - Finally despite they deemed the economic analysis as very relevant, some experts showed reservations as to the feasibility of such approach in health promotion and prevention:

    ["…*very hard to demonstrate*"]

    ["*Difficult to evaluate economic term mentioned but when possible it is highly relevant*"]

  - The lack of studies of this sort was also argued as a major hurdle to use this type of criteria in assessing the quality of a practice

["……. comparison of cost-effect analysis is very important but there are hardly any studies for cost-effectiveness for health promotion studies and especially studies for the cost-effectiveness for low-income groups are scarce. And very often these are model studies. So this is I think this is a criteria which is difficult to meet"]

Experts' Comments related to priority:

- In alignment with the first round, some experts' expressed reservations as to attaching high priority to categories of adequacy, capacity and resources. Digging a bit further, they argued that such categories could penalise practices from those settings under economic constraint; the underneath reasoning seem to go along the lines of potential for misjudgement of otherwise good practices when resources were increasingly under pressure, limiting the ability of countries to sustain projects despite their relevant results

[*"High priority and very important criterion in several settings (e.g. countries under austerity)"*

["It *is an important priority no always relevant and in some cases highly costly"*]

- In addition, sustainability, which experts had considered important criteria for a good practice, was also closely linked to resources
[*"The funding and the continuation of the funding are very important for criteria within a country. But for a European best practice funding will be different for each country"*]

- Therefore, according to them, sustainability would depend on the country's economic situation rather than the practice itself (whether it is or not good, its impact on the population, or if the practice could embed into the organization)

[*"It is a true priority but continuation of the project viability of the funding is uncertain in settings with low resource capacity and under financial crisis"*]

- Some experts had also strong views about the tailoring of practices to the target population needs. The successful adoption of a practice would depend, among other things; on whether different dimensions of the cultural framework were taken into consideration

[*"Cultural and subcultural differences among settings may have an impact on the intervention outcomes*"].

- In this experts' opinion, a comprehensive assessment of the characteristics of the target population, a good method for their selection, and a health promoting setting approach were essential requirements to reach the adequate population

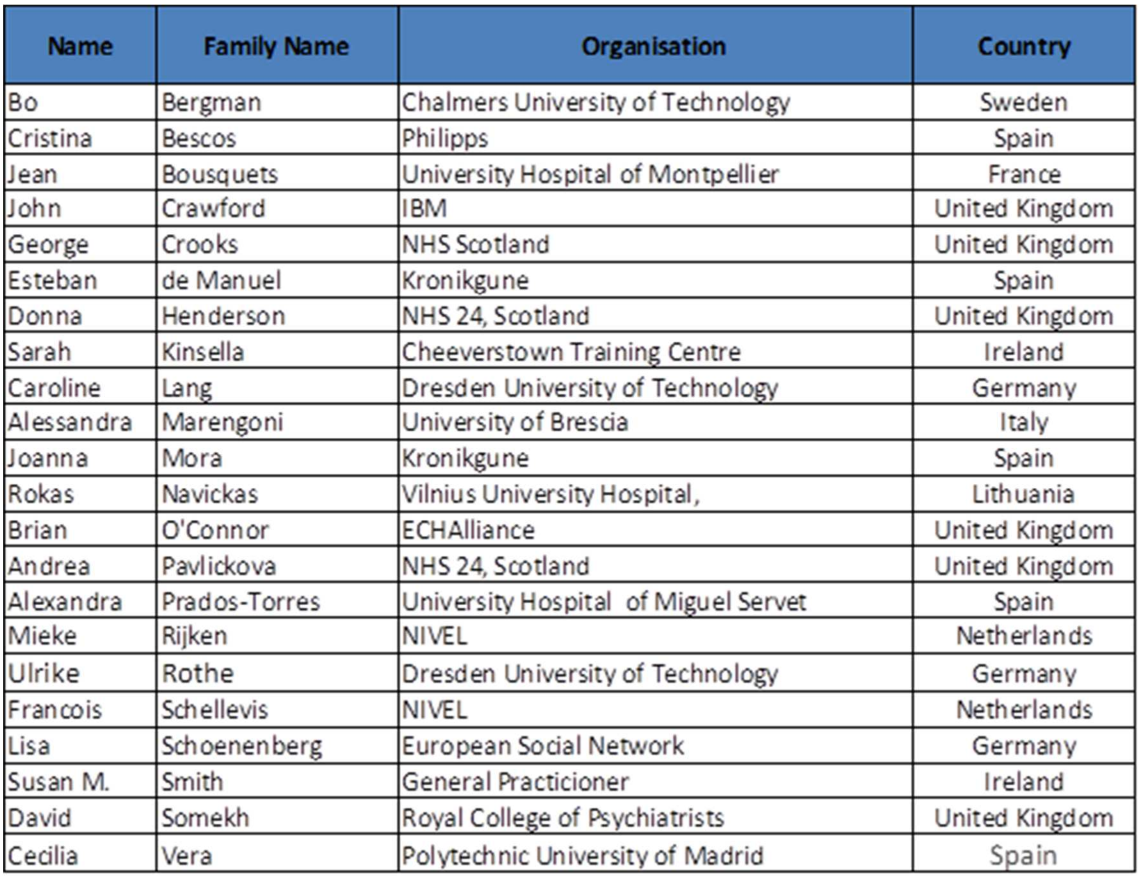
  [*"It has a high agreement that it is a very high priority"]*

- In spite of that, they also put forward potential pitfalls when assessing target population's needs, claiming that this requirement could be often "unrealistic" due to the diversity of settings and population the practice have to face

  [*"It is highly relevant but not feasible in all cases and in all settings. In several situations, background information and evidence is required that is lacking (e.g. in terms of heterogeneous population"]*

Annex 7: First and second rounds tables results for the Delphi-m in organizational Interventions focused on dealing with Chronic Patients with Multiple Conditions

List and affiliation of the expert panel involved in the Delphi-m



Name	Family Name	Organisation	Country
Bo	Bergman	Chalmers University of Technology	Sweden
Cristina	Bescos	Philipps	Spain
Jean	Bousquets	University Hospital of Montpellier	France
John	Crawford	IBM	United Kingdom
George	Crooks	NHS Scotland	United Kingdom
Esteban	de Manuel	Kronikgune	Spain
Donna	Henderson	NHS 24, Scotland	United Kingdom
Sarah	Kinsella	Cheeverstown Training Centre	Ireland
Caroline	Lang	Dresden University of Technology	Germany
Alessandra	Marengoni	University of Brescia	Italy
Joanna	Mora	Kronikgune	Spain
Rokas	Navickas	Vilnius University Hospital,	Lithuania
Brian	O'Connor	ECHAlliance	United Kingdom
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Alexandra	Prados-Torres	University Hospital of Miguel Servet	Spain
Mieke	Rijken	NIVEL	Netherlands
Ulrike	Rothe	Dresden University of Technology	Germany
Francois	Schellevis	NIVEL	Netherlands
Lisa	Schoenenberg	European Social Network	Germany
Susan M.	Smith	General Practicioner	Ireland
David	Somekh	Royal College of Psychiatrists	United Kingdom
Cecilia	Vera	Polytechnic University of Madrid	Spain

First Round Tables (Online) – Relevance Assessment

Table 9. Relevant criteria and categories for interventions' assessment obtained from the first online round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R	NCR	IR

						(7-9)	(4-6)	(1-3)
1	Defined intended effect	1	Key elements of the intervention were clearly defined and related to the intended effect (based on strong theoretical basis, providing a clear understanding of the chain of causation and the interactions between processes).	8	2	21	1	0
		2	The intervention was based on a clear assessment of needs of the population it will serve	8	2	20	2	0
2	Theory grounds	4	The intervention included change management elements, identifying the necessary actions to remove legal, organisational, and financial or skill barriers.	8	2	21	1	0
		5	The intervention was based on a clear understanding of the contextual factors that would affect the outcomes (i.e. characteristics of the health system, coverage, characteristics of the population, socioeconomic environment).	8	1	20	2	0
		6	There had been an explicit process of public consultation and stakeholders' engagement prior to the implementation of the intervention, with clear procedures to foster collaboration.	8	1	18	4	0
		9	An economic evaluation comparing incremental cost-effectiveness of existing alternatives of intervention was carried out (or accounted for if already existed).	8	1	21	1	0
3	Aims and objectives	10	The intervention's aims and objectives were clearly specified and adjusted to the SMART rule (Specific/Measurable/Acceptable/Realistic/Time framed).	9	1	20	2	0
		11	The aims and objectives of the intervention were related to a situation analysis and needs assessment.	8	2	20	2	0
4	Target group / population addressed	12	Target groups were risk-stratified using evidence-based sound methodology and taking into account different dimensions (quality of life, frailty, clinical susceptibility, functional autonomy, mental health).	8	2	19	3	0
		13	There was a detailed description of the estimated number and profile of the patients receiving the intervention.	7	1	20	2	0
		14	Instruments for patient needs' assessment were selected on the basis of an explicit review of the updated evidence.	8	1	19	3	0

		16	The intervention was sensitive to cultural beliefs and socioeconomic characteristics of the individuals.	8	1	18	4	0
5	Intervention design	18	The different professional disciplines and services that were involved in the intervention are clearly identified, with appropriate mechanisms of coordination among them.	8	2	20	2	0
		19	The intervention defined specific care pathways for patients based on their clinical assessment.	8	2	21	1	0
		20	Patients' care plans (including goal-setting) were discussed and agreed with the patients or their representatives.	8	1	21	1	0
		21	There was an individual supervision of the patient across the diagnostic and therapeutic processes (including the definition of the case-manager role).	8	1	19	3	0
		22	Poly-pharmacy and patient adherence to treatments were specifically addressed in the design of the intervention.	9	1	19	3	0
		23	The intervention placed a specific role/function for caregivers, involving them in care support infrastructure for dependent patients.	8,5	1	22		0
6	Strategies and methods of implementation	25	All the processes involved in the intervention were clearly defined and mapped, with explicit milestones that allow for an adequate monitoring of the intervention.	8	1	21	1	0
		26	There was an explicit human resources policy, with a definition of professional roles involved, criteria for professional recruitment and training plans (including a clear definition of qualifications and skills).	8	1	20	2	0
		27	There was a defined strategy to align staff incentives and motivation with the intervention objectives.	8	2	19	3	0
		28	The intervention included a learning system to support reflective healthcare practice among professionals involved.	8	1	19	3	0
7	Leadership	29	There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined.	8,5	1	22		0
8	Stakeholders involvement and participation	30	There was explicit commitment and support among stakeholders involved in the intervention (e.g providers, patients, community, governing boards of the healthcare system,...).	8	1	22		0

		31	The professionals involved in the intervention and/or the organisation team members supported individual's self-management (e.g. through patient education, patient activation and empowerment).	8	1	21	1	0
		32	The intervention included a system to support patient engagement and self-management (bidirectional communication, assistance at home, counselling, integration in patient's community, monitoring, emergency care rapid response, telephone follow-up, etc.).	9	1	21	1	0
		33	Social care and healthcare were integrated into a functionally unified assistance network.	8	1	20	2	0
9	Interaction with regular care delivery structure and society network	34	The sharing and flow of information across all care providers (i.e. health and social services and different levels or instances within them) was shaped to facilitate transition and sufficient access to relevant information within the scope at any level.	8	1	22	0	0
		35	The intervention was integrated or fully interacting with the regular healthcare delivery system to avoid creation of self-contained parallel circuits functioning in the margins of established devices of care.	8	1	20	2	0
		36	The intervention fostered continuous engagement and coordination with different community resources (i.e. main town halls, social services, pharmacies and local associations).	8	1	19	3	0
10	Capacity and resources	37	Investment in human capital by means of training/education activities for healthcare providers, caregivers and patients was present.	8	1	21	1	0
		38	The workload (cognitive, physical, time) for the organization and the professionals involved had been previously estimated.	8	0	20	2	0
11	Information systems	39	The intervention integrated different Information and Communication Technologies (e.g. accessible channels of communication, dedicated software,…).	8	2	20	2	0
		41	There was an integrated system of patient clinical data that can be accessed and updated by professionals in real time across the various care levels.	8	1	22	0	0
		43	The best available evidence (guidelines, protocols, etc.) was easily available for health professionals.	8	1	20	2	0
		44	There existed a defined policy to ensure acceptability of information technologies among their users	8	2	19	3	0

			(professionals and patients), including involvement of end-users in the process of change.					
12	Evaluation framework and regularity	45	The intervention included a monitoring & evaluation system with a defined framework for assessment and an information system feeding defined indicators and standards of care.	8	1	20	2	0
		46	Evaluation activities followed clear milestones and were sustained along the intervention.	8	0	19	3	0
		47	The evaluation framework included a baseline multidisciplinary assessment for all the relevant outcomes (i.e. health problem, safety, clinical effectiveness).	8	1	20	2	0
		48	Indicators took into account economic aspects (i.e. budgetary impacts, efficiency gains) as well as patient and caregivers perspectives.	8	0	21	1	0
		49	The outcomes framework was shared among providers to foster collaboration and integration.	8,5	1	21	1	0
		50	Outcomes assessment focused on health impact (i.e. mental, physical and social status or functioning, patient assessment, symptoms control and pain treatment, quality of life) and satisfaction with care experience.	8,5	1	22	0	0
		51	The evaluation included healthcare utilization and quality and safety improvements in the different levels involved in the intervention (e.g. hospital care, community care, primary care, specialists' visits, pharmaceutical consumption or institutional long term care).	8	1	22	0	0
14	Relevance of assessment outcomes	54	Evaluation results were relevant and linked to the stated goals and objectives.	8,5	1	22	0	0
		55	Evaluation results were linked to actions to reshape the implementation accordingly.	9	1	22	0	0
		56	Outcomes assessment enabled outcome-based contracts (few, clear, concise and readily communicated indicators).	8	1	20	2	0
15	Sustainability	57	The continuation of the project was ensured through ownership and/or institutional anchoring, and there was	8	1	21	1	0

			enough support for the intervention amongst both those who implemented it and the target group.					
		58	The financial viability of the intervention was guaranteed in the long term (including a risk-adjusted funding scheme, identification of necessary resources and budget impact of the implementation, including all relevant costs and its distributions among stakeholders, partners, and the organization.	8,5	1	21	1	0
		59	The sustainability strategy considered a range of contextual factors (i.e. structural funds, resources from project partners, synergy with local industry and technology involving private and public sector and citizens).	8	2	22	0	0
16	Scalability and knowledge exchange	60	The Intervention potential for scalability was assessed in terms of prospective size of the population targeted, key factors, barriers and facilitators.	8	1	22	0	0
		61	There were systematic networking efforts (i.e. knowledge exchange and learning networks, strategies of communication and dissemination, tailored diagnosis of scaling up possibilities) to foster the exchange of information, mutual support and cooperation with other community resources.	8	1	21	1	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 10. No consensus criteria and categories for interventions' assessment obtained in the first round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution* R (7-9)	NCR (4-6)	IR (1-3)
2	Theory grounds	3	The intervention was aligned with the political agenda at the institutional, local, national or international level.	7	1	13	8	1
		7	An explicit comparison to existing alternatives of intervention was carried out (or accounted for if already	7	1	18	4	0

			existed) including impact on different dimensions of health care such as quality and safety.					
		8	An explicit comparison to existing alternatives of intervention was carried out (or accounted for if already existed) in terms of impact of different dimensions such as equity, solidarity and responsiveness.	7	1	13	9	0
4	Target group / population addressed	15	Clear protocols were developed to identify the individual patient needs and to determine eligibility for service and referral to/from other agencies.	8	1	18	4	0
5	Intervention design	17	There is a detailed description of the location of the intervention, including the main characteristics of the area and population in which the intervention was implemented.	7	2	12	10	0
		24	There was a defined plan for social marketing activities, including communication and reaching-out strategies, definition of material and messages targeting specific groups and other community and social actions (training materials, job aids….).	7	1	17	5	0
11	Information systems	40	The intervention included prescription support tools allowing communication among the healthcare professionals.	8	2	18	4	0
		42	There existed a specific funding program for the information systems (including management and clinical practice).	7	2	16	6	0
13	Assessment of coordination and organizational aspects	52	Rapid consultation and response devices were in place linked to the intervention monitoring (i.e. phone use when fast response is needed, use of a "call centre" as core enabling proactive problem solving and activation of resources.	8	2	17	5	0
		53	The patient and main caregiver / family roles were strengthened in the intervention incorporating specific devices for psychological /emotional support.	8	2	19	2	1

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Second Round Tables (Online) – Relevance Assessment and Prioritization

Table 11. Criteria and categories (no reached agreement in the first round) assessed as relevant for interventions' assessment obtained in the second round

Criterion-ID	Criterion	Category-ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
4	Target group / population addressed	15	Clear protocols were developed to identify the individual patient needs and to determine eligibility for service and referral to/from other agencies	7	1	19	1	0
5	Intervention design	17	There is a detailed description of the location of the intervention, including the main characteristics of the area and population in which the intervention was implemented	7	1	19	1	0

Vote distribution*:
R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 12. Criteria and categories (no reached agreement in the first round) discarded for intervention's assessment in the second round

Criterion- ID	Criterion	Category-ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
2	Theory grounds	3	The intervention was aligned with the political agenda at the institutional, local, national or international level.	7	2	13	7	0

		7	An explicit comparison to existing alternatives of intervention was carried out (or accounted for if already existed) including impact on different dimensions of health care such as quality and safety.	7	1	12	7	0
		8	An explicit comparison to existing alternatives of intervention was carried out (or accounted for if already existed) in terms of impact of different dimensions such as equity, solidarity and responsiveness.	6	2	8	12	0
5	Intervention design	24	There was a defined plan for social marketing activities, including communication and reaching-out strategies, definition of material and messages targeting specific groups and other community and social actions (training materials, job aids….).	7	2	13	7	0
11	Information systems	40	The intervention included prescription support tools allowing communication among the healthcare professionals.	7	2	13	7	0
		42	There existed a specific funding program for the information systems (including management and clinical practice).	7	2	13	7	0
13	Assessment of coordination and organizational aspects	52	Rapid consultation and response devices were in place linked to the intervention monitoring (i.e. phone use when fast response is needed, use of a “call centre” as core enabling proactive problem solving and activation of resources.	7	1	17	3	0
		53	The patient and main caregiver / family roles were strengthen in the intervention incorporating specific devices for psychological /emotional support.	7	1	17	1	2

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 13. Relevant criteria and categories for intervention’s assessment ordered by their average priority scores obtained from the second round.

Note: Categories coloured in blue correspond to *no consensus categories* obtained in the first round and subsequently selected as relevant in the second round, and the category coloured in green corresponds to the category assigned low priority in the second round ranked by priority weight.

Criterion-ID	Criterion	Category-ID	Category	Priority-Weight

7	Leadership	**29**	There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined.	**162**	**162**
9	Interaction with regular care delivery structure and society network	**35**	The intervention was integrated or fully interacting with the regular healthcare delivery system to avoid creation of self-contained parallel circuits functioning in the margins of established devices of care.	**166**	**162**
		33	Social care and healthcare were integrated into a functionally unified assistance network.	**164**	
		36	The intervention fostered continuous engagement and coordination with different community resources (i.e. main town halls, social services, pharmacies and local associations).	**160**	
		34	The sharing and flow of information across all care providers (i.e. health and social services and different levels or instances within them) was shaped to facilitate transition and sufficient access to relevant information within the scope at any level.	**158**	
1	Defined intended effect	**2**	The intervention was based on a clear assessment of needs of the population it will serve.	**164**	**161**
		1	Key elements of the intervention were clearly defined and related to the intended effect (based on strong theoretical basis, providing a clear understanding of the chain of causation and the interactions between processes).	**157**	
8	Stakeholder involvement and participation	**31**	The professionals involved in the intervention and/or the organization team members supported individual’s self-management (e.g. through patient education, patient activation and empowerment).	**163**	**161**
		32	The intervention included a system to support patient engagement and self-management (bidirectional communication, assistance at home, counselling, integration in patient’s community, monitoring, emergency care rapid response, telephone follow-up, etc.).	**161**	
		30	There was explicit commitment and support among stakeholders involved in the intervention (e.g. providers, patients, community, governing boards of the healthcare system,...).	**159**	
5	Intervention design	**20**	Patients’ care plans (including goal-setting) were discussed and agreed with the patients or their representatives.	**171**	

		19	The intervention defined specific care pathways for patients based on their clinical assessment.	**166**	**159**
		22	Poly-pharmacy and patient adherence to treatments were specifically addressed in the design of the intervention	**163**	
		18	The different professional disciplines and services that were involved in the intervention are clearly identified, with appropriate mechanisms of coordination among them.	**159**	
		23	The intervention placed a specific role/function for caregivers, involving them in care support infrastructure for dependent patients.	**156**	
		17	There is a detailed description of the location of the intervention, including the main characteristics of the area and population in which the intervention was implemented.	**155**	
		21	There was an individual supervision of the patient across the diagnostic and therapeutic processes (including the definition of the case-manager role).	**145**	
10	Capacity and resources	**37**	Investment in human capital by means of training/education activities for healthcare providers, caregivers and patients was present.	**166**	**158**
		38	The workload (cognitive, physical, time) for the organization and the professionals involved had been previously estimated.	**150**	
15	Sustainability	**58**	The financial viability of the intervention was guaranteed in the long term (including a risk-adjusted funding scheme, identification of necessary resources and budget impact of the implementation, including all relevant costs and its distributions among stakeholders, partners, and the organization.	**163**	
		57	The continuation of the project was ensured through ownership and/or institutional anchoring, and there was	**158**	

			enough support for the intervention amongst both those who implemented it and the target group.		**158**
		59	The sustainability strategy considered a range of contextual factors (i.e. structural funds, resources from project partners, synergy with local industry and technology involving private and public sector and citizens).	**152**	
3	Aims and objectives	**11**	The aims and objectives of the intervention were related to a situation analysis and needs assessment.	**158**	**156**
		10	The intervention's aims and objectives were clearly specified and adjusted to the SMART rule (Specific/Measurable/Acceptable/Realistic/Time framed).	**154**	
11	Information systems				**155**
		43	The best available evidence (guidelines, protocols, etc.) was easily available for health professionals.	**161**	
		41	There was an integrated system of patient clinical data that can be accessed and updated by professionals in real time across the various care levels.	**155**	
		44	There existed a defined policy to ensure acceptability of information technologies among their users (professionals and patients), including involvement of end-users in the process of change.	**153**	
		39	The intervention integrated different Information and Communication Technologies (e.g. accessible channels of communication, dedicated software,…).	**151**	
12	Evaluation framework and regularity	**45**	The intervention included a monitoring & evaluation system with a defined framework for assessment and an information system feeding defined indicators and standards of care.	**162**	**155**
		46	Evaluation activities followed clear milestones and were sustained along the intervention.	**158**	
		47	The evaluation framework included a baseline multidisciplinary assessment for all the relevant outcomes (i.e. health problem, safety, clinical effectiveness).	**157**	

		51	The evaluation included healthcare utilization and quality and safety improvements in the different levels involved in the intervention (e.g. hospital care, community care, primary care, specialists' visits, pharmaceutical consumption or institutional long term care).	**155**	
		48	Indicators took into account economic aspects (i.e. budgetary impacts, efficiency gains) as well as patient and caregivers perspectives.	**154**	
		50	Outcomes assessment focused on health impact (i.e. mental, physical and social status or functioning, patient assessment, symptoms control and pain treatment, quality of life) and satisfaction with care experience.	**152**	
		49	The outcomes framework was shared among providers to foster collaboration and integration.	**149**	
2	Theory grounds	**5**	The intervention was based on a clear understanding of the contextual factors that would affect the outcomes (i.e. characteristics of the health system, coverage, characteristics of the population, socioeconomic environment).	**160**	**154**
		4	The intervention included change management elements, identifying the necessary actions to remove legal, organizational, and financial or skill barriers.	**155**	
		6	There had been an explicit process of public consultation and stakeholders' engagement prior to the implementation of the intervention, with clear procedures to foster collaboration.	**150**	
		9	An economic evaluation comparing incremental cost-effectiveness of existing alternatives of intervention was carried out (or accounted for if already existed).	**149**	
16	Scalability and knowledge exchange	**60**	The Intervention potential for scalability was assessed in terms of prospective size of the population targeted, key factors, barriers and facilitators.	**155**	**154**
		61	There were systematic networking efforts (i.e. knowledge exchange and learning networks, strategies of communication and dissemination, tailored diagnosis of scaling up possibilities) to foster the exchange of information, mutual support and cooperation with other community resources.	**153**	
14		**54**	Evaluation results were relevant and linked to the stated goals and objectives.	**160**	**151**

	Relevance of assessment outcomes	**55**	Evaluation results were linked to actions to reshape the implementation accordingly.	**157**	
		56	Outcomes assessment enabled outcome-based contracts (few, clear, concise and readily communicated indicators).	**135**	
4	Target group	**14**	Instruments for patient needs' assessment were selected on the basis of an explicit review of the update evidence.	**153**	**149**
		16	The intervention was sensitive to cultural beliefs and socioeconomic characteristics of the individuals.	**153**	
		13	There was a detailed description of the estimated number and profile of the patients receiving the intervention.	**148**	
		15	Clear protocols were developed to identify the individual patient needs and to determine eligibility for service and referral to/from other agencies.	**147**	
		12	Target groups were risk-stratified using evidence-based sound methodology and taking into account different dimensions (quality of life, frailty, clinical susceptibility, functional autonomy, mental health).	**142**	
6	Strategies and methods of implementation	**28**	The intervention included a learning system to support reflective healthcare practice among professionals involved.	**154**	**149**
		26	There was an explicit human resources policy, with a definition of professional roles involved, criteria for professional recruitment and training plans (including a clear definition of qualifications and skills).	**152**	
		25	All the processes involved in the intervention were clearly defined and mapped, with explicit milestones that allow for an adequate monitoring of the intervention.	**152**	
		27	There was a defined strategy to align staff incentives and motivation with the intervention objectives.	**139**	

Experts' Comments during the first and second rounds with regard to relevance and priority

1. Experts' comments with regard to relevance:

- One of the issues gathered from those comments was the role of economic aspects of an intervention. In some experts' view there should be a "macro" approach to set the grounds that goes beyond the scope of any intervention. They seemed to suggest that such framing is a pre-condition for the relevance of assessing the economic aspects of any specific intervention:

  ["……if we can persuade Governments that the Cost of Health and Social Care is in fact an annual investment in the Economy of their country and will create economic activity and jobs, the Economy Department starts to invest alongside the Health department."]

Following the same argument, other participants supported an explicit analysis of return on investment (ROI), valuing long term-gains (patient outcomes and efficiency) and affordability as the key to sustainability of any practice:

[“…… economic evaluation is vital; ………….work being turned down because the ROI was not done. Much of today’s spend, especially public money means you must convince the finance department”]

- Another topic mentioned by the experts was the trade-off between how well tailored a practice is to the needs of its target population and its generalisability. Some participants expressed concern about putting too much weight in valuing a practice on the basis of its specificity which may erode its potential for scalability or adoption in other settings:

[“…depends on the nature of intervention. The more specific it is in terms of addressing a certain population’s needs; it may reduce the generalization to other populations.”]

2. Experts’ Comments related to priority

- Related to both transferability and feasibility pre-conditions, some experts highlight how organizational elements key to the success of a practice might be structural rather than features of the specific intervention subject to assessment:

[“…If the organization has certain aspects already in place, they do not need to be part of the integrated care approach but it is for all the health and care processes. If the organization does not have certain infrastructures in place, then they become necessary and therefore essential in the intervention. How to score those general necessary aspects? Fast response access, ICT infrastructure...”]

[“Much focus remains on the coordination of health services, the inclusion of social care needs to happen, but is a longer term goal in many regions”]

- In terms of the coordination aspect with social and community services, there was a general consensus about being a differential element of good practice:

> *[“The cooperation with social services is important, especially in order to provide seamless care (for instance, from hospital discharge to home care. Often social services work with vulnerable people and can direct them to certain health care facilities.”]*

However some experts resented with the idea to apply those criteria to interventions that they consider naturally exclusive of health care:

> *[“Depends on aims of intervention. May not be possible or necessary to integrate a healthcare intervention (such as a medicines review) with social care in some settings”]*

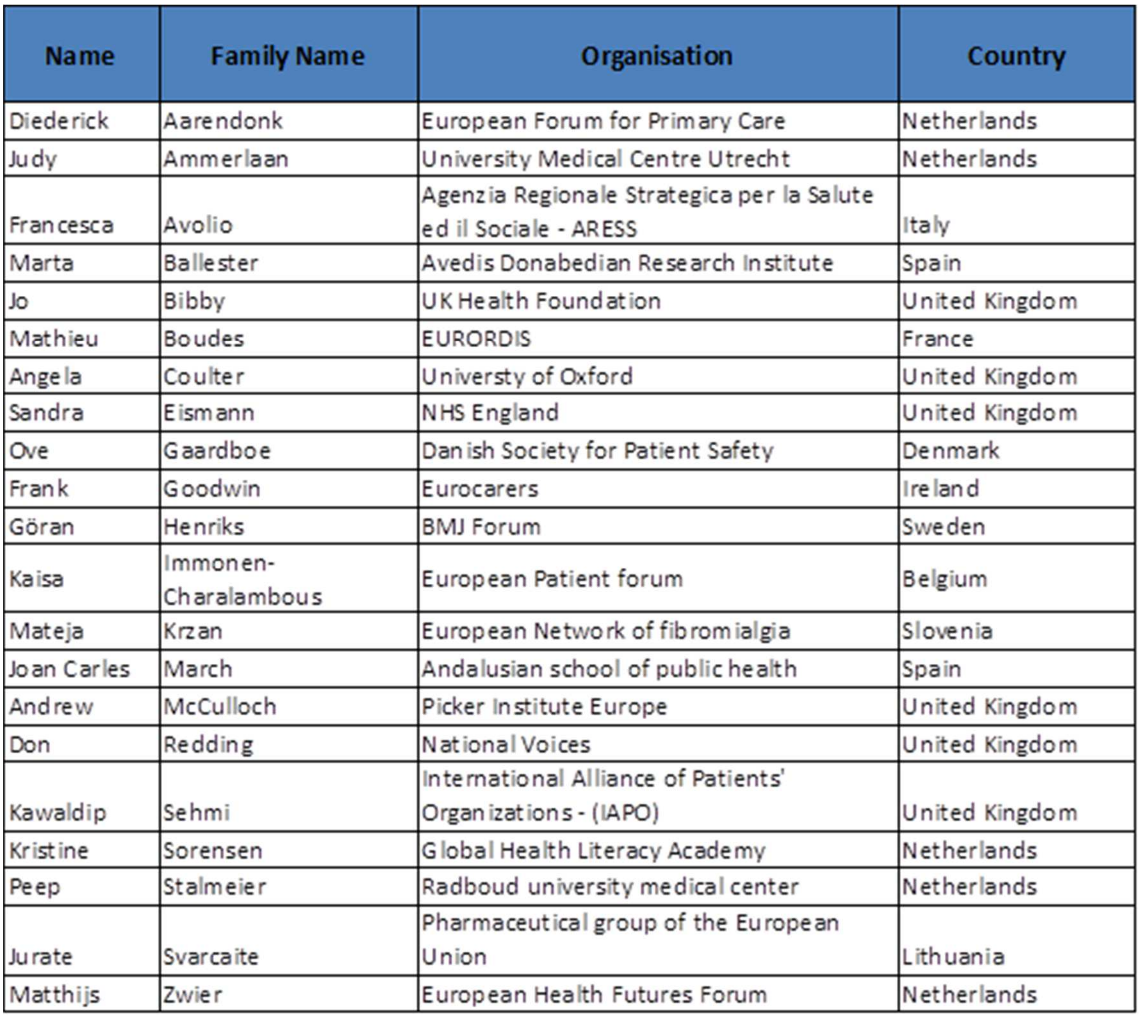
While some others emphasised the challenges of bridging across those, in their view, still separate “worlds”:

> *[…However, in many joint working approaches there is a strong medical focus, characterised by the use of medical terms and clinical information and communication systems. In addition, cooperation within a team of health and social care professionals can be undermined by professional stereotypes and different work philosophies…]*

All these comments and concerns, expressed during both rounds, were duly addressed and dealt with during discussions at the face-to-face meeting.

Annex 8. First and second rounds results tables for the Delphi-m in Patient’s empowerment Interventions with chronic conditions

List and affiliation of the expert panel involved in the Delphi-m



Name	Family Name	Organisation	Country
Diederick	Aarendonk	European Forum for Primary Care	Netherlands
Judy	Ammerlaan	University Medical Centre Utrecht	Netherlands
Francesca	Avolio	Agenzia Regionale Strategica per la Salute ed il Sociale - ARESS	Italy
Marta	Ballester	Avedis Donabedian Research Institute	Spain
Jo	Bibby	UK Health Foundation	United Kingdom
Mathieu	Boudes	EURORDIS	France
Angela	Coulter	Universty of Oxford	United Kingdom
Sandra	Eismann	NHS England	United Kingdom
Ove	Gaardboe	Danish Society for Patient Safety	Denmark
Frank	Goodwin	Eurocarers	Ireland
Göran	Henriks	BMJ Forum	Sweden
Kaisa	Immonen-Charalambous	European Patient forum	Belgium
Mateja	Krzan	European Network of fibromialgia	Slovenia
Joan Carles	March	Andalusian school of public health	Spain
Andrew	McCulloch	Picker Institute Europe	United Kingdom
Don	Redding	National Voices	United Kingdom
Kawaldip	Sehmi	International Alliance of Patients' Organizations - (IAPO)	United Kingdom
Kristine	Sorensen	Global Health Literacy Academy	Netherlands
Peep	Stalmeier	Radboud university medical center	Netherlands
Jurate	Svarcaite	Pharmaceutical group of the European Union	Lithuania
Matthijs	Zwier	European Health Futures Forum	Netherlands

First Round Tables (Online) – Relevance Assessment

Table 15. Relevant criteria and categories for interventions' assessment obtained from the first online round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution *		
						R (7-9)	NCR (4-6)	IR (1-3)
1	Defined intended effect	1	Key elements of the intervention embraced patient-centred care seeking self-management improvement as stated effect.	8	2	19	2	0
		2	Key elements of the intervention embraced patient-centred care seeking shared decision making as stated effect.	8	2	20	1	0
		4	The objectives showed alignment with patient preferences and values.	9	1	19	2	0
2	Theory grounds of intervention	6	The intervention was aligned with a comprehensive approach to patient's empowerment.	8	2	20	1	0
		8	The intervention was based on the patient's and/or carer's specific values, preferences, beliefs, needs, capacities, circumstances and wishes.	9	2	20	1	0
		11	The intervention considered health professionals' needs in terms of enhancing/acquiring the right skills, knowledge and attitudes to foster patient empowerment (i.e. Self-management, shared decision making, education-knowledge and value concordance).	8	1	20		1
4	Target group / population addressed	15	All actors intervening in the care chain (patients, carers, professionals….) were identified and considered in the intervention.	9	1	20	1	0
5	Intervention design	19	The intervention was designed and implemented in consultation with the target population (patients, carers and professionals).	9	1	21	0	0
		20	There was a clear description of the patients, carers and professionals' specific role and/or contribution at each point in the care chain.	8	1	20	1	0
		21	Organisational structures supporting patient empowerment were clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	8	2	20	1	0

		22	Patient and stakeholder participation/involvement was planned and programmed (activation, tracking systems, formal commitments, contracts or agreements regular mechanisms for communicating are established).	8	1	18	3	0
6	Leadership	25	There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined.	8	2	21	0	0
		26	The leader was a person of reference/"champion" for the involved stakeholders with experience, trajectory and connections to the relevant networks.	8	1	19	2	0
7	Multi-stakeholder involvement	27	The principal actors in each setting were involved in the planning and implementation of the project.	8	1	212	0	0
		28	All the actors intervening in the care chain to empower patients were identified/ considered (health authorities, health administration, health professionals, communities….) and their support was secured.	8	2	21	0	0
8	Adequacy, capacity and resources	30	ject leaders and all others involved in the project were adequately qualified to accomplish their tasks.	8	2	20	1	0
		31	The allocation of funding and resources were specified in regards to stability and commitment.	8	2	18	3	0
		32	The provision of resources covers all the elements of the intervention (addressed to patients, professionals and carers) and justifies sufficiency for the described tasks.	8	1	18	3	0
		33	Organisational structures were clearly defined and described (i.e responsibility assignments, flows of communication and work and accountabilities).	7	1	20	1	0
9	Information systems	34	The information generated by the intervention was systematically registered and integrated within the regular circuits of health care information in place (electronic health record, patient file, clinical notes…).	8	2	21	0	0
		35	The architecture of the information system allowed professionals and patients Personal Health Care Information access and management (including Health Care Record, patient file, and clinical notes, open health information, decision support for patients and professionals).	8	2	21	0	0
		36	The intervention included tools and social networks allowing communication among different stakeholders (patients and professionals).	8	2	16	5	0

10	Interaction with care delivery system	37	The intervention was inserted in the existing organization of care consistently over time.	8	1	17	4	0
		38	The intervention addressed the patient’s transition across different levels of care ensuring communication and cooperation between professionals, centres, programmes or services.	8	2	18	3	0
		39	The intervention sought linkage and coordination between community services and health care delivery systems to empower patients.	8	1	17	3	0
11	Ethical considerations	41	Rights on information access and right to refuse to be informed or treated were respected and enhanced.	8	2	21	0	0
		42	The intervention's objectives and strategy were transparent to patients /carers involved and professionals.	9	1	21	0	0
		43	Potential burdens, including harm of the intervention for patients were addressed.	9	1	21	0	0
12	Evaluation	45	There was a validated method and/or tools for regular evaluation in place for assessing the progress and/or impact of the implemented intervention on patient/user empowerment.	8	2	20	1	0
		46	Information /monitoring systems were in place to regularly deliver data aligned with evaluation and reporting needs.	8	1	19	2	0
		47	The evaluation framework included assessment of all relevant outcomes: quality of life, costs, service/system utilization, self-management, patient’s experience, professional satisfaction, shared-decision making and education/knowledge.	8	1	18	3	0
		48	The evaluation results were relevant and linked to the stated goals and objectives.	8	1	21	0	0
		49	The results of evaluation were linked to actions to reshape the implementation accordingly.	9	2	21	0	0
13	Sustainability	50	The continuation of the project was ensured through ownership and/or institutional anchoring.	8	1	20	1	0
		51	The intervention promoted alliances, collaborative frameworks with other stakeholders.	8	2	18	3	0

14	Scalability	54	There was an analysis of requirements for potential scalability such as patient characteristics, (i.e. stage of disease/dependence of patients and, other characteristics of importance for the elements of patient empowerment i.e education-knowledge, shared decision-making and self-management).	8	1	18	3	0
		55	There was an analysis of requirements for potential scalability such as patient's support i.e. community resources, patient networks.	8	2	19	2	0
		56	There were specific knowledge transfer strategies in place (evidence into practice).	8	2	17	4	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 16. No consensus criteria and categories for interventions' assessment obtained in the first round

Criterion- ID	Criterion	Category-ID	Categories	Median	IQR	Vote distribution*		
						R	NCR	IR

						(7-9)	(4-6)	(1-3)
1	Defined intended effect	3	Key elements of the intervention embraced patient-centred care seeking education-knowledge as stated effect.	8	2	19	1	1
		5	The objectives showed alignment with adopted guidelines, programmes and policies, and a relevant scope for expansion.	7	2	15	6	0
2	Theory grounds of intervention	7	The practice follows a strategic framework, seeking to develop a systemic vision of the implications of empowering patients for the organization.	7	1	17	3	0
		9	The intervention was tailored to the health system organizational characteristics and socioeconomic environment.	7	1	16	4	0
		10	There was a baseline assessment of the situation (including team and other stakeholders' readiness to engage) used to better shape the intervention according to the established ‘departing point’.	7	1	18	1	2
		12	A comparison to existing alternatives of intervention was carried out including impact on different dimensions of patient empowerment (i.e. Self-management, shared decision making, education-knowledge and value concordance).	7	2	14	7	0
		13	A comparison to existing alternatives of intervention was carried out including impact in terms of health care utilization (e.g. visits, hospitalizations, treatments, tests...).	7	1	14	6	1
3	Aims and objectives	14	The concept included a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed).	7	2	15	5	1
4	Target group / population addressed	16	The needs of the intervention’s target group/s in the setting were adequately identified and considered (a comprehensive assessment of patients/users/professionals specificities has been carried out).	8	2	19	1	1
		17	Methods used for selection of target population/were described, documented and suitable to their characteristics	7	2	14	6	1

5	Intervention design	18	The design thoroughly described the methodology of intervention: recruitment, location, concrete activities and timeframe (sequence, frequency, duration).	7	1	18	2	1
		23	Community engagement was planned and organised to include relevant stakeholders from the local civil society (i.e main town halls, NGOs, business, individuals….).	7	2	15	6	0
6	Leadership	24	The institutional leadership was aligned with the scope of the implementation.	8	1	19	0	2
7	Multi-stakeholder involvement	29	Social support (in terms of gaining the support of stakeholders outside the health system) is arranged.	7	2	15	6	0
11	Ethical considerations	40	Conflict of interests among stakeholders and individuals involved were analysed.	7	2	14	7	0
12	Evaluation	44	luation process involved the engagement of stakeholders, including those participating in program operation, those served or affected by the program; and primary key users/participants.	8	2	19	1	1
13	Sustainability	52	The financial viability of the intervention was guaranteed in the long term.	7	2	15	6	0
14	Scalability	53	There was an analysis of requirements for potential scalability such as adaptability and perceived challenges for healthcare organization/governance (trialability, stepwise introduction, technology support requirements…).	7	2	16	5	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Second Round Tables (Online) – Relevance Assessment and Prioritization

Table 17. Criterion and category (no reached agreement in the first round) assessed as relevant in the second round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution*		
						R (7-9)	NCR (4-6)	IR (1-3)
12	Evaluation	44	The evaluation process involved the engagement of stakeholders, including those participating in program operation, those served or affected by the program; and primary key users/participants.	8	1	19	1	0

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 18. Criteria and category (no reached agreement in the first round) discarded in the second round

Criterion- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution		
						R (7-9)	NCR (4-6)	IR (1-3)
1	Defined intended effect	3	Key elements of the intervention embraced patient-centred care seeking education-knowledge as stated effect.	7	1	11	9	0
		5	The objectives showed alignment with adopted guidelines, programmes and policies, and a relevant scope for expansion.	6	2	6	12	2
2	Theory grounds of intervention	7	The practice follows a strategic framework, seeking to develop a systemic vision of the implications of empowering patients for the organization.	7	2	15	4	1
		9	The intervention was tailored to the health system organizational characteristics and socioeconomic environment.	6,5	10	10	0	0
		10	There was a baseline assessment of the situation (including team and other stakeholders' readiness to	7	2	12	7	1

			engage) used to better shape the intervention according to the established 'departing point'.					
		12	A comparison to existing alternatives of intervention was carried out including impact on different dimensions of patient empowerment (i.e. Self-management, shared decision making, education-knowledge and value concordance).	6	1	8	10	2
		13	A comparison to existing alternatives of intervention was carried out including impact in terms of health care utilization (e.g. visits, hospitalizations, treatments, tests...).	6	2	9	9	2
3	Aims and objectives	14	The concept included a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed).	7	2	14	5	0
4	Target group / population addressed	16	The needs of the intervention's target group/s in the setting were adequately identified and considered (a comprehensive assessment of patients/users/professionals specificities has been carried out).	7	2	12	8	0
		17	Methods used for selection of target population/were described, documented and suitable to their characteristics	7	2	12	7	1
5	Intervention design	18	The design thoroughly described the methodology of intervention: recruitment, location, concrete activities and timeframe (sequence, frequency, duration).	7	2	14	6	0
		23	Community engagement was planned and organised to include relevant stakeholders from the local civil society (i.e main town halls, NGOs, business, individuals….).	6	1	8	12	0
6	Leadership	24	The institutional leadership was aligned with the scope of the implementation.	7	1	13	6	1
7	Multi-stakeholder involvement	29	Social support (in terms of gaining the support of stakeholders outside the health system) is arranged.	7	1	12	6	1
11	Ethical considerations	40	Conflict of interests among stakeholders and individuals involved were analysed.	6	2	7	11	1
13	Sustainability	52	The financial viability of the intervention was guaranteed in the long term.	7	1	11	9	0

14	Scalability	53	There was an analysis of requirements for potential scalability such as adaptability and perceived challenges for healthcare organization/governance (trialability, stepwise introduction, technology support requirements…).	6	2	6	13	1

Vote distribution*:

R- Relevant
NCR-No clearly relevant
IR-Irrelevant

Table 19. Relevant criteria and categories for intervention's assessment ordered by their average priority scores obtained from the second round

Note: Categories coloured in blue corresponds to *no consensus category* obtained in round one and subsequently selected as relevant in the second round, and categories coloured in green correspond to the category assigned *low priority* in the second round ranked by priority weight.

Criterion-ID	Criterion	Category-ID	Category	Priority weight	
1	Defined intended effect	**1**	Key elements of the intervention embraced patient-centred care seeking self-management improvement as stated effect.	156	160
		2	Key elements of the intervention embraced patient-centred care seeking shared decision making as stated effect.	158	
		4	The objectives showed alignment with patient preferences and values.	166	
2	Theory grounds of intervention	6	The intervention was aligned with a comprehensive approach to patient's empowerment.	155	157
		8	The intervention was based on the patient's and/or carer's specific values, preferences, beliefs, needs, capacities, circumstances and wishes.	162	
		11	The intervention considered health professionals' needs in terms of enhancing/acquiring the right skills, knowledge and attitudes to foster patient empowerment (i.e. Self-management, shared decision making, education-knowledge and value concordance).	155	

4	Target group / population addressed	15	All actors intervening in the care chain (patients, carers, professionals….) were identified and considered in the intervention.	149	149
5	Intervention design	19	The intervention was designed and implemented in consultation with the target population (patients, carers and professionals).	160	154
		20	There was a clear description of the patients, carers and professionals' specific role and/or contribution at each point in the care chain.	155	
		21	Organisational structures supporting patient empowerment were clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	150	
		22	Patient and stakeholder participation/involvement was planned and programmed (activation, tracking systems, formal commitments, contracts or agreements regular mechanisms for communicating are established).	151	

Criterion -ID	**Criterion**	**Category-ID**	**Category**	**Priority weight**	
6	Leadership	25	There was a clear leadership commitment, and the responsibilities of the different partners and the relationships among them were well defined.	156	155
		26	The leader was a person of reference/"champion" for the involved stakeholders with experience, trajectory and connections to the relevant networks.	153	
7	Multi-stakeholder involvement	27	The principal actors in each setting were involved in the planning and implementation of the project.	160	157
		28	All the actors intervening in the care chain to empower patients were identified/ considered (health authorities, health administration, health professionals, communities….) and their support was secured.	154	
8	Adequacy, capacity and resources	30	The project leaders and all others involved in the project were adequately qualified to accomplish their tasks.	157	152
		31	The allocation of funding and resources were specified in regards to stability and commitment.	151	
		32	The provision of resources covers all the elements of the intervention (addressed to patients, professionals and carers) and justifies sufficiency for the described tasks.	153	
		33	Organisational structures were clearly defined and described (i.e responsibility assignments, flows of communication and work and accountabilities).	148	

9	Information systems	34	The information generated by the intervention was systematically registered and integrated within the regular circuits of health care information in place (electronic health record, patient file, clinical notes…).	152	144
		35	The architecture of the information system allowed professionals and patients Personal Health Care Information access and management (including Health Care Record, patient file, and clinical notes, open health information, decision support for patients and professionals).	148	
		36	The intervention included tools and social networks allowing communication among different stakeholders (patients and professionals).	133	

Criterion -ID	Criterion	Category-ID	Category	Priority weight	
10	Interaction with care delivery system	37	The intervention was inserted in the existing organization of care consistently over time.	146	154
		38	The intervention addressed the patient's transition across different levels of care ensuring communication and cooperation between professionals, centres, programmes or services.	162	
		39	The intervention sought linkage and coordination between community services and health care delivery system to empower patients.	154	
11	Ethical considerations	41	Rights on information access and right to refuse to be informed or treated were respected and enhanced.	164	163
		42	The intervention's objectives and strategy were transparent to patients /carers involved and professionals.	163	
		43	Potential burdens, including harm of the intervention for patients were addressed.	163	
12	Evaluation	44	The evaluation process involved the engagement of stakeholders, including those participating in program operation, those served or affected by the program; and primary key users/participants.	143	154
		45	There was a validated method and/or tools for regular evaluation in place for assessing the progress and/or impact of the implemented intervention on patient/user empowerment.	152	
		46	Information /monitoring systems were in place to regularly deliver data aligned with evaluation and reporting needs.	153	

		47	The evaluation framework included assessment of all relevant outcomes: quality of life, costs, service/system utilization, self-management, patient's experience, professional satisfaction, shared-decision making and education/knowledge.	153	
		48	The evaluation results were relevant and linked to the stated goals and objectives.	158	
		49	The results of evaluation were linked to actions to reshape the implementation accordingly.	162	

Criterion -ID	Criterion	Category -ID	Category	Priority weight	
13	Sustainability	50	The continuation of the project was ensured through ownership and/or institutional anchoring.	148	149
		51	The intervention promoted alliances, collaborative framework with other stakeholders.	150	
14	Scalability	54	There was an analysis of requirements for potential scalability such as patient characteristics, (i.e. stage of disease/dependence of patients and, other characteristics of importance for the elements of patient empowerment i.e education-knowledge, shared decision-making and self-management).	142	141
		55	There was an analysis of requirements for potential scalability such as patient's support i.e. community resources, patient networks.	144	
		56	There were specific knowledge transfer strategies in place (evidence into practice).	136	

Experts' Comments during the first and second rounds with regard to relevance and priority

1. Experts' Comments related to relevance.

- Experts commented on the importance of having a strategy framework to empower patients within the organizations. However, there expressed concerns about the risk of losing patient's focus in favour of the organization's objectives and results:

  [“I agree with a framework strategy, but I disagree with the development of a systemic vision. The most important reason is that you will easily lose focus on individual patients and shift towards result on an organizational level”]

- Education and knowledge, though it is well supported if centred on patient's needs, they questioned its impact on empowerment:

  [“…education-knowledge should be based on what a patient wants to know. Just testing the education-knowledge could give a positive result, but doesn't necessarily mean that it has an effect on empowerment!”]

- Regarding comments about the concept of leadership within an organization, some experts voiced concern about valuing too much leadership in a practice. The expressed argument was that others “champions” from the organization can have more effective influence in the outcome of the intervention versus leadership.

  [“…leaders only contribute marginally to effective implementation”]

  [“The leader would necessarily have to be a champion, would not it? What is important is that there are other champions in the network that will have an influence on the outcome.”]

2. Experts' Comments related to priority

- Again, the difficulties and lack of interaction among different levels of care was stressed by some experts.

  [“The linkage between health and social are vital. There is a deficiency in practice with separate departments, budgets, etc.”]

However, enhancing the information systems would foster the communication across services was seem as one, among others, of the possible areas that could facilitate this separation

[“… seems to be obligatory… information flows are undoubtedly vitally important.”]

- Some expert also revealed the difficulty of evaluating interventions to empower patients throughout usual measurement systems:

> *[“Difficult to measure empowerment through the traditional way, putting a number is unrealistic”]*

Along these comments, they also mentioned the importance of clearness and succinctness information to be collected to facilitate its obtention

> *[“…whenever talking about information collection, it needs to be carefully designed so that the information collected is only what is meaningful and important to evaluate the project, and does not represent an excessive burden on the people who have to record it.”]*

Also stakeholders involved in the intervention, especially patients, should also be engaged in any evaluation process:

> *[“… of course users/patients have to be involved in the evaluation.”*]

Along the same lines other participant supported the idea of adding patients’ perspective to the intervention evaluation

> *[“…it is also important that "self-management improvement" and "shared decision-making" are evaluated according to patients' perspective (what matters for the patient) over and above what matters for the healthcare system or professionals. This selection of what matters most is what will make the outcome patient centred in a meaningful way”].*

And the main outcomes should be also put on patients’ experiences and needs:

> *[“…main focus should be on the health care providers and patients, their experiences and patient outcomes”]*

- Related to sustainability and despite is not always seen as priority, some experts emphasized that should be taken into account when the intervention is designed:

> *[“Sustainability is a phase that is not always in the centre of our attention. I think it should be, to embed the intervention”]*

Others argued that it is not always possible to foresee sustainability of a practice and

that some of them could not be affordable in the present but may result in cost reduction in the long term.

> *[“Ideally there should be an idea of sustainability, but it has to be recognised that this is not always feasible or at least it cannot be foreseen in advance”.]*

> *[“…of course financial viability is crucial, but by improving quality of care and experience of care, reduction of costs is imminent. The thing is that an intervention*

> *could be part of an investment in health. In other words it could be part of reducing costs in the long term whilst be financially unviable at present times"]*

All these concerns were addressed and dealt with during discussions at the face-to-face meeting.

Annex 9. First and second rounds results tables for the Delphi-m in Diabetes

List and affiliation of the expert panel involved in the Delphi-m

Name	Family Name	Organisation	Country
Cristian	Andriciuc	European Patients Forum	Romania
Andreas	Birkenfeld	Technical University of Dresden	Germany
Alain	Brunot	Ministry of Health	France
Xavier	Cos Claramunt	Instituto de Salud Carlos III	Spain
Agnieszka	Daval-Cichon	European Health Futures Forum	Belgium
Roberto	D'Elia	Ministry of Health	Italy
Ingvild	Felling Meyer	The Norwegian Directorate of Health	Norway
Anne-Marie	Felton	Foundation of European Nurses in Diabetes	United Kingdom
Filippo	Graziani	European Patients Forum	Belgium
Eva-Maria	Kernstock	Gesundheit Österreich GmbH	Austria
Jana	Klavs	National Association of Nurses in Endocrinology	Slovenia
Silke	Kuske	Heinrich-Heine-Universität Düsseldorf	Germany
Tiina	Laatikainen	National Institute for Health and Welfare	Finland
Marie Laure	Le Pommelec	Diabetes Patients Association	France
Jaana	Lindström	National Institute for Health and Welfare	Finland
Peggy	Maguire	European Institute of Women Health	Ireland
Konstantinos	Makrilakis	University of Athens	Greece
Joao	Malva	University of Coimbra	Portugal
Eduard	Montanya Mias	Instituto de Salud Carlos III	Spain
Stefano	Nervo	Diabetes Forum	Italy
Alberto	Piaggesi	European Wound Management Association	Italy
Milivoj	Pileti_	National Institute of Public Health	Slovenia
Andrea	Pizzini	General Practicioner	Italy
Jan	Schulze	Technical University of Dresden	Germany
Lurdes	Serrabulho	Associação Protectora dos Diabéticos de Portugal	Portugal
Monica	Sørensen	The Norwegian Directorate of Health	Norway
Manuel	Teixeira Veríssimo	Portuguese Society of Internal Medicine	Portugal
Dimitri	Varsamis	NHS England	United Kingdom

First Round Tables (Online) – Priority Assessment

Table 21. High priority categories for interventions' assessment obtained from first online round

Criteri on- ID	Criterion	Category -ID	Categories	Median	IQR	Vote distribution *		
						HP (7-9)	MP (4-6)	LP (1-3)
1	Comprehensiveness of the intervention	1	A comprehensive assessment of relevant interventions was carried out (or accounted for if it already existed) (i.e. efficacy, cost-effectiveness, quality, safety, etc.)	8	1	23	5	0
		3	The intervention has a comprehensive approach to diabetes addressing relevant contextual indicators (i.e. prevalence of diabetes in the population, percentage of the population physically inactive, prevalence of overweight, obesity and abdominal obesity in population, prevalence of population following national recommendations on nutrition, etc.).	8	1	25	3	0
2	Care intervention design	7	The design is appropriate and builds upon relevant data, theory, context, evidence, previous practice including pilot studies.	9	1	27	1	0
		8	The design thoroughly describes the practice in terms of purpose, SMART objectives, methods (e.g., recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration).	8	1	25	3	0
		9	There were a clear inclusion and exclusion criteria regarding program participation, including an estimated number and profile of the patients targeted by the intervention.	8	1	22	4	1
		10	In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).	8	1	25	3	0
		13	Follow up of mutually agreed care plans was specifically addressed in the design of the intervention.	8	1	24	4	0
		14	Problems related to poly-pharmacy were taken into account.	8	1	25	5	1
		15	Clinical pathways are defined for the intervention.	8	1	24	4	0
		16	Structure and content of the intervention has been defined and established at individual level including specific targets and a follow-up plan.	8	1	23	4	1

		18	A theoretical basis of the program exists and includes a description of the method, description of activities within a chain of causation and time frame, and a description of interactions between key stakeholders and processes.	7,5	1	25	2	1
		19	The following elements of the program are described and theoretically justified in terms of frequency, intensity, duration, selection and recruitment method, location (setting).	8	1	22	6	0
		22	The intervention includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.	8	0	25	2	1
3	Ethical considerations	23	The intervention is implemented equitably (i.e. proportional to needs).	8	1	24	3	1
		24	The intervention's objectives and strategy are transparent to the target population and stakeholders involved.	8	1	25	3	0
		25	Potential burdens of the intervention (i.e. psychosocial, affordability, accessibility, etc.) are addressed and the benefit -burden balance are fairly balanced.	8	1	25	3	0
		26	Patients' and/or carers' rights to be informed, to decide about their care, participation and issues regarding confidentiality, were respected and enhanced.	9	1	27	1	0
4	Governance and project management	27	There was a defined strategy to align staff incentives and motivation with the intervention objectives.	8	1	22	3	3
		28	The intervention included organizational elements, identifying the necessary actions to remove legal, managerial, and financial or skill barriers.	8	1	24	2	2
		29	The intervention integrated different information and communication technologies (e.g. accessible channels of communication, dedicated software etc.)	7	1	22	3	0
		30	Information technology systems supporting the implementation of screening are available to health care provider level.	8	1	26	1	1
		32	There was a defined policy to ensure acceptability of information technologies among users (professionals and patients), to enable their involvement in the process of change.	8	1	23	3	2
		33	The best available evidence (guidelines, protocols, etc.) was easily available for health professionals.	8	1	25	3	0

		35	Multidisciplinary approach for interventions is supported by the health care provider.	8,5	1	26	1	1
		36	Medical record system supports the intervention.	8	1	26	1	1
		39	There was a clear description of the patients, carers and professionals’ specific role and their contribution was appropriately planned, supported and resourced.	8	1	26	1	1
		40	There was an efficient leadership and clear commitment to the intervention from the participating organizations.	8	1	27	1	
5	Interaction with care delivery system	42	The intervention was integrated or fully interacting with the regular care delivery system.	8	1	24	4	0
		43	In health promotion interventions for diabetes, health care providers collaborate with other stakeholders.	9	1	26	1	0
		44	The intervention creates ownership among the target group and several stakeholders considering multidisciplinary, multi-/inter-sectorial, partnerships and alliances, if appropriate.	8	1	24	4	0
		45	The intervention considers creating effective linkages with all relevant parts of the health and care system.	8	1	25	3	0
		46	The intervention enhances and supports the patients and/or carers' ability to effectively interact with the health and care system.	8	1	27	1	0
6	Education and training	47	Prevention strategies, adapted to different levels of risk, are included in the education of the health care professionals.	9	1	27	1	0
		49	Trainers/educators are adequately qualified in terms of knowledge, techniques and approaches they use.	9	1	28		0
		50	An education program is in place to empower patients with diabetes to strengthen their health literacy, self-management, health promotion and prevention of diabetes complications, stress management…).	9	1	26	2	0
7	Patient empowerment	51	The intervention achieves meaningful participation of the target population (during design and implementation) developing its strengths, resources and autonomy (e.g. assets-based and/or salutogenic approach).	8	1	27	1	0
		52	The intervention actively promotes patient empowerment by using appropriate mechanisms (e.g.	9	1	28	0	0

			self-management support, shared decision making, education-information or value clarification).					
		53	The intervention considered all stakeholders' * needs in terms of enhancing/acquiring the right skills, knowledge and behaviour to promote patient empowerment (*patients, carers, health and care professionals, policy makers, etc.).	8	1	24	4	0
		54	Organizational structures supporting patients' empowerment were clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	8	1	26	2	0
		56	The professionals involved are trained and competent to support individual's self-management (e.g. through professional development programs to promote patient empowerment).	8	1	27	1	0
8	Evaluation	58	Evaluation took into account social and economic aspects from both patient and formal and informal caregiver's perspectives.	8	1	23	4	1
		59	Evaluation outcomes were linked to the stated goals and objectives.	9	1	28	0	0
		60	Evaluation outcomes were shared among stakeholders and linked to actions to foster continuous learning and improvement.	8,5	28	0	0	0
		61	Outcomes assessment enabled performance-based contracts.	8	1	25	5	1
		62	There is a defined and appropriate evaluation framework assessing structure, process and outcomes considering, e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome).	8	1	25	2	1
		63	There is a defined monitoring process to assess the outcomes of the interventions (i.e. proportion of high-risk individuals achieving clinically significant changes in risk factors at 1 year follow-up, proportion of planned intervention visits completed over 1 year, proportion of persons with diabetes with parameters under/above a defined target; mortality rate from cardiovascular event, quality of life, etc.)	9	1	27	0	1

9	Sustainability	64	The sustainability strategy considered a range of contextual factors (e.g. health and social policies, innovation, cultural trends and general economy).	8	1	22	5	0
		65	There is broad support for the intervention amongst those who implement it.	8	1	27	1	0
		67	The continuation of the project has been ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities.	8	0	27	1	0
10	Scalability and transferability	69	Potential impact on the population targeted (if scaled up) is assessed.	8	1	22	6	0

Vote distribution*:

HP- High priority
MP-Medium priority
LP-Low priority

Table 22. Discarded categories for interventions' assessment obtained in the first online round

Criterion- ID	**Criterion**	**Category -ID**	**Categories**	**Median**	**IQR**	**Vote distribution ***		
						HP (7-9)	**MP (4-6)**	**LP (1-3)**
1	Comprehensiveness of the intervention	2	The intervention is aligned with a policy plan implemented at the institutional, local, national and international level.	7,5	2	21	6	1
		4	Risk-profiling protocol to identify levels of risk has been evaluated at national level (risk-stratification).	7,5	2	21	6	1
		6	The intervention placed a specific role/function for caregivers, involving them in care support infrastructure for patients when appropriate, and the patient agrees.	7,5	2	20	7	1
2		11	Target population is defined on the basis of needs assessment including strengths and other characteristics (e.g. motivation, readiness for change, awareness, interpersonal relationships and support, cultural/spiritual/religious and community involvement, etc.).	7	2	21	5	2
		17	The coverage of the program is explicitly declared (e.g. local, regional or national level).	8	2	19	8	1

	Care intervention design	20	There is a detailed description of care setting (location: in/out-patient, health care provider) or social environment (e.g. through group sessions).	7	2	19	5	4
4	Governance and project management	37	There is a clear description of the health care organizations (i.e. governmental body, insurer, primary care organizations, hospitals, etc.) and/or relevant stakeholders (i.e. patient's associations, diabetes specialized care associations, NGOs, etc.) who planned and initiated the intervention.	7	3	18	8	2
7	Patient empowerment and participation	55	Leadership of the intervention is effective in exhibiting commitment to patients' empowerment and is both credible and effective.	8	2	21	4	3

Vote distribution*:

HP- High priority
MP-Medium priority
LP-Low priority

Table 23. Categories that did not reach agreement in the first online round

	Criterion		**Categories**	**Median**	**IQR**	**Vote distribution ***		

Criterion- ID		Category -ID				HP (7-9)	MP (4-6)	LP (1-3)
1	Comprehensiveness of the intervention	5	Validated risk assessment tools are available during the intervention to stratify patients by their individual risk profile.	8	2	24	4	0
2	Care intervention design	12	The intervention was designed to foster discussion and agreement with patients about their care plans (including goal-setting).	8	2	23	5	0
		21	All relevant stakeholders (patients, carers, professionals, community groups, statutory bodies, etc.) were considered and key stakeholders identified.	8	2	26	2	0
4	Governance and project management	31	nformation generated by the intervention was systematically recorded and is accessible to professionals and patients, and where appropriate embedded in existing information systems.	8	2	26	2	0
		34	Organizational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	8	2	26	1	1
		38	Training needs of the health professionals are assessed and taken into account in the development of the program/intervention.	8	2	27	1	0
		41	All team members involved had appropriate capacities, experience, training and support to accomplish their tasks.	8	2	23	4	1
6	Education and training	48	Educational and training programs are evidence-based and fully described in terms of content and format, considering individual needs and learning styles (e.g. description of didactical principles, scheduling and number of sessions, etc.)	9	2	26	2	0
8	Evaluation	57	There was a baseline multidisciplinary assessment for all the relevant outcomes and processes.	8	2	24	3	1
9	Sustainability	66	There is broad support for the intervention amongst the intended target populations.	8	2	26	2	0
		68	Human and financial resources for the long term future of the project have been identified and action has been taken to secure them.	8	2	26	2	0
10	Scalability and transferability	70	There is a specific knowledge transfer strategy in place (evidence into practice).	8	2	24	4	0
		71	There is an analysis of requirements for potential scalability and transferability.	8	2	26	2	0

Vote distribution*:

HP- High priority
MP-Medium priority
LP-Low priority

Second Round (Online) – Priority Assessment

Table 24. Criteria and categories (no reached agreement in the first round) assessed as high priority in the second online round

Criterion- ID	**Criterion**	**Category-ID**	**Categories**	**Median**	**IQR**	**Vote distribution ***		
						HP (7-9)	**MP (4-6)**	**LP (1-3)**
5	Comprehensiveness of the intervention	5	Validated risk assessment tools are available during the intervention to stratify patients by their individual risk profile.	8	1	26	0	0
12	Care intervention design	12	The intervention was designed to foster discussion and agreement with patients about their care plans (including goal-setting).	8	1	26	0	0

Vote distribution*:
HP- High priority
MP-Medium priority
LP-Low priority

Table 25. Criteria and categories (no reached agreement in the first round) discarded in the second online round

Criterion- ID	**Criterion**	**Category-ID**	**Categories**	**Median**	**IQR**	**Vote distribution ***		
						HP	**MP**	**LP**

						(7-9)	(4-6)	(1-3)
2	Care intervention design	21	All relevant stakeholders (patients, carers, professionals, community groups, statutory bodies, etc.) were considered and key stakeholders identified.	8	0	23	3	0
4	Governance and project management	31	The information generated by the intervention was systematically recorded and is accessible to professionals and patients, and where appropriate embedded in existing information systems.	8	1	24	2	0
		34	Organizational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	8	1	22	4	0
		38	Training needs of the health professionals are assessed and taken into account in the development of the program/intervention.	8	1	25	1	0
		41	All team members involved had appropriate capacities, experience, training and support to accomplish their tasks.	8	1	23	3	0
6	Education and training	48	Educational and training programs are evidence-based and fully described in terms of content and format, considering individual needs and learning styles (e.g. description of didactical principles, scheduling and number of sessions, etc.)	8	2	24	2	0
8	Evaluation	57	There was a baseline multidisciplinary assessment for all the relevant outcomes and processes.	8		24	2	0
9	Sustainability	66	There is broad support for the intervention amongst the intended target populations.	8	2	24	2	0
		68	Human and financial resources for the long term future of the project have been identified and action has been taken to secure them.	8	1	21	5	0
10	Scalability and transferability	70	There is a specific knowledge transfer strategy in place (evidence into practice).	8	2	23	3	0
		71	There is an analysis of requirements for potential scalability and transferability.	8	1	23	3	0

Vote distribution*:

HP- High priority
MP-Medium priority
LP-Low priority

Table 26: Priority criteria and categories for intervention’s assessment ordered by their average priority weight scores obtained from the second round.

Note: Category coloured in blue corresponds to no consensus categories obtained in round one and subsequently selected as priority in the second round ranked.

Criterion-ID	**Criterion**	**Category-ID**	**Criterion**	**Priority weight**	
6	Education and training	**47**	Prevention strategies, adapted to different levels of risk, are included in the education of the health care professionals.	238	237
		49	Trainers/educators are adequately qualified in terms of knowledge, techniques and approaches they use.	241	
		50	An education program is in place to empower patients with diabetes to strengthen their health literacy, self-management, health promotion and prevention of diabetes complications, stress management…).	232	
7	Patient empowerment and participation	51	The intervention achieves meaningful participation of the target population (during design and implementation) developing its strengths, resources and autonomy (e.g. assets-based and/or salutogenic approach).	234	227
		52	The intervention actively promotes patient empowerment by using appropriate mechanisms (e.g. self-management support, shared decision making, education-information or value clarification).	243	
		53	The intervention considered all stakeholders’ * needs in terms of enhancing/acquiring the right skills, knowledge and behaviour to promote patient empowerment (*patients, carers, health and care professionals, policy makers, etc.).	211	
		54	Organizational structures supporting patients' empowerment were clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	215	
		56	The professionals involved are trained and competent to support individual’s self-management (e.g. through professional development programs to promote patient empowerment).	231	
3	Ethical considerations	23	The intervention is implemented equitably (i.e. proportional to needs).	215	224

		24	The intervention's objectives and strategy are transparent to the target population and stakeholders involved.	226	
		25	Potential burdens of the intervention (i.e. psychosocial, affordability, accessibility, etc.) are addressed and the benefit - burden balance is fairly balanced.	218	
		26	Patients' and/or carers' rights to be informed, to decide about their care, participation and issues regarding confidentiality, were respected and enhanced	236	
8	Evaluation	58	Evaluation took into account social and economic aspects from both patient and formal and informal caregiver's perspectives.	206	223
		59	Evaluation outcomes were linked to the stated goals and objectives.	241	
		60	Evaluation outcomes were shared among stakeholders and linked to actions to foster continuous learning and improvement.	237	
		61	Outcomes assessment enabled performance-based contracts.	200	
		62	There is a defined and appropriate evaluation framework assessing structure, process and outcomes considering, e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome).	220	
		63	There is a defined monitoring process to assess the outcomes of the interventions (i.e. proportion of high-risk individuals achieving clinically significant changes in risk factors at 1 year follow-up, proportion of planned intervention visits completed over 1 year, proportion of persons with diabetes with parameters under/above a defined target; mortality rate from cardiovascular event, quality of life, etc.).	234	
5	Interaction with the health and care delivery system	42	The intervention was integrated or fully interacting with the regular care delivery system.	216	219
		43	In health promotion interventions for diabetes, health care providers collaborate with other stakeholders.	229	
		44	The intervention creates ownership among the target group and several stakeholders considering multidisciplinary, multi-/inter-sectorial, partnerships and alliances, if appropriate.	210	
		45	The intervention considers creating effective linkages with all relevant parts of the health and care system.	217	

		46	The intervention enhances and supports the patients and/or carers' ability to effectively interact with the health and care system.	221	
9	Sustainability	64	The sustainability strategy considered a range of contextual factors (e.g. health and social policies, innovation, cultural trends and general economy).	204	219
		65	There is broad support for the intervention amongst those who implement it.	231	
		67	The continuation of the project has been ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities.	223	
2	Care intervention design	7	The design is appropriate and builds upon relevant data, theory, context, evidence, previous practice including pilot studies.	234	214
		8	The design thoroughly describes the practice in terms of purpose, SMART objectives, methods (e.g., recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration).	225	
		9	There were a clear inclusion and exclusion criteria regarding program participation, including an estimated number and profile of the patients targeted by the intervention.	202	
		10	In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).	220	
		12	The intervention was designed to foster discussion and agreement with patients about their care plans (including goal-setting).	211	
		13	Follow up of mutually agreed care plans was specifically addressed in the design of the intervention.	213	
		14	Problems related to poly-pharmacy were taken into account.	209	
		15	Clinical pathways are defined for the intervention.	213	
		16	Structure and content of the intervention has been defined and established at individual level including specific targets and a follow-up plan.	205	
		18	A theoretical basis of the program exists and includes a description of the method, description of activities within a chain of causation and time frame, and a description of interactions between key stakeholders and processes.	209	

		19	The following elements of the program are described and theoretically justified in terms of frequency, intensity, duration, selection and recruitment method, location (setting).	208	
		22	The intervention includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.	217	
4	Governance and project management	27	There was a defined strategy to align staff incentives and motivation with the intervention objectives.	195	214
		28	The intervention included organizational elements, identifying the necessary actions to remove legal, managerial, and financial or skill barriers.	208	
		29	The intervention integrated different information and communication technologies (e.g. accessible channels of communication, dedicated software etc).	190	
		30	Information technology systems supporting the implementation of screening are available to the health care provider level.	213	
		32	There was a defined policy to ensure acceptability of information technologies among users (professionals and patients), to enable their involvement in the process of change.	205	
		33	The best available evidence (guidelines, protocols, etc.) was easily available for health professionals.	225	
		35	Multidisciplinary approach for interventions is supported by the health care provider	228	
		36	Medical record system supports the intervention.	224	
		39	There was a clear description of the patients, carers and professionals' specific role and their contribution was appropriately planned, supported and resourced.	222	
		40	There was an efficient leadership and clear commitment to the intervention from the participating organizations.	227	
1	Comprehensiveness of the intervention	1	A comprehensive assessment of relevant interventions was carried out (or accounted for if it already existed) (i.e. efficacy, cost-effectiveness, quality, safety, etc.)	215	213
		3	The intervention has a comprehensive approach to diabetes addressing relevant contextual indicators (i.e. prevalence of diabetes in the population, percentage of the population physically inactive, prevalence of overweight, obesity and abdominal obesity	218	

			in population, prevalence of population following national recommendations on nutrition, etc.).		
		5	Validated risk assessment tools are available during the intervention to stratify patients by their individual risk profile.	206	
10	Scalability and Transferability	69	Potential impact on the population targeted (if scaled up) is assessed.	213	213

Experts' Comments during the first and second rounds with regard the priority

- One of the main concerns gathered from those comments was related to whether a comprehensive diabetes management practice, that included risk stratification to identify patients in the greatest need of intervention, allows better systematic allocation of resources to optimize the function and value of each provider and thus obtain better health outcomes:

  [“The value of risk assessment depends on the ability to change the intervention accordingly. When it comes to prevention, the recommended intervention is mostly the same, independent on the risk factors- or degree”].

  [“When we are dealing with interventions in general, I think it is important to be able to assess the participants' risk profile (type of "risk" depending on the intervention in question)”]

- Another concern for some of the experts was how to handle information and communication systems and technologies. Even agreed that it enables access to information, facilitate the relation to different levels of social and health care and the management of the diabetes, patients remain cautious about its accessibility and confidentiality of the information managed:

  [“As a patients' association, we remain very distrustful and cautious about the accessibility of the information recorded in systems. We consider it needs a high level protection”]

  Some others questioned the difficulties encompassed when trying to integrated different information and communication technologies:

  [“So if the one to adapt/adopt the intervention doesn't have the same technology he cannot use it?”]

  However, despite the difficulties, it is suggested the potential benefits for health care provider to have access to information technology systems for quality improvement:

  [“The electronic clinical record also offers to the health care professional the possibility to check their own indicators ....”]

- Patients' access to information and resources are also present in the expert’s comments. It was pointed out that the best evidence must be available not only to health care professionals but also to other actors:

[“….and for the stakeholders as associations recognized by the Public Health Authorities”]

and in any multidisciplinary approach to the intervention, a patient with expertise, must also be fully involved:

[“….. and the "patient expert" trained to support others patients in managing their living with diabetes”]

- Despite that it was addressed that practice must enhance and support the patient in order to facilitate its interaction with the health and care system, as it does not always happens, and it was seen as an improvement area for health professionals and the system:

  [“I think that the patient's side must be improved. Besides to be more present the building phase of these strategies also on their assessment and evaluation”].

- The reliance on health policy as the main drive to achieve good practices and have a good impact, was an issue that was also addressed in previous Delphi-m by other experts. However, it was questioned in this Delphi-m that a practice may not necessarily lead towards national level policy or have impact:

  [*“Interventions that are developed and implemented at local levels only, may have bigger impact than national policies”]*

- Within the comments expressed, it was also questioned what it had to do with the practice care setting, due to the different health care organization, stakeholders and governance:

  [“Care settings and what they represent differ greatly from country to country. What is a specialist task one place might be delivered in primary care in another country”]

  [“…many depend a lot on the type of program/intervention in question and on the type of healthcare organization.”]

  [“Again, this may vary according to local settings. Some places nutritionists or physical activity specialists are available, while others only have the clinicians and maybe a nurse. If the latter apply, they might benefit the integration of the intervention in their practice as well”].

- Finally, Evaluation, Sustainability and Scalability, areas addressed as very important for strategic clinical policy making, were questioned if they were important to obtain an optimal practice:

> *[“…some interventions may be best practice even if not having fully undertaken a full cycle of evaluation, sustainability or scalability”].*

- Again, as happened in other’s Delphi-m comments Sustainability was linked to resources rather to the quality of practice itself (whether it has an impact on the population, or if it addresses population needs, or the practice can anchor into the organization etc.)

> *[“For example, a local best practice may then seize due to lack of funds or prioritisation, irrespective of how good or best practice it was”].*

All these concerns were addressed and dealt with during discussions at the face-to-face meeting.