2nd MEETING OF THE GOVERNING BOARD JA-CHRODIS

3rd February 2016

Venue: Classrooms 9-10, Escuela Nacional de Sanidad,
Instituto de Salud Carlos III (ISCIII)
Avda. Monforte de Lemos, 5
28029 Madrid, Spain

AGENDA

Open Session with Executive Board	
14:00 - 14:10	**Opening** **Alfonso Beltrán,** Deputy Director for International affairs, Health Institute Carlos III. **Paloma Casado**, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality. **Wolfgang Philipp,** Unit C1 Programme management and diseases, DG SANTE, European Commission.
14:10 - 15:00 14:10-14:25	**Follow up on JA-CHRODIS: main milestones and future steps** Presentation of the overall Joint Action CHRODIS **Carlos Segovia**, Coordinator JA-CHRODIS
14:25-14:35	Overview of PKE **Enrique Bernal,** Work Package 4 leader.
14:35-14:45	Conclusions of the Advisory Board meeting **Advisory Board member**
14:45-15:00	**Questions**
15:00 - 15:20 15:00-15:10	**WP6: Care pathways approaches for multimorbid chronic patients.** **Rokas Navickas,** WP6.
15:10-15:20	**Discussion** **Facilitator: Carlos Segovia**, Coordinator JA-CHRODIS.
15:20 - 15:45 15:20–15:30	**GB priorities on JA-CHRODIS activities and areas of work:** **Survey feedback** **Carmen Arias,** Spanish Ministry of Health, Social Services and Equality; **Alexander Haarmann** (WP5); **Rokas Navickas** (WP6); **Jelka Zaletel** (WP7).
15:30-15:45	**Discussion** **Facilitator: Carlos Segovia**, Coordinator JA-CHRODIS.
15:45 - 16:15	**Coffee break**
Closed Session of the Governing Board	
16:15 – 17:30	**Discussion on the maintenance of Chronic diseases on the EU Health Agenda. Contributions of JA-CHRODIS and the potential for future activities.** • What could help to keep chronic diseases as a public health priority on the political health agenda in the European Union: ➢ Reflections form a Commission perspective. **Wolfgang Philipp,** European Commission, DG SANTE, Unit C1 Programme management and diseases ➢ Exchange of views on positions from Member States. GB members • Products of JA-CHRODIS developed up to now: exchange of views on meaningfulness and potential for implementation. • Exchange of good practices: "The sewing thread of JA CHRODIS". **Carlos Segovia**, Coordinator JA-CHRODIS. • The future process. ALL. **Facilitator: Isabel Saiz,** Spanish Ministry of Health, Social Services and Equality

17:30 – 17:45	**Conclusions and next steps** **Paloma Casado**, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality

Objectives:

- To present progress and future steps of the Joint Action CHRODIS – focusing on implementation and potential for policy making at national level.
- To obtain GB feedback on the activities of the JA-CHRODIS and its alignment with GB priorities.
- To analyse how the results and the output of JA-CHRODIS can contribute to keep chronic diseases on the EU Health Agenda.

Participants:

- Representatives of the Ministries of Health of the following EU Member States: AT, BE, BG, CY, HR, EE, FI, FR, DE, EL, IT, LT, PT, SI, UK, ES, and Norway.
- Representatives of the European Commission.
- Representatives of the WHO Regional Office for Europe.
- Representative of the Advisory Board.
- Leaders of the work packages.

Expected outcomes:

- To start collecting the GB's views on some of the key deliverables/results of the JA-CHRODIS available until now in order to generate synergies with member States' health initiatives in chronic diseases. This may contribute to the remaining work of the Work Packages and the future use of JA-CHRODIS gather experiences and developed tools in national policies/plans.
- To analyse how the work developed in JA-CHRODIS can contribute to meet priorities demanded by members of the GB.
- To gather the GB views regarding political and methodological actions at EU level needed to merge efforts aimed at keeping chronic diseases on the political health agenda of the European Union;

The debates will be addressed through guided questions previously sent and the answers or others suggestions received from the participants prior to the meeting.

'This event arises from the Joint Action CHRODIS, which has received funding from the European Union, in the framework of the Health Programme (2008-2013). Sole responsibility lies with the authors and the Consumers, Health, Agriculture and Food Executive Agency is not responsible for any use that may be made of the information contained therein.

Opening

Alfonso Beltran, Deputy Director of the National Institute of Health Carlos III, welcomed all the participants to the second meeting of the Governing Board, and thanked them for their collaboration pointing at the relevance of the Governing Board for the JA-CHRODIS.
Paloma Casado, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality, reflected on the importance of the burden of chronic diseases in Europe, and the potential benefit from the work undertaken by JA-CHRODIS for actions within national strategies or initiatives in chronic diseases. In particular, after two years work, health authorities can facilitate the transfer and implementation of collected experiences and tools developed in JA-CHRODIS. Moreover, this Governing Board forum is an opportunity to initiate actions towards the maintenance of chronic diseases and healthy ageing in the political health agendas.
Stephan Schreck, Head of Unit Health Programme and Diseases of the DG Sante of the European Commission (EC) thanked the Ministries of Health involved for taking the political lead in addressing chronic diseases at European level.
The EC wants to create synergies between different areas affecting chronic diseases in general and not only specific ones: Health promotion and disease prevention considered in this JA are, among others, areas of interest for the EC health agenda.
2016 is the year of delivery for JA-CHRODIS and the EC is looking to the results of this important enterprise in funding and in number of partners. Significant achievements have already been obtained like the Platform of Knowledge Exchange, where good practices will be uploaded, should be disseminated, and used all around the EU. For this the contribution of the ministries of health is also crucial.

Follow up on JA-CHRODIS: main milestones and future steps

Carlos Segovia, Coordinator of the Joint Action CHRODIS, summarised the main achievements of the different work packages up to now and the next steps for this year, namely:

- Scientific publications of the WPs' results, expert meetings and country reports up to now: (http://www.chrodis.eu/scientific-publications/; http://www.chrodis.eu/our-work/05-health-promotion/wp05-activities/country-reports/).
- Two Delphi processes ended regarding good practice criteria in relation to health promotion and primary prevention and organisational interventions (with particular emphasis in interventions on multimorbid patients; and two more ahead (patient empowerment and diabetes).
- WP 5 selection of 41 good practices on health promotion and primary prevention of chronic diseases across Europe.
- WP 4 has already settled some of the basic functionalities of the Platform for Knowledge Exchange (PKE): help desk, clearing house, digital library.
- Other deliverables like the evaluation plan for the monitoring of the JA-CHRODIS and the framework for impact assessment; the Governing Board annual report.
- Series of dissemination activities like JA-CHRODIS newsletters and promotional video.

The coordinator explained how to approach the general and strategic goal of exchanging and transferring good practices, and promote this in an innovative way. A draft document was

presented to the GB "The Sewing Thread of JA-CHRODIS" which looks at the different options to facilitate the exchange, transfer and scaling-up of good practices. A possible model with the establishment of communities of practices in order to orientate the fields of good practices that need to be fed into the PKE and that articulates the scaling up and transferring of the good practices in the PKE to new settings.

Enrique Bernal, WP4 leader explained the basic structure and main functionalities of the PKE: help desk, clearing house and digital library. There are different roles to access the platform: as expert, reviewer, practice owner, etc. with different interfaces: from uploading a practice to the assessment of the practice according to the Delphi criteria and a final decision to classify the practice in the clearing house as a candidate, good or best practice.
Contact with the owners of the practices can be also facilitated by the help desk for a better understanding or assistance for the transfer.

Anne Hendry, member of the Advisory Board (AB), presented the conclusions of the AB meeting.
The AB was pleased with the progress of the JA-CHRODIS that although having an ambitious task also counts with pragmatic approach like the Delphi criteria for the assessment of GP or the functionality of the PKE. Having identified GPs is good but the problem is to really cover the gaps and needs in chronic diseases. AB pointed 3 main difficulties: i) to cover all management levels of care involved in chronic diseases (micro and macro); ii) to have a good balance between an evidence based assessment and leave room for the emergent practices; iii) to detect GPs with an added value while keeping cost-efficient.
For the implementation of the GPs, the AB recommended to look at different experiences in transferability (like WHO level) taking into account the cultural context.
For the sustainability of the JA-CHRODIS the maintenance of the collaboration created among the different communities of the JA-CHRODIS family is key and for this the involvement of Member States and regions is needed. Moving from an expert point of view to a networking group can also help.
Finally, a good dissemination and marketing plan for the PKE are needed and the AB will support in this sense.

WP6: Care pathways approaches for multimorbid chronic patients.

Rokas Navickas WP6 co-leader introduced the work performed within the work package on multimorbidity.
First of all, they scaled the problem and identified the needs in this topic. Additionally, a systematic review of existing patient-centred comprehensive care programs in databases from Ministries of Health, Academia and scientific community was performed.
They have also identified case studies/practices in multimorbidity however there is little evidence on the success of implemented experiences for managing multimorbidity. Therefore it was difficult to classify them as good practices.
Nevertheless, based on the systematic review and the case studies identified, they have elaborated a guideline on the best possible care model for multimorbid patients. The model includes, among others (16), the following components:

- Regular comprehensive assessment of patients and individualized care plans with the participation of the patient and family.
- Multidisciplinary, coordinated team, including a professional appointed as coordinator
- Training members of the multidisciplinary team and care providers to tailor self-management support based on patient preferences and competencies.
- Electronic patient records and computerized clinical charts in order and exchange of patient information.
- Supporting access to community- and social- resources and involvement of social network (informal).

Next steps lead to move from theory to practice. This Multimorbidity Care Model should be reviewed by MS, adapted into their national health care systems and shared among the different MS.

Discussion

IT: from their point of view prevention and addressing common risk factors are crucial for tackling multimorbidity.
Regarding components of the MM care model, the confidentiality issue needs to be considered carefully for the exchange of clinical information. An active and fully involved role of the nurses must be also observed.
They would find useful the development of precise guidelines and to develop licensed training programmes at EU level. Identify the costs involved in interventions of the different components of the model can also help from the political side.
WP6 answer: training programmes are to be performed along 2016. The prevention is addressed by WP5 and it would be useful to identify possible targets for our interventions. In this sense the population stratification tools help to focus on targets.

FR: This draft model is an interesting synthesis and will be shared with different stakeholders for comments. This model is close to different experiments. It would be useful to establish a link between what it is produced by JA-CHRODIS and other JAs like the JA on frailty.

NO: The Multimorbidity WP is regarded to be the most important, both because a majority of the patients have more than one chronic disease and because the way of approaching these different diseases show major similarities: The importance of early diagnosis, secondary prevention, a structured follow up and treatment according to guidelines and education of the patients. For these reasons Norway has a general strategy on NCDs, not on strategies on individual diseases. The model presents generic elements that are important in handling all the NCDs. The transfer of a good practice as a whole is difficult as there are many health system differences within Europe regarding responsibility, organising and financing. It is important to look for functional elements and a political commitment is needed.
WP6 answer: The aim of WP6 is to look for what has been done and identify a referential framework for multimorbidity care. MS need to adapt this model to their health settings.

ES: as a general remark assessment of any intervention on multimorbidity care is essential. Consequently, we are missing an assessment plan as a component of the MM Care Model.

WP6 answer: the assessment side can be covered within the PKE regarding Good Practices on multimorbidity.
The Coordinator of the JA asked the members of the GB for feedback to this draft document on the Multimorbidity care model.

GB priorities on JA-CHRODIS activities and areas of work: Survey feedback

Carmen Arias, Secretariat of the Governing Board from the Spanish Ministry of Health, presented the results of the Survey sent to GB members last October regarding their priorities on JA-CHRODIS activities and areas of work.
The aim was to know which fields within the three main WPs of JA-CHRODIS (promotion & prevention, multimorbidity and diabetes) their country would benefit more by sharing good practices across Europe.
About half of the answers indicated multimorbidity as the area they were interested the most, and in particular, the exchange of good practices on the continuity of care, the coordination between primary and specialized care and between health and social services care got high score. Assessment of the needs and experiences of evaluation were also highly demanded by the Ministries of Health.
Implemented health promoting environments and diabetes prevention programmes were the aspect request from the promotion and prevention WP and diabetes WP of JA-CHRODIS.
The leaders of the WP 5, 6 and 7 explained how the work done in their WPs responds to the priorities of the GB:

Alexander Haarmann from WP5 summarised the products up to now: the country reviews, the definition criteria for the identification of good practices on health promotion and primary prevention, and the collection of 41 good practices for health promotion (41).
These good practices are very different and generally, each one can cover many aspects requested by the GB.
This year WP5 will have study visits to six of these practices and they will also focus on key elements that facilitate transferability.
The added value of their work is the availability of all this valuable information and the network already established.

Rokas Navickas explained with more detail the components of the MM care model, and how they may contribute to achieve GB's priorities on MM.
. According to the survey results one of the aspects more requested by the GB members regarding MM was the coordination, comprehensiveness and continuity of multi-professional health services in primary care. WP6 coleader explained that at least two component of the MM care model can respond directly to this demand: i) the component of a multidisciplinary team which include a coordinator figure, and ii) the regular comprehensive assessment of patients.
Control of polypharmacy can also be addressed by the multidisciplinary team.
To avoid barriers from one setting to another they proposed that social services may be incorporated to health services or an efficient coordinator mechanism to be set.
In order to promote home assistance they consider that the IT technologies and electronic solutions should to be used.

Jelka Zaletel, from WP7 emphasized that Diabetes is a complex disease worth to be treated specifically and not only from the general point of view of multimorbidity. Moreover, Diabetes is one of the first diseases where the coordinated management of the patient has been approached and therefore is a clear example of how a health system can be organised for chronic diseases management.
Work in this WP aims at developing recommendations to improve early detection and preventive interventions, and to improve the quality of care for people with diabetes. For this an overview on programs/practices on prevention and management of diabetes, education of patients and training for professionals has been performed and is available. According to the development of criteria for good practices are currently on going and they will also collect and describe 'potential good practices' that could feed the PKE.
WP7 are developing a policy brief on National Diabetes Plans highlighting the strong advocacy at the society by inclusion of patient organisations. There is a need to shift from the existing system with an institutional point of view towards a patient point of view.
The final deliverable is a Guide for National Diabetes Plans that the GB will give feedback on.

Discussion

IT: The inclusion of patients in the NDP could work for the clinical and diagnosis side; however, the lack of funding regarding the preventive activities makes their participation in this area difficult.
WP7 leader argued that diabetes patients demand action on prevention and enhance literacy in order to avoid disease complications. Funding by the government and not only by the pharmaceuticals is also needed. Community resources can have an impact for the improvement of diabetes conditions; however, institutional changes are needed.

PT: For MM they found it is important to prioritise efforts and focus on specific pathologies. Patient education is more effective than education for health managers and it is needed to avoid disease complications. The involvement of nurses is also crucial.

NO: It is important to ensure sustainability of actions. This is a reason why Norway has adopted a general chronic disease strategy rather than disease specific strategies.

AB: In Scotland they ensure the patient participation by creating an umbrella of patient organisations.

FR: They find useful to have a common framework for more than one chronic disease, as soon as these diseases require the same patterns for action plan;
However, rather than chronic diseases at large, they suggest narrowing the scope of the work in prevention deciding in which diseases or fields to focus, (in the first meeting it was said that JA-CHRODIS had a focus on DM and Cardiovascular disease prevention but communication tools describe chronic diseases in general). Advocacy groups are important stakeholders for NCD strategy but do no drive the choice of diseases targeted in national policy.

Using a reference to a comprehensive NCD control framework, like that of the action plan of WHO Euro, might help to clarify the aims of expected contributions from future JAs.

ES: We find useful the tools that help governments to put on the ground the recommendations and guidance on promotion and prevention, multimorbidity and Diabetes. Implementation is very important and is not enough to know what to do, but also how to do it.
In particular the coordination among different sectors and improvement of quality of care are areas where good practices examples can help. We are interested in detecting cases, in seeing practices that implement the theory.
In Spain we have a national methodology for the collection, selection, exchange, transfer and scaling-up of good practices and synergies with the JA-CHRODIS can be established.

Closed session of the Governing Board: Discussion on the maintenance of chronic diseases on the EU Health Agenda. Contributions of JA-CHRODIS and the potential for future activities.

What could help to keep chronic diseases as a public health priority on the political health agenda in the European Union? Reflections from a European Commission perspective.

The European Commission needs Member States commitment on the practical effect of the different programmes and actions on non-communicable diseases.
There are many actions on risk factors and health determinants, many Joint Actions on cancer, dementia, nutrition, etc. Some will continue in the next work plan for 2016 of the Health Programme.

At the end of the day, they need to know the actual added value of what is already provided.
JA-CHRODIS has created the Platform for Knowledge Exchange and there are many other results on the table. It is important to keep in mind that JA-CHRODIS ends at the beginning of 2017, but it can serve as a seed of the work in this field for the future.
Member States have to considerer which elements can be implemented in order to be profitable enough for the Commission to invest in chronic diseases.

Guided Questions

1. *What should be done to keep chronic diseases (CDs) on the political health agenda of the European Union? How could the GB members steer this discussion in the respective Member States?*

DE: It is important that CDs remain in their political agenda and Germany is interested in keep participating in any EU structure created with MS to this aim. They want to improve networking in order to facilitate the implementation of the work. They want to look at chronic diseases from a broad perspective.
BE: CDs is also high on their political agenda and would like support from WHO/European Commission in existing gaps: guidance on multimorbidity and research on clinical and social factors. BE is committed to boost the involvement of professionals and other stakeholders. They also prefer a general chronic disease strategy rather than disease specific strategies.
IT: There are many reasons to support CDs and to keep them in the political agenda: Savings due to lower cost of good prevention strategies in relation to a much higher spending in new cancer treatments; gains due to the good health that enable to stay longer at work, etc. Additionally, there is a lack of coherence between the measures of different actors (i.e. measures proposed by the Ministry of Health and the Ministry of Finances on the Tobacco issue). Therefore, it is important to make use of the evidence and science from JA-CHRODIS, but we need to talk to politicians in their own language through, for instance, policy briefs and involving other ministries like finances in CDs.
FR: There are many reasons for the EC to support further work on CDs, especially within continuity and support of actions already performed in different fields of direct competences of EC: regulation of food advertising/ labelling; tobacco and alcohol regulation; or requirements for life style indicators in the European regulatory system for medicines. For France, the national strategy for health is going in the same direction, so there is a favourable ground. Another

argument would be to show the consistency of the different actions performed or supported by the EC (JAs, partnerships, initiatives).
PT: Actions at EU level must be in line with efforts on CDs pursued by WHO initiatives: to avoid premature mortality from CDs. Continuity of political commitment is needed.
ES: In order to keep chronic diseases on the political health agenda discussion in a working group at EU level involving Ministries of Health of all the MS should be maintain. MS support to disseminate the different JA-CHRODIS gather experiences and tools is also needed.
NO: We are aware of the work performed in JA-CHRODIS. The challenge is how MS can assess it and implement it. This will require, on one hand, the involvement of the health professionals but just as much political decisions to bring about necessary changes in the health system.
EC: Just to have interest is not enough to keep the EC support on CDs if the MS do not get involved and if the added value of the actions is not achieved. Additionally, the EC agreed on keeping in mind the possible conflict of interest of different sectors. EC is planning a meeting with MS to decide how to approach CDs next April.

2. *Would the creation of a permanent network or working group of governmental representatives on chronic diseases from Member States at the EU level, managed by the European Commission, be useful to drive the chronic disease agenda further? And to generate impact in Member States with respect to the prevention and management of chronic diseases?*

IT: Agrees with the creation of a permanent network of governmental representatives on CDs from MS at EU level, but it should be thoroughly analysed and results should be obtained. We know that permanent mechanisms need to be financially sustainable, but sometimes specific measures carry high costs (Ebola..). There should be a balance between gains and costs considering that CDs requires action.
When holding the presidency Ministries of Health can also influence the health agenda including CDs as a topic in different programmes: the Council of the EU, the Chief Medical Officers, etc.
ES: supports the creation of this permanent network and emphasised the needed to tackle CDs at political level.
EC: The creation of a new working group has to be balanced very carefully. There are advantages and disadvantages within the several initiatives that could be considered as alternatives:

- The surveillance services performed by ECDC on communicable diseases cannot be extended to NCD.
- Create a mechanism with a common case definition and indicators on NCDs, but this would need the support from MS.
- ERIC (European Research and Innovation Consortium), recently established for health information that could help policy makers in making decisions. Analysis of surveillance data that should be financed by MS but the challenge is that it is not mandatory.
- To include NCDs in other EC groups already established with the MS.

All these options might be dealt with at the next EC meeting with MS (21 April 2016) to decide how to approach CDs.

3. *Which of the products of JA-CHRODIS, developed up to now, do you find useful and have the potential for implementation or further development into national policies or activities in response to chronic diseases?*

4. What could you do to facilitate the exchange of good practices identified by JA-CHRODIS, and other EU projects with respect to chronic diseases in your country?

EC: JA-CHRODIS was initiated, among others, as a way to support MS to deal with the burden of CDs at a time of economic crisis. In 2017, the EC will analyse the results of the measures performed and the usefulness of the Health Programme in general. So the implementation of products from this JA and others into national policies or activities is of great relevance.

FR: There is a huge amount of work performed in JA-CHRODIS and time will be required for appropriation of JA-CHRODIS outcomes by stakeholders. The PKE (1.0) that is expected to be ready at the end of the JA should be disseminated at the local level, to assess the adaptation for would-be users. For instance, should the PKE be adapted between national languages and English to bridge a possible language gap? that would require additional work; work in WP6 and WP7 can be used to discuss policy design.

ES: Different actions could be done: to disseminate JA-CHRODIS and its products at different settings and with different means; to establish synergies between the national methodology for the collection, selection, exchange, transfer and scaling-up of good practices and the ones proposed by JA-CHRODIS (use of criteria for assessment of GP obtained by Delphi processes); help to feed the PKE with the good practices identified at national level.

Additionally, the PKE should be used in other EU funded initiatives.

DE: The country report on health promotion and primary prevention developed by WP5 is very useful and some feasible activities and recommendations can be found. They want to go on collaborating with this WP.

LT: they will present the MM care model from WP6 at political level and want to carry out a pilot with it. They also want to include GPs into the PKE.

IT: They support the training aspect and the development of useful tool kit for different sectors involved in the care delivery. The main value is to work on through specific sectors of the care delivery according to their needs: the education at schools, the caregivers, the finance agents, etc.

They also find added value in the PKE and they will try to find synergies with their national system to collect GPs.

BE: They are planning to perform a reform of their health service covering NCDs, so they will facilitate relevant documents from JA-CHRODIS to their practitioners, and ask them if they can apply them.

In BE the competences regarding the health promotion are at local level and they will also inform the regional authorities work on this field.

PT: To use World Health Day as an opportunity to disseminate the products of JA-CHRODIS. GPs on diabetes can be useful for them.

5. Regarding the promotion of a continuous exchange of good practices, the document "The Sewing Thread of JA-CHRODIS" includes different elements. What it is your opinion of them and how could you support them at the country level? There was not enough time to discuss this question.

Conclusions:

- The involvement and feedback of the GB on JA-CHRODIS and its products is of crucial relevance for this Joint Action.

- The GB should disseminate the products of JA-CHRODIS to different stakeholders through different means. They should promote the implementation and exchange of good practices; establish synergies between the national methodology for the collection, selection, and continuous exchange of good practices and the ones proposed at JA-CHRODIS and its PKE.
- The GB should make efforts to keep chronic diseases at the European health agenda.
- A permanent network of governmental representatives on chronic diseases at EU level could be useful, but it needs to be effective and produce something.
- Key components of the Multimorbidity Care Model are not disease specific, but structural aspects of the health system. The GB would like to see examples not only of what to do, but also of how to do it.

Next Steps:

- Collect feedback from the Governing Board to JA-CHRODIS' key deliverables/milestones.
- Follow up on the efforts done by the members of the GB to keep chronic diseases in their national and EU health agenda, and the extent of how the products of JA-CHRODIS could impact on national policies/plans.
- GB next face to face meeting: June 2016

Annex I
PARTICPANTS LIST
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