ANNUAL REPORT ON SUSTAINABILITY

Report on the conclusions of the discussion of the Ministries of Health Forum on the future plans for making the activities of JA-CHRODIS sustainable in time

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CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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Executive Summary/Abstract

During the second trimester of 2016, the forum of representatives of Ministries of Health (Governing Board) created in JA-CHRODIS continues its work in order to generate synergies between EU Members States, EEA countries and EU institutions which contribute to the maintenance of chronic diseases and healthy ageing in the EU health agenda.

Apart from the current representatives of health ministries of Members States, EEA countries, and of the European Region of the World Health Organization (WHO) and the European Commission as observers, new countries were invited to the 4th Meeting of the Governing Board (GB) and representatives from the Health Ministries of Slovakia and Serbia attended that meeting.

This report provides information on the conclusions raised at the 3rd and 4th Meetings of the GB. Additionally, Annex 3 collects all feedbacks received from members of the GB to the key deliverables and milestones of the JA-CHRODIS that were identified as requiring feedback from the GB in the Framework plan of the GB. It is a deliverable of the JA-CHRODIS D09-01.03.

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Acknowledgments

Governing Board members, Executive Board members and all partners at JA-CHRODIS.

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Introduction

JA-CHRODIS is a Joint Action (JA) co-financed by the European Commission and Member State authorities under the Second EU Public Health Programme[1] 2008-2013. The JA-CHRODIS aims to promote and facilitate a process of exchange and transfer of good practices between European countries and regions, addressing chronic conditions, with a specific focus on health promotion and prevention of chronic conditions, multi-morbidity and diabetes.
In order to set up an appropriate framework for the participation of EU and EEA Member States in the JA-CHRODIS, the Consortium agreed to create a Governing Board (GB) of representatives from the Ministries of Health (MoH) of the Member States of the European Union and EEA countries.

On the 8th of April, 2014, the Spanish Secretary General for Health invited the Permanent Representation of the UE and the EEA Member States to nominate a representative from their Ministries of Health to join the Governing Board. Seventeen Member States (AT, BE, BG, CY, HR, EE, FI, FR, DE, EL, IT, LT, NL, PT, SI, UK, ES) and Norway nominated representatives. The European Commission, Directorate General for Health & Food Safety (DG Santé), and WHO Regional Office for Europe also designated a delegate for the GB.

The GB has maintained relevant policy-makers informed and contributed to improve the technical work and the strategic progress of the JA-CHRODIS, then facilitating the use of JA-CHRODIS experiences and developed tools in national policies/plans to address chronic diseases.

[1] http://ec.europa.eu/health/programme/policy/2008-2013/index_en.htm

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1. Third Meeting of the GB

The third meeting of the GB took place in Brussels on the 16th of June 2016, with the participation of representatives from the Ministries of Health of 14 EU and EEA Member States, as well as representatives from the DG Santé.
During the meeting, the follow up of the JA's activities and future steps were reported and some of the key deliverables/results of the JA-CHRODIS were discussed to obtain GB's comments and feedback on their potential implementation into national policies or plans on chronic diseases. In particular the synergies and possible barriers of using the CHRODIS platform in the different MS were treated and a workshop to collect the inputs from the GB members into the Guide on National Diabetes Plans was performed. Finally, there was a debate on proposals for actions of the GB at the Final Conference of JA-CHRODIS.

The main conclusions of the meeting were:

- The involvement and feedback of the GB on JA-CHRODIS and its products is of crucial relevance in order to know if they approach real needs and problems and if they would be feasible and applicable.
- WP2, regarding dissemination of JA-CHRODIS: suggestions were made to know the origin or background of people accessing the web-site and to increase JA-CHRODIS visibility. Additionally, in order to involve policy makers, it was suggested to develop summaries of the main products of JA-CHRODIS.
- WP5, regarding the study visit on health promotion and chronic disease prevention: The objective is to describe common patterns for the transferability beyond the specific practice. Support for an evaluation process and information on costs were requested. Cross-border study visits may also help to identify hard core elements of transferability.
- WP6, regarding MultiMorbidity Care Model: General agreement to the list of components as starting point. For a model the relationship between components might be described. Although little evidence exists, the cost-effectiveness aspect was suggested as an improvement and pilot studies as a way to get it. A questionnaire on the applicability of the MM care model will be distributed for the GB contribution.
- WP4, regarding Tools for the exchange of good practices: sustainability might be considered by the members of the GB after testing the functionalities of the CHRODIS Platform (from 4 July). The conflict of interest and incentives for the owners of the practices were discussed.
- Preliminary suggestion for the Final Conference:
  - To present national cases aligned with JA-CHRODIS products;
  - To considerer the cost-effectiveness aspects in the outputs presented;
  - To issue the JA-CHRODIS conclusions of the Final Conference;
  - To present the set of criteria to evaluate good practices at the final conference of JA-CHRODIS.
- 2nd JA chronic diseases:

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- More than 50 AP from 22 countries (Serbia and Moldova) up to the time. Final number still tbc.
- GB structure to be discussed in the consortium.

Minutes of the 3rd meeting of the GB are included in this report as Annex 1.

2. Fourth Meeting of the GB

The fourth meeting of the GB took place in Brussels on the 29th of November 2016, with the participation of representatives from the Ministries of Health of 11 EU and EEA Member States, as well as representatives from the DG Santé.

During the meeting, the follow up of the JA's progress was reported and feedbacks and information on the use/impact at national level of key deliverables/results of the JA-CHRODIS were collected from members of the GB. The Terms of Use of the CHRODIS Platform were discussed, in particular regarding the Digital Library, in order to have the comments from the GB before the opening of the platform to the public. Finally, the GB's intervention at the Final Conference was presented and there was an ending debate on how to improve the work of the GB looking forward to the 2nd JA on Chronic Diseases (JA-CHRODIS Plus).

The main conclusions of the meeting were:

- WP5, regarding the Recommendation report on applicability and transferability of practices into different settings and countries:
  - Success factors for transferability of Good Practices (GPs) were found interesting in particular the modularity. These factors probably could be useful in fields other than health promotion and prevention.
  - In order to create ownership for the transfer of a GP it is important to raise acknowledgement of the project and to implement it at local level with a key person involved.
- WP7, regarding the Guide for the National Diabetes Plans:
  - The innovative value on leadership of the developed Guide for National Diabetes Plans (NDP) could be a useful tool for political change. Social more that medical science skills could help in the evaluation.
  - It was asked that the Guide for NDP could have a broader scope/ visibility for cardiovascular risk and other NCDs.
  - Further details would be needed for the implementation and use of the Guide for NDP at Primary care level.
- WP4, regarding the exchange of good practices (CHRODIS Platform):
  - A general interest on the JA-CHRODIS Platform (CP) was expressed by several countries in particular when including information from different EU projects on chronic diseases (i.e. SIROCO project, etc.) and adapting the Platform to the EU set of quality criteria to evaluate GPs.

- Some concerns where the long term sustainability of the CP, the difficulties related with the reviewers, the language limitation, the incentives for the owners to upload GPs into the Platform and the update of the GPs.
- The flexibility to include different projects and the EU set of quality criteria for GPs is an advantage of the CP. Using a translation engine, the creation of a Federation of Platforms with the same mechanism and reviewers and the development of a sustainability plan foreseen at the next JA CHRODIS Plus were indicated as some solutions to the concerns of the MoHs. Finally, an incentive for the owners could be having a European evaluation of their practices together with getting in contact with a practice community. It was proposed to include a continuous evaluation mark to assure the updating of the GPs.

- WP6, regarding skills and competencies for case management training programmes: The definition of skills and competencies for case manager and the basic structure of the training programme were useful for the MoHs; however, awareness was raised to focus at the definition of the functions for case manager and to avoid the contracting issues.
- WP2, regarding the final conference: Invitations for participating at the final Conference of JA-CHRODIS were already sent to the Minister of Health of Finland, Germany, Bulgaria, Malta and Spain. It was suggested to avoid duplication on topics addressed by the different participants.
- WP3, regarding the Impact Plan and Evaluation JA-CHRODIS: Final evaluation report of JA-CHRODIS will be ready for the final conference. Suggestion to include a deeper assessment of the evolution of the work of the partnership will be taken into account for the next JA-CHRODIS Plus.
- Terms of Use (ToU) of the JA-CHRODIS Platform: After discussion it was agreed to adopt the proposed ToU of the CHRODIS Platform but to added instruction to the helpdesk reviewers indicating that content of the Digital Library should be limited to documents, web sites, etc. only from public institutions/bodies, until an editorial policy document is developed.
- Member States' plans to implement products of the JA-CHRODIS: Although subject to deeper analysis and further political support and time, MoHs indicated several products of JA-CHRODIS or CHRODIS-Plus they could use/implement: JA-CHRODIS Platform, case manager training programme, key issues on the scalability of GPs and the GPs on health promotion and prevention that continued to be a field of interest for the next JA. Moreover, for CHRODIS-Plus, it was asked to have a more horizontal approach for all NCDs ,to link with the WHO Global Plan for NCDs, and to have more specific examples of GPs on Multimorbidity management and diabetes.
- 2nd JA-CHRODIS PLUS: Implementation and piloting activities will be the cornerstone for next CHRODIS Plus, but the GB would be asked to promote the political interest and the integration of products into national/local policies. Members of the GB pointed out the many layers of decision-making from the ministerial to the local level, and as main difficulties, the lack of enough time and evidence on cost-effectiveness.
- Improvement of the work of the GB in the next JA-CHRODIS PLUS: In general the continuation of the Governing Board for the next Joint Action was supported; however, several items to improve its work were mentioned: work with summaries of deliverables, improved feedback from the GB

and dialogue with leaders of the WPs, clearly formulate the purpose of the meetings and feedback from the GB, guarantee a quality threshold of the deliverables and maintain a fluent dialogue with the new Steering Group on Promotion and Prevention of the European Commission.

Minutes of the 4th meeting of the GB are included in this report as Annex 2.

3. Key deliverables and milestones from WP4, WP5, WP6 and WP7 sent to GB for information or feedback.

In order to support the GB's contribution to increase the added value of the technical work and strategic progress of the JA-CHRODIS, a Framework plan for the GB was developed. Key deliverables and milestones from the work packages of the JA-CHRODIS were identified for information or feedback from the GB with a detailed timeline included as an annex.
The draft Framework plan was approved by the Executive Board in June 2015 and it was sent to the GB members in September 2015. An update of the framework plan regarding the timeline for some deliverables according to an amendment of the grand agreement was communicated to the GB in May 2016.

Written comments from the Members of the GB received via email are included in this report as Annex 3. Comments to the deliverable completed during the Governing Board meetings are included in the minutes of those sessions.

Find below the complete list of deliverables and milestones that according to the updated GB Framework plan have been sent to the GB for information or feedback:

- **WP3:**
  - "Interim evaluation report" (for information).
- **WP4:**
  - "Selecting CHRODIS criteria to assess good practices in interventions related to chronic conditions: health promotion and primary prevention" (for information).
  - "Selecting CHRODIS criteria to assess good practices in interventions related to chronic conditions: organizational interventions with particular emphasis in interventions on multimorbid patients" (for information).
  - "Selecting CHRODIS criteria to assess good practices in interventions related to chronic conditions. Delphi Panel in the area of patient's empowerment interventions with chronic conditions" (for information).
  - "Selecting CHRODIS criteria to assess good practices in interventions related to chronic conditions: Diabetes" (for information).
  - Link to CP: Help-desk services, clearing-house and Digital library (for information).
- **WP5 :**

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- “Identification of 3 Good practices per participating MS in health promotion and primary prevention of chronic diseases: Report, annex and executive summary” (for information).
- “Country reviews on health promotion and chronic disease prevention approaches” (for information).
- “Recommendation report on applicability and transferability of practices into different settings and countries” **(for feedback).**

- **WP6 :**
  - “Report from data analysis and evidence from literature to identify high care demanding population” (for information).
  - “Report on care pathways approaches for multimorbid chronic patients (included the meetings with experts to assess accuracy of collected evidence and select good practices, identify commonalities for care management of multi-morbid patients)” **(for feedback).**
  - “Reports on meetings with experts for designing multi-morbidity case management programmes” **(for feedback).**
- **WP7:**
  - “Policy Brief: National Diabetes Plans in Europe: What lessons are there for the prevention and control of chronic diseases in Europe?” (For information).
  - “Recommendations to improve the quality of care for people with diabetes: minimum set of indicators” **(for feedback).**
  - “Guide for National Diabetes Plans” **(for feedback).**

* **WP2:** Members of the GB have been included in the distribution list of WP2 and therefore they are directly and continuously informed about website news, promotional materials, newsletters, etc.

Conclusions and lessons learnt for JA-CHRODIS Plus

As concluded during its third meeting, the involvement and feedback of the GB on JA-CHRODIS and its products is of crucial relevance in order to know if they approach real needs and problems and if they would be feasible and applicable.

During this third and last year of the JA-CHRODIS, the Governing Board has been able to analyse key deliverables and milestones, with a focus on their implementation into national policies or plans on chronic diseases:

- A general interest on the JA-CHRODIS Platform (CP) has been expressed by several countries in particular when including information from different EU projects on chronic diseases (i.e. SIROCO project, etc.) and adapting to the EU set of quality criteria to evaluate GPs. However, some concerns are the long term sustainability of the CP, the language limitation, the incentives for the owners to upload GPs, etc. that should be carefully address since the beginning of the next JA-CHRODIS Plus.
- Good Practices on health promotion and prevention, the study visits and the success factors for the scalability of GPs were highly valued by MoHs and continue to be a field of interest for next JA CHRODIS Plus.
- The MultiMorbidity Care Model is considered a good starting point for the National Plans to follow, and the definition of skills and competencies for case manager addresses a complex topic and it is considered, very useful for some MoHs. Moreover, a pilot study on case manager training programme could provide valuable information if performed in the next JA- CHRODIS Plus.
- The innovative value on leadership of the developed Guide for National Diabetes Plans (NDP) could be a useful tool for political change, but it was suggested that it should have a broader scope for other NCDs and further details would be needed for its use at primary care level.

Regarding the future JA-CHRODIS Plus, members of the GB suggest a more horizontal approach for all NCDs and to link it with the WHO Global Plan for NCDs. Representatives of the MoHs in the GB are informed that implementation and piloting activities will be the cornerstone for the next JA-CHRODIS Plus, and they will be asked to promote the political interest and the integration of products into national/local policies.

Among others, the proposals to improve the work of the GB for the next JA-CHRODIS PLUS are, to enhance feedback from the GB and dialogue with leaders of the WPs; to guarantee a quality threshold of the deliverables and to maintain a fluent dialogue with the new Steering Group on Promotion and Prevention of the European Commission in order to contribute keeping chronic diseases in the national and EU health agendas.

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Annex 1. Minutes of the 3rd Meeting of the GB

THIRD MEETING OF THE GOVERNING BOARD

16th June 2016

Venue: Rue du Trône, 62

Brussels 1050, Belgium

AGENDA

OPEN SESSION WITH EXECUTIVE BOARD	
10:00-10:15	**Opening** **Carlos Segovia,** Co-ordinator of the JA-CHRODIS, Carlos III Health Institute **Paloma Casado**, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality **Ingrid Keller,** Policy Officer – chronic diseases, Health Programme Chronic Diseases Unit, DG SANTÉ, European Commission
10:15-13:15	**Follow up on JA-CHRODIS: milestones** Dissemination JA-CHRODIS, **Anne Pierson** (WP2) **Q&A**
	Study visits, **Alexander Haarmann** (WP5) **Q&A**
	Short re-cap of the MM Care Model, planned training programme, and applicability of the MMM, **Graziano Onder** (WP6) Short comments from Member States to the model **Facilitator: Carlos Segovia,** Co-ordinator JA-CHRODIS **Tour de Table**
	Tools for the exchange of good practices **Facilitator: Enrique Bernal** (WP4) **Tour de Table**
	Workshop on the Guide for the National Diabetes Plans • Presentation of the work of WP7 • Introduction to the workshop **Facilitators: Marina Maggini** (WP7)**, Jelka Zaletel** (WP7)
13:15-14:30	**Lunch**
CLOSED SESSION OF THE GOVERNING BOARD	

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14:30-16:45	**Discussion of the following topics:** • PKE • Follow-up on the impact of the products of JA-CHRODIS on the national policies/plans of the GB Member States • Final Conference of JA-CHRODIS (GB´s Declaration?) **Future steps:** • Activities on chronic diseases at EU level: 2nd JA on Chronic Diseases **Ingrid Keller** (European Commission) **Facilitator**: **Ingrid Keller** (European Commission)
16:45-17:00	**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 the national level
- To obtain GB feedback on the activities of the JA-CHRODIS and its alignment with GB priorities
- To discuss the design of the Final Conference

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, NED, 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 collect the views of the GB regarding which of the JA-CHRODIS deliverables/products they would include into their national policies or plans on chronic diseases;
- To collect inputs into the Guide on National Diabetes Plans;
- To gather information about synergies and possible barriers of using the PKE in the different MS;
- To discuss possible proposals for actions of the GB for the Final Conference.

'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.

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List of participants

Governing Board members

SURNAME	NAME	ORGANIZATION
BOURGEOIS	Jolyce	Health, Food Chain Safety and Environment, Belgium
BRUNOT	Alain	General Directorate for Health, France
BUDEWIG	Karen	Federal Ministry of Health, Germany
CASADO	Paloma	Spanish Ministry of Health, MSSSI, Spain
FOTEVA	Elvira	Ministry of Health, Bulgaria
GHEBREIGZABIHER	Ghebremerain	Permanent Representation of Italy
GUERRA	Ranieri	Ministry of Health, Italy
GUDANAVICIENÈ	Ieva	Ministry of Health, Lithuania
KALIVA	Fofo	Ministry of Health, Greece
LUKKA	Kaija	Ministry of Social Affairs, Estonia
MAGAJNE	Marija	Ministry of Health, Slovenia
OGAR	Petter	Ministry of Health, Norway
POLJICANIN	Tamara	Croatian Institute of Public Health, Croatia
SARLIO-LÄHTEENKORVA	Sirpa	Ministry of Social Affair and Health, Finland
De ZWART	Wil	Ministry of Health, Welfare and Sports, Netherlands

Governing Board Secretariat

SURNAME	NAME	ORGANIZATION
ARIAS	Carmen	Ministry of Health, Social Services and Equality, Spain
SAIZ	Isabel	Ministry of Health, Social Services and Equality, Spain

European Commission/CHAFEA members

SURNAME	NAME	ORGANIZATION
GATZOULIS	Loukianos	DG Sante-EC

SURNAME	NAME	ORGANIZATION
KELLER	Ingrid	DG Sante –EC

Executive Board members

SURNAME	NAME	ORGANIZATION
BERNAL	Enrique	Instituto Aragonés Ciencias de la Salud, IACS, ES
CATTANEO	Clotilde	EuroHealthNet, BE
CEDIEL	Patricia	Institute of Health Carlos III, ISCIII –FCSAI, ES
COSTONGS	Caroline	EuroHealthNet, BE
DEL RÍO	Catalina	Institute of Health Carlos III, ISCIII –FCSAI, ES
ESPALLARGUES	Mireia	Agency for Health Quality and Assessment of Catalonia, AQuAS, ES
GALLINAT	Anna	EuroHealthNet, BE
HAARMANN	Alexander	Federal Centre for Health Education, BZgA, DE
JUREVIČIENĖ	Elena	Vilniaus Universiteto Ligonés Santarişkių Klincos, VULSK, LT
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LAUNA	Ramón	Instituto Aragonés de Ciencias de la Salud, IACS, ES
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MAMMARELLA	Federica	Agenzia Italiana del Farmaco, AIFA, IT
ONDER	Graziano	Agenzia Italiana del Farmaco, AIFA, IT
PIERSON	Anne	EuroHealthNet, BE
RIBEIRO	Rogério	Portuguese Diabetes Association, APDP , PT
SEGOVIA	Carlos	Institute of Health Carlos III, ISCIII, ES
ZALETEL	Jelka	National Institute of Public Health, NIJZ, SL

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Opening

Carlos Segovia, Co-ordinator of the JA-CHRODIS, Health Institute Carlos III, welcomed all the participants to the third meeting of the Governing Board. He highlighted that the involvement and feedback of the GB on JA-CHRODIS and its products are of crucial relevance. It is important to know if the results obtained in JA-CHRODIS address real needs and problems and if these results would be feasible and applicable in the countries.

Paloma Casado, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality, said that now JA-CHRODIS has developed products and it is time for the GB to provide its feedback regarding their applicability, barriers and facilitators. We should think about how to facilitate their implementation in the national policies/programmes on chronic diseases and how to make them sustainable.

Ingrid Keller, Policy Officer – chronic diseases, Health Programme Chronic Diseases Unit, DG SANTÉ, European Commission, emphasized that we should look for useful results not only to fulfil the Grant Agreement of the Joint Actions or to deliver reports for CHAFEA's archives. She reminded everyone that we should work towards one of the indicators used for the assessment of the 3rd Health Programme: how many good practices have been implemented in the Member States.

After a round table presentation, the leaders of the different work packages reported on their work progress.

Follow up on JA-CHRODIS: milestones
WP2: Dissemination JA-CHRODIS

A summary of the activities done was presented and an increase in the dissemination activities was observed compared to 2014. Some of the dissemination activities have been performed in languages other than English. Information on the promotion activities at conferences and workshops was also provided.

Statistics were presented on web-site access, sections checked, etc., keeping in mind that it is not a web-page for the public in general but for a targeted audience.

For the future steps, the web-page will undergo a change to make it more user-friendly. It will focus on the results of the JA-CHRODIS and a new promotional video will be developed.

Some of the events ahead are the European Public Health EPH Conference (9th- 12th November 2016), a Stakeholders' Workshop at the European Parliament (28th November 2016), webinars and the JA-CHRODIS Final Conference (27th-28th February 2017). The European Health Forum Gastein (28th- 30th September 2016) has been identified but not sure how JA-CHRODIS will be presented and

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WP2 leader asked members of the GB for contacts of the organiser. Suggestions for the agenda of the Final Conference from the GB are also welcome.

Discussion:
NL asked where people accessing the JA-CHRODIS web-site were coming from, and that maybe in order to know their background some basic questions could be included when accessing the web-site. This information can be used for evaluation.
FI commented on making the web-site more visible in order to increase the number of visitors, and suggested making the materials in the web-site more accessible to policy makers by preparing summaries of the main documents.

WP5: Study visits
Alexander Haarmann summarised the work completed till now: the definition of 10 criteria for the identification of good practices (GPs) on health promotion and primary prevention (Delphi panel), the collection of 41 good practices on health promotion and primary prevention of chronic diseases across Europe, and the study visits to 7 of these practices in order to identify key elements that facilitate transferability.
He described some of the lessons learnt from the study visits up to now that have the aim of identifying common patterns beyond the specific case as essential factors for transfer & upscaling. Links to JAs with related topics may be increased and findings can provide ideas to be developed for JA-CHRODIS 2.
A deliverable with conclusions from these study visits will be developed and a WP5 meeting & workshop will be held in November or December.

Discussion
EC asked about identification of specific successful elements (not only factors that facilitate transferability), but WP5 explained that for the successful transfer of a GP you have to adapt it to the context and for this you need factors for the upscaling.
WP5 clarified that one of the criteria of the Delphi panel applied to the 41 good practices regarding transferability consists of the information provided by the owner of the Practice, if the Practice had been transferred to a different region or setting. i.e., a mobile unit, this would be easier to transfer than one embedded in a health system.
IT asked if the impact assessment of the Practices has been analysed in order to have financial grounds for supporting the implementation of GPs in their country. **WP5** explained that this is one of the reasons why they have an evaluation item of the Practice that is key to comparison, however, and although WP5 included some health outcomes indicators and cost questions, this aspect is difficult to measure. **Co-ordinator also** pointed out that sometime Practices do not have complete cost/evaluation information, but the health problem is on the ground. JA-CHRODIS tries to give options and core elements to be used for the transfer but it is up to the Ministries of Health (MoH) to implement the GPs and later on MoH can also assess the efficiency.

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EuroHealthNet suggested reviewing existing cost data, even if indirect (i.e., savings due to working healthier/longer, to avoidable sick leave, etc.) and try to make a general statement. However, these exercises can be especially difficult for the health promotion field.
FR suggested, at least, providing criteria for a good evaluation and increasing the visibility of those practices that have already undergone a favourable evaluation (evaluation report is available online).
FI inquired if there was any cross-border GP as this could provide more information on transferability, but **WP5** said that even if this was not exactly the case, some of the GP could be useful in another country.

WP6: Short re-cap of the Multimorbidity Care Model (MMM), planned training programme, and applicability of the MMM.
Graziano Onder summarised the work done within this work package: after a systematic review of existing patient-centred comprehensive care programs, they found very heterogenic practices and little evidence on the success of implemented experiences. Nevertheless, after the expert meeting they elaborated a guideline on the best possible care model for multimorbid patients including 16 components.
Comments on the Multimorbidity Care Model (MMM) from FR and ES have been received, and in general, the MMM aligns with the interest of the respective Ministries of Health (MoHs).

FR comments focused on 3 main issues:

- Geriatric, social and psychological skills should be a key part in the model.
- The role of the patient and informal caregivers should be considered.
- Stratification instrument. Multimorbidity patients are at higher risk for disease patterns, low social economic status and poor physical function. The exposure to inappropriate cares should be considered (inappropriate prescribing /detection of frail people).

WP6 explained that these are aspects that are observed in the MMM. Actually they identified in the MMM the need for comprehensive and multidisciplinary assessment and intervention and although not completely developed, they mention the stratification aspects to be present when identifying people targeted for intervention (not only health problems but social and mental health conditions).

The barriers for the implementation of the MMM described by FR relate to the training of health care personnel in multidisciplinary approaches and shifting from disease-centred to patient-centred care. Also, the role of patients and relatives is not sufficiently supported.
For **ES**, the decentralised management of the Health System might jeopardise the implementation of the model.

Elena Jurevičienė reported on a web-based questionnaire regarding the applicability of the MMM questions component by component. Possible barriers for the implementation of the Model are the differences among health systems, the investment in care management and training or the challenge

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for change. This is against the possible gains such as further savings, better quality or reduced hospitalisation. This questionnaire will be distributed to the members of the GB for them to complete.

The last deliverable of the WP6 is to define the multi-morbidity case management training programme. For this another questionnaire has been distributed among the partners and meetings with experts to discuss skills and competencies will be organised.

Discussion

EuroHealthNet suggested linking data from social registries (unemployment, eviction) with health data (alcohol consumption, etc.…). **WP6** explained that for some countries this is not possible due to data protection and confidentiality issues so the clinical information system component of the model is flexible enough to fit different needs and circumstances.

SI reported on an eHealth platform (containing health reports and prescription data, etc.) which it is currently being developed at the European level to be used in the future for this model.

IT indicated that for the time being, it would be an economic challenge to implement the MMM as it implies changes in the health system that are not currently feasible. Chronic care needs matter more than cure, so the resources needed for medicalisation and care-givers support should and might be relevant.

Therefore and because there is little evidence for the success of the MMM, it was proposed to consider Members States' adherence to the model by reaching a consensus process, e.g., in a conference.

EC (integrated care): the scientific evidence is long to remain unresolved because there is not systematic data collection; the peer review process is not used for publication; there is not a right methodology for integrated care (including multimorbidity) assessment. However, the problem is there and MoH have to decide how and when to act.

FR: there is some evidence on the need and efficiency of action on patient education and quality of health services that can be used. Patient decision sharing should be emphasised.

SI liked this deliverable from JA-CHRODIS, but to constitute a model the interrelation of its different components should be taken into account (weigh the relevance of each component, etc., this comment was supported also by **NO**). Additionally, health economists should be included in the list of experts at the expert meeting for a better efficiency assessment.

ES reiterated its comment regarding the lack of a general assessment component to be included in the model, apart from that of the regular comprehensive assessment of patients.

A few countries have started piloting (or will) integrated care programmes and some components of the MMM will be useful. The piloting results can provide information on the efficiency and enrich the model:

- **NL**: pilot to be finished by the end of 2016;
- **BG:** they are developing a MM guideline in September 2016 and will look for interactions and usefulness of the MMM. Belgium will start a pilot in 2017 on integrated care and MM and would

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be able to apply some of the components of the MMM. However, changes in the legislation would be required before general implementation.

- **NO:** have applied only some of the components.
- **SI:** have already included some initiatives to be part in their health system and the MMM will be useful.
- **EE:** currently piloting integrated care programme but their main difficulty is to link health TIC system with social databases because of the privacy of the data.
- **EL:** The MMM is a JA-CHRODIS outcome useful for them as they are currently reforming primary care by creating local health units responsible for the population's health and supporting outpatient clinics in order to increase the efficiency of the system.
- **ES:** we have finished a project on stratification of the population according to the situation of each person and his or her needs. Future development of this project might include social and mental health data.

WP4: Tools for the exchange of good practices

Enrique Bernal, WP4 leader explained that the two concepts underline the CHRODIS Platform: the transferability of Practices and the sustainability.

To cover transferability a formative vs. summative assessment of the Practices is made with the philosophy of learning by doing more than limiting to collect only cost-effective ones. The Delphi Criteria and categories are broad enough to allow the evaluation of any chronic condition and some of them assess the potential of the Practice when transferred to other place.

For sustainability the trust on the large consensus of the Delphi process and to enhance the ownership of a big community of experts are important together with avoiding hard thresholds and implementing an adaptive and scalable technology (it is a live project). The possibility of multi-language and other developments can be approached in the next chronic JA.

The estimated costs of The CHRODIS Platform per year are 200.000 Euros and from 4 July, Member States could test the submission of practices. The link to The CHRODIS Platform was provided and a workshop was announced to take place included at the event with the European Parliament next 28 November (tbc). The WP4 leader also invited the members of the GB to include materials in the digital library.

Once the Practices are submitted by owners, practices are assessed by two reviewers and if discrepancies exist, a referee will decide. The score follows the Delphi criteria. Then the Practice is displayed according to scores and it is classified in 3 categories as "promising", "good" or "best". The 30% of practices with the lowest scores will be considered promising, the 30% with the highest values will be considered best. It was proposed to clearly distinguish those Practices that have undergone a previous formal evaluation. If the Practice is classified in the last 10% percentile, it will not be shown at the clearing house.

Discussion:

SI asked on the funding of The CHRODIS Platform after the 2nd JA on chronic diseases. **SI** would need time to assess the utility of The CHRODIS Platform (probably more than the end of JA-CHRODIS) prior to deciding.
Similarly, **FR** questioned if there would be enough time to perform a survey in order to study how The CHRODIS Platform is perceived from would-be users, regardless if the 2nd JA on chronic diseases would continue with The CHRODIS Platform or not.
EuroHealthNet indicated that the time frame for assessing The CHRODIS Platform could be too little and wondered how The CHRODIS Platform can be linked to the EU Health Policy Platform (https://webgate.ec.europa.eu/hpf/). It was also proposed to clearly indicate in the submission of a Practice if it has undergone previously an official evaluation.
BE commented on the language that up to now is only English unless for the future JA on chronic diseases the multi-language tool is agreed upon.
SI, DE and ES expressed their concern on how to identify conflicts of interest in the practices' owners when submitting for assessment or when content is submitted to the digital library.
DE inquired about the quality check for Practices in the different sections of the Platform.

WP4 leader explained that the digital library is a repository of any other documents of interest for the chronic diseases community (maybe this is the place for national plans or Strategies for chronic diseases). The practices submitted through the clearing house are evaluated and scored following Delphi criteria. Additionally Practices with a previous formal evaluation will also be clearly distinguished. Other existing initiatives like the EIP-AHA have a lighter approach and rely on practices self-regulation that also will apply by itself in The CHRODIS Platform.
FI indicated that this is an interesting initiative and similar to national ones. **FI** will launch a call of good practices on health promotion in their country (open until September). **FI** suggested the possibility of telling the owners to upload their Practices to The CHRODIS Platform. **FI** asked if The CHRODIS Platform also can be used, not only as a tool for implementation, but as a tool for evaluation of Practices.
Finally, **FI and NL** questioned what the incentives for owners to upload practices were.
NL also asked when and how would you know the success of The CHRODIS Platform.

WP4 explained that it could take approximately 4 hrs to upload a Practice and in 1 day the practice could be evaluated and feedback sent to its owner. I.e., the 41 GPs from WP5 can be ready in 2 months. This could be sufficient time to have a first experience and opinion on the Platform and decide on this during the 2nd JA on chronic diseases. Still, only the Ministries of Health of the Members States can determine The Platform utility and decide to use The CHRODIS Platform and whether they like the product or not, in order to use it to address the Chronic diseases in their countries and across Europe.
Regarding the conflict of interests, WP4 leader clarified that The CHRODIS Platform is open to the public. When it comes to the contents submitted to the digital library do not follow an assessment process as in the clearinghouse, but they are supervised by the help desk manager. He also explained the different measures to prevent the conflict of interest to happen:

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- Control at the registration of the users and the possibility of tracking down misuse;
- Disclaimer when registering into the platform – acceptance of terms of use: when it comes to the submission of a practice or any other content authors has to confirm that they have not conflicts of interest with regard to the submission of that material.;
- The Executive Board will elaborate a clear list of criteria for the help desk manager detect irregular entries of content in the digital library.
- There is an implicit supervision by the community of users that act as self-controllers.

Piloting and checking on the usability have been done; however, a new version will be ready from 4 July. WP4 will take into consideration the proposal of clearly indicating in the submission of a Practice if previously the practice has undergone an official evaluation.
WP4 reported that The CHRODIS Platform also can be used as a tool for evaluating and implementing Practices, mainly through the help desk and also to study possible barriers for implementation.
Regarding the incentives, WP4 consider that it would be enough just the reputation for the owners to have their Practices in a good ranking within The CHRODIS Platform, regardless of the challenge of transferability. In this regard, the representative from the Integrated Care Unit at the European Commission said that for the reference sites of the EIP-AHA reputation was a powerful incentive, but also the network established new collaborations; however, it is worth highlighting the visibility of the benefits.
It is important to have a substantial number of Practices in The CHRODIS Platform by next meeting of the GB (29th Nov 2016) in order to see the potential and the real scope of the CP. So members of the GB may help and commit to submit practices. Also the number of professionals using the CP can be an indicator.

Ingrid Keller from the Health Programme Unit of the EC explained that there are other JAs which develop IT tools and EC does not take over all of them. The CHRODIS Platform is a specific case different to the Health Policy Platform where the objective is not to exchange GPs. The continuation of the CHRODIS IT Platform in the second JA on chronic diseases is under the decision in the current consortium, but will also have to take into account view of new associated partners.

WP7: Presentation of the work of WP7 and Workshop on the Guide for the National Diabetes Plans

Marina Maggini presented the overview of the progress made in WP7: this includes, among others, an overview on programs/practices on prevention and management of diabetes, education of patients and training for professionals. They have mapped the National Diabetes Plans (NDP) across Europe and elaborated a policy brief. Additionally, a SWOT analysis has been developed to give a qualitative overview, by country, of the current policies and programs, including successful strategies to improve prevention of diabetes and the quality of care for people with diabetes.

WP7 has also finished the Delphi process on Diabetes in collaboration with WP4. The Delphi on diabetes defined 9 quality criteria made up of 39 categories ranked and weighted. Based on these criteria, recommendations to improve the prevention of diabetes and the quality of care were defined. Currently, the report on quality criteria and recommendations is under revision by WP7 partners. This core set of quality criteria, and recommendations are general enough to be applied in different countries and to be used in other chronic diseases.

WP7 is currently collecting the description of potential good practices on prevention, management, health promotion, education and training that could feed The CHRODIS Platform.

Next steps will be to define the Guide for National Diabetes Plans including the essential elements of any diabetes plan. A WP7 meeting in Rome on the 20-21 October was announced.

Jelka Zaletel facilitated a workshop to collect the opinions of members of the GB on the leadership from top-down and bottom-up initiatives, and the linkage between them based on the GB members' personal experiences. This will contribute to complete the Guide for National Diabetes Plans.

Closed session of the Governing Board:

Items on The CHRODIS Platform and the follow-up on the impact of the products of JA-CHRODIS on the national policies/plans of the GB Member States were already discussed at the open session.

Final Conference of JA-CHRODIS (GB´s Declaration?):

The final conference will be organised on 28th February 2017. The Co-ordinator explained the general content idea: the conference may start with a holistic view of the current situation of chronic diseases, then summarising specific products of JA-CHRODIS and it could finalise with the future steps for chronic diseases approach in a wider context, with the continuation of the 2nd JA on chronic diseases and the declaration of the GB.

IT proposed to present cases of national plans that align with products of JA-CHRODIS. In IT, one of these cases will finish at the end of the year.

IT also suggested including the added value when presenting the outputs. The cost-efficiency is a relevant factor and otherwise outputs are just theoretical. It also could be focused on the fact that beside the economic impact of chronic diseases for the society, the JA-CHRODIS results do not produce cost but rather produce savings to the system.

Regarding the GB declaration, **IT** proposed a JA-CHRODIS conference declaration.

SI indicated that for political declarations other structures should be involved (i.e., Declarations at the Council of the EU with the next presidencies on board). SI is not totally in favour of a declaration.

NO suggested that the final conference could tackle chronic disease in general and products of the JA-CHRODIS. It is important to clearly know the aim and the target group of the Final Conference in order to propose ideas.

NL wondered who will sign the declaration: all countries participating in the GB of JA-CHRODIS? If not all of them then, a signing list?

Ingrid Keller reminded that this JA-CHRODIS was conceived after the EC report to the Council on the outcome of the reflection process on chronic Diseases. She suggested that at the Final Conference improvement/s on chronic diseases planned or possibly already obtained in a country after implementing some JA-CHRODIS results could be presented.

Also to link this JA with other related ones or big projects even organising pre- or post-Conference events with them (i.e., European project regarding a pilot on Cardiovascular diseases).

Ingrid Keller invited the GB to think about the consequences and the real benefits of a GB declaration. Also considering the time frame for the Final Conference of JA-CHRODIS, the Grand Agreement of the 2nd JA on chronic disease will be closed; therefore, no real influence will be obtained. Ingrid Keller recommended going for a Council Declaration if a political commitment is clear and propose it to the next presidencies at the Council of the EU.

ES believed that we should pursue concrete/specific commitments with products of JA-CHRODIS. Coordination should reflect on the target audience for the Final Conference (policy makers, health professionals, scientists and academia, public in general…).

BE supported the suggestions of connecting with other JAs or projects and to present the output with examples of cases in countries.

FR suggested to also link JA-CHRODIS future steps within the future commitments on NCDs for 2018 under the WHO NCD Global Plan, and to present the products from WP5, WP6 and WP7 within the framework of the WHO Euro NCD plan. FR also suggested emphasizing impact of JA-CHRODIS products as a case study for policy on non- communicable disease prevention and care. This might help to broaden the scope of the outcomes.

FI suggested to have a final conference action oriented towards assessing what has changed and what has not regarding the impact and management of chronic diseases**.** FI is not in favour of a declaration and thinks it is not the right procedure and the objective is not clear. Moreover the final Conference does not need a Declaration.

DE considered presenting chronic diseases at a wider level and to bring many of the initiatives to fight them.

Coordinator said that they would take note of the different proposals and it was agreed not to go for a GB or JA-CRHODIS declaration at the Final Conference.

Activities on chronic diseases at EU level: 2nd JA on Chronic Diseases

Ingrid Keller reported that, although today was the deadline for submissions and final number was to be confirmed, up to now more than 50 Associated partners were already appointed from 22 countries (MT, PL, HU, CY, HR, Serbia and Moldova, etc.). Moldova's involvement is nevertheless pending on formalities for complete participation in the Health Programme. Some countries have

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nominated a high number of bodies (up to 8) and research institutes and universities are appointed in a higher number than in the current JA-CHRODIS. The EC budget is 5 million Euros.

An InfoDay will be held next 5th July and maybe for this JA on chronic diseases to be extended until 6 July. Moreover, an intranet for the nominees will be created and the first draft proposal would need to be finished by a date to be given by Chafea, which could be end of September 2016 already.

Following recommendations from the evaluation of the 2nd Health Programme, Eastern European Member States should be supported for leading functions, as up to now Eastern MS are participating in JAs but they are not coordinating them, except Slovenia. Additionally, the EC must also keep in mind that an appropriate management of such a large partnership is preserved.

Regarding the criteria to validate good practices, Ingrid Keller informed that the European Commission would like to find a set of common criteria for the different initiatives that are collecting good practices (rare diseases, nutrition and physical activity…). The WHO has also some criteria, but they are too general.

The EC plans to organize a back-to-back meeting to the next GB one on 29th November with all Member States. The aim is to discuss a proposed set of criteria and these will be used to evaluate practices in general. The idea is that Member States would adopt/endorse the set of criteria at the final conference of JA-CHRODIS.

EI ask for the maintenance of the GB structure at the next JA, however, Ingrid Keller answered that it is to be decided by the new consortium.

Conclusions:

- The involvement and feedback of the GB on JA-CHRODIS and its products is of crucial relevance in order to know if they approach real needs and problems and if they would be feasible and applicable.
- WP2: suggestions were made to know the origin or background of people accessing the web-site and to increase JA-CHRODIS visibility. In order to involve policy makers, to develop summaries of the main products of JA-CHRODIS.
- WP5: The objective is to describe common patterns for the transferability beyond the specific practice. Support for an evaluation process and information on costs were requested. Cross-border study visits may also help to identify hard core elements of transferability.
- WP6: General agreement to the list of components as starting point. For a model the relationship between components might be described. Although little evidence exists, the cost-effectiveness aspect was suggested as an improvement and pilot studies as a way to get it. A questionnaire on the applicability of the MM care model will be distributed for the GB contribution.
- WP4: sustainability might be considered by the members of the GB after testing the functionalities of The CHRODIS Platform (from 4 July). The conflict of interest and incentives for the owners of the practices were discussed.
- Preliminary suggestion for the Final Conference:

- To present national cases aligned with JA-CHRODIS products;
- Considerer the cost-effectiveness aspects in the outputs presented;
- Just to issue the JA-CHRODIS conclusions of the Final Conference. ;
- Presentation of the set of criteria to evaluate good practices at the final conference of JA-CHRODIS.

- 2nd JA chronic diseases:
  - More than 50 AP from 22 countries (Serbia and Moldova) up to the time. Final number still tbc.
  - GB structure to be discussed in the consortium.

Next steps:

- Collect feedback from the Governing Board to JA-CHRODIS' key deliverables/milestones.
- Contributions of the GB to the WP6 questionnaire on applicability of the MM care Model.
- Stakeholder Workshop with the European Parliament 28th November 2016 tbc.
- Next meeting GB 29th November 2016.
- Back-to-back meeting to the one of the GB 29th November, calling Competent Authorities of all Member States on general criteria to evaluate good practices.

Link to presentations: http://www.chrodis.eu/event/3rd-ja-chrodis-governing-board-meeting/

Annex 2. Minutes of the 4th Meeting of the GB

4th MEETING OF THE GOVERNING BOARD

29th November 2016

Venue: Netherlands House for Education and Research (Neth-ER)
Brussels meeting room
22, Rue d'Arlon
Brussels 1050, Belgium

AGENDA

OPEN SESSION WITH THE EXECUTIVE BOARD	
9:15-9:45	**Opening** **Carlos Segovia,** Coordinator of the JA-CHRODIS, Carlos III Health Institute. **Paloma Casado**, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality. **Ingrid Keller,** Policy Officer – Chronic Diseases, Health Programme Chronic Diseases Unit, DG SANTÉ, European Commission **Countries' Tour de Table**
9:45-11:00	**Follow up on JA-CHRODIS** **Carlos Segovia.** Coordinator JA-CHRODIS
	Recommendation report on applicability and transferability of practices into different settings and countries. **Alexander Haarmann** (WP5) **Q&A**

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	Guide for the National Diabetes Plans. **Jelka Zaletel** (WP7) **Tour de Table**
11:00-11:30	**Coffee break**
11:30-13:30	Exchange of good practices (CHRODIS Platform)**, Enrique Bernal** (WP4) **Tour de Table**
	Skills and competencies for case management training programmes. The curricula of case manager. **Graziano Onder & Rokas Navickas** (WP6) **Q&A**
	Dissemination JA-CHRODIS and Final Conference. **Anne Pierson** (WP2) **Q&A**
	Impact Plan and Evaluation JA-CHRODIS. **Rogerio Ribeiro** (WP3) **Q&A**
	Facilitator: Carlos Segovia. Coordinator JA-CHRODIS
13:30-14:30	**Lunch**
CLOSED SESSION OF THE GOVERNING BOARD	
14:30-16:45	**Discussion of the following topics:** • Terms of use of the JA-CHRODIS Platform • Intervention of the GB in the Final Conference of JA-CHRODIS (27/28 Feb 2017) • Member States' plans to implement products of the JA-CHRODIS • Update on the 2nd JA on Chronic Diseases • How to improve the work of the GB in the next JA on Chronic Diseases **Facilitator**: **Ingrid Keller** (European Commission)
16:45-17:00	**Conclusions and next steps** **Paloma Casado**, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality

Objectives:

- To follow-up on progress of the Joint Action CHRODIS
- To get feedback on the activities of the Joint Action CHRODIS
- To share information about the use/impact of the products of the JA-CHRODIS at the national level among members of the GB.
- To comment on the Terms of use of the CHRODIS platform
- To discuss on the GB's contribution/intervention at the final Conference of the JA-CHRODIS
- To discuss how to improve the work of the GB in the 2nd JA on Chronic Diseases
- To introduce JA-CHRODIS to countries that will participate in the new Joint Action on chronic diseases

Participants:

- Representatives of the Ministries of Health of the following countries: AT, BE, BG, CY, HR, EE, FI, FR, DE, EL, IT, LT, NL, PT, SI, UK, ES, and NO (Members of the GB)
- Representatives of the Ministries of Health of the following countries that will participate in the 2nd JA on Chronic Diseases: Czech Republic, Iceland, Ireland, Malta, Moldova, Serbia and the Slovak Republic
- Representatives of the European Commission.

- Representatives of the WHO Regional *Office* for *Europe*.
- Members of the Executive Board.

Expected outcomes:

- To receive feed-back to the "*Guide on National Diabetes Plans"*
- To inform about and facilitate the use of the Chrodis Platform in the different countries participating in JA-CHRODIS/in the new Joint Action
- GB to comment on the Terms of use of the JA-CHRODIS platform
- Recommendations for improving the work/impact of the GB of the next JA on Chronic Diseases

'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.

List of participants

Governing Board members

SURNAME	NAME	ORGANIZATION
ARRIAGA	Miguel	Ministry of Health, Portugal
BOURGEOIS	Jolyce	Health, Food Chain Safety and Environment, Belgium
BRUNOT	Alain	General Directorate for Health, France
BUDEWIG	Karen	Federal Ministry of Health, Germany
CASADO	Paloma	Spanish Ministry of Health, MSSSI, Spain
FOTEVA	Elvira	Ministry of Health, Bulgaria
NICOLETTI	Giovanni	Ministry of Health, Italy
OGAR	Petter	Ministry of Health, Norway
POLJICANIN	Tamara	Croatian Institute of Public Health, Croatia
SARLIO-LÄHTEENKORVA	Sirpa	Ministry of Social Affair and Health, Finland
De ZWART	Wil	Ministry of Health, Welfare and Sports, Netherlands

Invited Ministries of Health

SURNAME	NAME	ORGANIZATION
MATLONOVA	Zuzana	Ministry of Health, Slovakia
PAKOVIC	Ljubica	Ministry of Health, Serbia

Governing Board Secretariat

SURNAME	NAME	ORGANIZATION
ARIAS	Carmen	Ministry of Health, Social Services and Equality, Spain
SAIZ	Isabel	Ministry of Health, Social Services and Equality, Spain

European Commission/CHAFEA members

SURNAME	NAME	ORGANIZATION
KELLER	Ingrid	DG Sante –EC
SPANINKS	Thilo	DG Sante –EC

Executive Board members

SURNAME	NAME	ORGANIZATION
BERNAL	Enrique	Instituto Aragonés Ciencias de la Salud, IACS, ES
CEDIEL	Patricia	Institute of Health Carlos III, ISCIII –FCSAI, ES
DEL RÍO	Catalina	Institute of Health Carlos III, ISCIII –FCSAI, ES
ESPALLARGUES	Mireia	Agency for Health Quality and Assessment of Catalonia, AQuAS, ES
GALLINAT	Anna	EuroHealthNet, BE
HAARMANN	Alexander	Federal Centre for Health Education, BZgA, DE
JUREVIČIENĖ	Elena	Vilniaus Universiteto Ligonés Santarişkių Klincos, VULSK, LT
LAUNA	Ramón	Instituto Aragonés de Ciencias de la Salud, IACS, ES
MAGGINI	Marina	Istituto Superiore di Sanità, ISS, IT
MAMMARELLA	Federica	Agenzia Italiana del Farmaco, AIFA, IT
ONDER	Graziano	Agenzia Italiana del Farmaco, AIFA, IT
PIERSON	Anne	EuroHealthNet, BE
RIBEIRO	Rogério	Portuguese Diabetes Association, APDP, PT
SEGOVIA	Carlos	Institute of Health Carlos III, ISCIII, ES
ZALETEL	Jelka	National Institute of Public Health, NIJZ, SL

Main conclusions:

- WP5:
  - Success factors for transferability of Good Practices (GPs) were found interesting in particular the modularity. These factors probably could be useful in fields other than health promotion and prevention.
  - In order to create ownership for the transfer of a GP it is important to raise acknowledgement of the project and to implement it at local level with a key person involved.
- WP7:
  - The innovative value on leadership of the developed Guide for National Diabetes Plans (NDP) could be a useful tool for political change. Social skills more that medical science ones could help in the evaluation.
  - It was asked that the Guide for NDP could have a broader scope/ visibility for cardiovascular risk and other NCD.
  - Further details would be needed for the implementation and use of the Guide for NDP at Primary care level.
- WP4:
  - A general interest on the JA-CHRODIS Platform (CP) was expressed by several countries in particular when including information from different EU projects on chronic diseases (i.e. SIROCO project, etc.) and adapting the platform to the EU set of quality criteria to evaluate GPs.
  - Some concerns where the long term sustainability of the CP, the difficulties related with the reviewers, the language limitation, the incentives for the owners to upload GPs into the platform and the update of the GPs.
  - The flexibility to include different projects and the EU set of quality criteria for GPs is an advantage of CP. Using a translation engine, the creation of a Federation of platforms with the same mechanism and reviewers and the development of a sustainability plan foreseen at the next JA CHRODIS Plus were indicated as some solutions to the concerns of the MoHs. Finally an incentive for the owners could be having a European evaluation of their practices together with getting in contact with a practice community. It was propose to include a continuous evaluation mark to assure the updating of the GPs.
- WP6:

  The definition of skills and competencies for case manager and the basic structure of the training programme were useful for the MoHs however awareness were raised to focus at the definition of the functions for case manager and to avoid the contracting issues.
- WP2:

  Invitations for participating at the final Conference of JA-CHRODIS were already been sent to Minister of Health of Finland, Germany, Bulgaria, Malta and Spain. It was suggested to avoid duplication on topics addressed by the different participants.
- WP3:

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Final evaluation report of JA-CHRODIS will be ready for final conference. Suggestion to include a deeper assessment of the evolution of the work of the partnership will be taken into account for the next JA CHRODIS-Plus.

- Terms of use (ToU) of the JA-CHRODIS Platform:
  After discussion it was agreed to adopt the proposed ToU of the CHRODIS Platform but to added instruction to the helpdesk reviewers indicating that content of the Digital Library should be limited to documents, web sites, etc. only from public institutions/bodies, until and editorial policy document is developed.
- Member States' plans to implement products of the JA-CHRODIS:
  Although subject to deeper analysis and further political support and time, MoHs indicated several products of JA-CHRODIS or CHRODIS-Plus they could use/implement: JA-CHRODIS platform, case manager training programme, key issues on the scalability of GPs and the GPs on health promotion and prevention that continued to be a field of interest for next JA. Moreover, for CHRODIS-Plus, it was asked to have a more horizontal approach for all NCD and to link with the WHO Global Plan for NCD, and to have more specific examples of GPs on Multimorbidity management and diabetes.
- 2nd JA CHRODIS-PLUS:
  Implementation and piloting activities will be the cornerstone for next JA CHRODIS-Plus but GB would be asked to promote the political interest and the integration of products into national/local policies. Members of the GB pointed to the many layers of decisions from the ministerial to the local ones and the lack of enough time and evidence on cost-effectiveness as main difficulties.
- Improvement of the work of the GB in the next JA CHRODIS-PLUS:
  In general the continuation of the Governing Board for the next Joint Action was supported however several items to improve its work for next JA were mentioned: work with summaries of deliverables, improved feedback from GB and dialogue with leaders of the WPs, clearly formulate the purpose of meetings and feedback from GB, guarantee a quality threshold of the deliverables and maintain a fluent dialogue with the new Steering Group on Promotion and prevention of the European Commission.

Next steps:

- Report of the 4th meeting of the GB 29th November 2016
- Issue the 3rd deliverable (M37) from the GB.
- Collect feedback from the Governing Board to JA-CHRODIS' key deliverables/milestones from WP5 and WP6.
- Final Conference 27th-28th February 2017.

Link to presentations: http://chrodis.eu/event/ja-chrodis-4th-governing-board-meeting/

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Meeting contents

Opening

Carlos Segovia, Coordinator of the JA-CHRODIS, Health Institute Carlos III, welcomed all the participants to the fourth and final meeting of the Governing Board in particular to representatives from Ministries of Health (MoH) from Slovakia and Serbia that will be partners at the next Joint action (CHRODIS Plus).

He encouraged members of the GB to take this last opportunity to interact with the leaders of the work packages and give their feedback to the different products and deliverables produced to the date.

Paloma Casado, Deputy Director for Quality and Cohesion, Spanish Ministry of Health, Social Services and Equality, thanked everybody for coming. Paloma stated that the GB has been a pathway to collect MoH`s opinions on JA-CHRODIS products and to provide political relevance to JA-CHRODIS in order to facilitate the implementation of the results obtained.

Paloma also remarked that it has been a learning experience and an important mechanism for cooperation that can be taken forwarded and can be improved at the second JA, CHRODIS Plus.

Ingrid Keller, Policy Officer – chronic diseases, Health Programme Chronic Diseases Unit, DG SANTÉ, European Commission, suggested that being this the last meeting of the GB, members should participate actively. Ingrid reminded that EC does not want deliverables for their archive but for benefit of MoHs, for being used and piloted in their countries.

There are many meetings these days regarding JA-CHRODIS, CHRODIS Plus and the new EC Steering group on promotion and prevention, and it is important to link this GB to the one foreseen at the next JA, CHRODIS Plus especially within the work of the next WP4 that will include sustainability and policy action.

After a round table presentation, the coordinator and leaders of the different work packages (WPs) reported on their work progress.

Follow up on JA-CHRODIS (WP1)

Coordinator, Carlos Segovia presented and overview of the last relevant events since last GB meeting in June and he explained future events, primarily focus on dissemination activities (conferences, webinars, final Conference…). Carlos briefly explained some aspects of the proposal of the next JA, CHRODIS Plus that is much focus in piloting projects and implementation. Moreover, Carlos indicated that WP4 will develop activities on integration in National Policies and sustainability and this WP4 will be relevant for the interaction of the GB and EB of next JA.

Recommendation report on applicability and transferability of practices into different settings and countries (WP5)

Alexander Haarmann, leader of WP5 explained the work performed for this task.

They based their work on the results of 7 study visits of the GPs on health promotion and prevention identified and selected by partners in the WP5. Alexander briefly described each of the 7 study visits conducted.

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WP5 found that due to the different context it is difficult to identify the success factors for scaling up and it always would be subject to adaptation before the transfer, nevertheless WP5 has highlighted the following key factors in a preliminary report to the recommendation deliverable being prepared:

- Balance of bottom up and top-down approaches with inclusion of the target population when planning the intervention.
- Commitment and persistence of a key figure with high social skills at the implementation level.
- Intersectoral, multilevel and multiprofessional approach with commitment also at the highest level.
- Having a common core framework and adapting it to local needs.
- Evaluation plan with special emphasis on monitoring.
- Long term programs with regular funding.
- Modularity of different parts of the project that can be transferred separately and according to specific needs.
- Alignment with Regulation and legislation.

Alexander described other activities performed at conferences, WP meetings, etc.
The emphasis of the next JA CHRODIS PLUS would be the factual implementation of GPs and for that MoHs could help by answering questions such as: National preferences on particular GPs? National/regional/local needs? Support activities along the implementation…
MoHs could be asked for GPs to be transferred from one country to another.

Discussion
BE: Found very interesting the success factors described and would like more information on the report on how to apply them. →WP5: WP5 partners are thinking in including a mix of 1) a check list of what it would be needed to transfer a GP with 2) more information of each item that could be used according to the implementer's needs (modular transfer of a GP).
FI: Finnish MoH is working on transferring GPs at national level and will take into account these key factors. In general, GPs have a core of the practice and then, there is a variable flexibility on other aspects of the practice when transferring them to another setting.
FI wondered how many of the selected practices have been transferred. It is important to analyse the barriers for transferring GPs and to have flexibility for adapting them to local level. FI also asked how to create ownership at the new setting. →WP5: Up to now, none of the GP visited have been transfer to another setting. However, 50% of the GPs visited are similar projects between them, and therefore may be transferable..
For ownership, the more a practice is better known, the more accepted it could be in a new setting. Moreover, as soon as you start implementing a GP with the involvement of a key person at local level with commitment and with high social skills, the ownership also starts to increase.
Coordinator: Apart from these key factors, he asked how to develop the framework analysis for scaling up GPs. →WP5: Answered that you could take into account the Delphi criteria, relevant references and bibliography, then select from a list of identified GPs one that has been used in different settings and with a broad range of age, to scale it up.

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ES: Asked if these key factors are only for the scaling up of promotion and prevention GPs. → WP5: said that in view of deliverables from other WPs as the Guideline for NDP, it is possible that these key factors are also useful in other fields.
Coordinator: mentioned the difficulties in the coordination of different sectors as the health and social sectors and asked if WP5 found this difficulty at the study visits and if this could be a barrier for scaling up GPs. → WP5: Answered that it could be a barrier but in many of the practices visited the involvement of many different stakeholders was in place (agriculture, urban, health, etc sectors …) and still they were selected as Good Practices, so the coordination difficulty can be overcome.

Guide for the National Diabetes Plans (WP7)
Jelka Zaletel, co-leader of the WP7 explained the content of the Guide for NDP based on the input from the WP partners and GB contribution during the 3rd meeting of the GB last June.
In order to generate a NDP many actors have to be involved but a core-group of participants in developing the Plan has to be established. Additionally communication pathways and relationships have to be managed between the core-group and the outsiders.
Leadership at the bottom-up, top-down and for the linkage at horizontal level is needed to create ownership and to adopt new behaviours by experiencing them.

Discussion
HR: expressed it was an excellent guide and asked for the PPT presentation, leaflets and any kind of support to be forwarded to this GB member, so she can use it and explain it when liaising with policy makers and different stakeholders. Croatian GB member also proposed to have a workshop next to Final conference to present this Guide.
SK: thinks it is a very innovative point of view to orientate the conformation of a NDP, especially relate to leadership.
→WP7: offered to send/perform short presentation of the deliverables from WP7 for the GB distribution.
FR: Asked for considering the largest possible scope of the guide and more visibility of the capacity to use it not only for DM but also for other chronic diseases, first of all for cardiovascular/cardiometabolic risk. This would underscore the efficiency of the strategy through economy of scale, and prevent overlapping of policies. Otherwise, if the focus is DM as a study case an analysis of transferability of that frame to other chronic diseases would be useful. →WP7: answered than the scope from the beginning was to focus on Diabetes as a case study for strengthening health care for people with chronic diseases; however, WP7 can look for aspects that can be used to work with a broader scope. WP7 think that the Guide for NDP and the recommendations can be used in general (for different chronic diseases and for different countries and settings…).
FI: Congratulated for the work, likes the suggestion of the Guide on leadership but, as FR, chronic diseases need to be managed with an horizontal scope for different diseases and having a broader scope for policy makers.

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NO: Believed that communication of results and guide for planning is important at a political level but it would be better to show something applicable to the NCD in general, considering that in practice, General Practitioner do not work with single pathologies and people with diabetes normally have several pathologies. →WP7: in Slovenia the work with DM was one priority issue at the begging however changes performed in the health/services provision focus on DM affected to the structure of all chronic diseases management. WP7 proposed to elaborate a 1 page summary of the messages obtained in the different deliverables related to DM but making them broader to NCD. For this, WP7 called for the help from the GB in reviewing the summaries.
ES: Considering that in Spain there is a National Strategy for Diabetes stablished since 2006, ES believed that this Guide for NDP can be a good starting point to help other MoHs organising the start of NDP. For next JA-CHRODIS+, ES would rather need further development on specific ways of implement it and detailed description of GPs on Diabetes. ES believes that the only way to go from paper to real practice is through GPs. →WP7: Explained that for next JA, implementation will be the focus and JA-CHRODIS+ partners will test in practice some of the results from the current JA-CHRODIS.
Coordinator: asked how to manage the resistance for change and how evaluation can help on this. → WP7: answered that a good way it can be to help people to find the positive factors that they want to keep and the reasons of those factors to what they oppose in order to help them to find a way out. The evaluation helps knowing that everyone can keep learning and improving, and using more social skills that medical science ones.

Exchange of good practices (CHRODIS Platform) (WP4)
Enrique Bernal, leader for WP4 summarised the state of art of the Clearinghouse (CH) and the Digital Library (DL) part of the CHRODIS Platform. Next month, 20 GPs are expected to be uploaded (18 from WP5, 2 from WP7, none from WP6 or for patient empowerment). Additionally, up to now around 84 documents, web pages and other material have been uploaded at the DL.
Regarding the comments from DE to the DL, WP4 also explained that the most of the comments made do not apply to the CHRODIS platform because these comments refer to information relevant for patient clinical advice. Nevertheless, other comments have been taken into account (some of them were already included in the Terms of Use (ToU) of the Platform, whilst others have been added or improved). As for next steps the submission of GPs from different EU projects is being analysed (SIROCO project, EIPAHA, FOCUS, POLYCARE, NOURISHING…) and there is the possibility to connect the Platform with other projects as a single enter point at EU level.
For the new JA, some proposals are:

- Generate and work with a translation engine
- Community building tools
- Support tool as on-line implementation
- Work for the interoperability with other systems
- Federation of platforms: to generate ad-hoc platform for specific countries working with the same criteria and methodology but with specific adaptation for the language, the reviewers, etc.

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Now is time for the GB to decide if the JA-CHRODIS platform is useful for them.

Discussion:

BE found very useful to joint information from different EU projects on chronic diseases in a single platform and asked if it is possible to include links to web pages in languages others than English. →WP4: confirmed that although abstract and relevant information has to be in English it is possible to have links to web pages in other languages. Moreover for next JA there are several options to overcome the language issue such as the translation engine or the federation of platforms.

FI indicated that the CHRODIS Platform could be useful if many countries use it and if it is sustainable. In FI, the MoH did not finally use the Platform for evaluation of their GPs during a national call in 2016 because ofthe language limitation as English is the only language at present for the Platform. Moreover, there is another JA on obesity that also evaluates GPs and it use is not succeeding. FI asked which it was the plan to foster the use of the platform. →WP4: told that in the next JA there will be a sustainability plan and WP4 thinks that it could be sufficient if 3-4 countries want to use it as long runner partners through the federation of platforms and the maintenance of the CHRODIS Platform will not be too expensive. For incentives to owners, an idea could be to have a GP stamp by the EU. It might be also the case that some countries can be interested in certain parts of the Platform but not in others (as the NL that has a Promotion platform but may need the multimorbidity GPs).

PT MoH is currently working at a National platform for GPs and it would be a good idea to use the one from CHRODIS. The incentive for owners is that it is good just to show your results to other peers. PT MoH is still considering who would be the reviewers of the GPs at Portugal and asked how this can be linked with CHRODIS platform. → WP4: answered that if there are national reviewers for the GPs that follow the same Delphi criteria, these reviewers could just give a click and link it with the European platform.

NL congratulated WP4 for the short time used for setting up the platform as their national one took longer than 3 years. NL MoH thought it is a very good idea to joint it with other chronic diseases projects and commented that the translation issue could be a limitation factor that could delay the uploading of GPs. NL asked how the GPs will be updated. →WP4: gave several ideas on the update of GPs, from looking for an improvement in the result of the GP evaluation (i.e. the GP passes from promising to good or best in a certain time), to add a continuous evaluation mark thus old practices have to include an extra assessment (currently, there is a small check box to indicate that the GP has already been evaluated).

DE the Platform can be useful but the DE MoH needs more time to proof the Platform.

On the ToU and the comment from DE to the DL, DE MoH thinks that it would be worthy to describe a requirement that the content is evidence-based in order to limit the type of document, not only of the commercial scope but also to ensure the scientific quality scope of documents available at the DL. →WP4 believed that there is no need to manage the scientific quality of documents beforehand and indicated that the adequate measures can be taken later on.

HR might be interested in a federal Platform but asked how and who choose the reviewers. Regarding the ToU, HR thinks that there is a big difference in between the requirement for the GPs (Delphi process..) and the ones for the content of the DL (only commercial ban). →WP4 explained

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that any user can register as a reviewer and can get GPs to review. Next JA foresees to create a community of practices that may self-regulate the reviewer selection. Finally the help desk manager also supervises the reviewers' applications.

IT had some concerns regarding the long term use of the platform after the next JA and also the possible duplications that the federation of platforms may originate. It should be avoided to have different countries working on the same products independently. IT thinks that the use of the CHRODIS Platform depends on a political decision and that there could be difficulties with the reviewers (not enough in number or in quality). Moreover, this kind of platform at EU level can have a selection bias and local GPs can be lost; therefore a dissemination and encouraging campaign is needed to upload GPs and to maintain the interest on the long term, together with clearly stated expectations on what the CHRODIS platform is offering. IT thought that it is a challenge to work with other platforms from EU with different kind of products (EIP-AHA collects GPs when some of the "practices" in EIP-AHA repository are programmes…). And finally, there is a new group organized by the European Commission that will discuss how to manage the different products and projects on chronic diseases. →WP4: was aware of the current context at EU level and thinks that the JA CHRODIS platform is flexible enough to include different projects:

Regarding the EIP-AHA, it depends on the content the owners can upload information at the DL instead of at the Clearinghouse according to a final agreement with EIP-AHA currently in process.

Another option it would be to include, as an additional field of criteria, the ones from Sirocco project to the evaluation of the GPs.

Finally, the EU set of quality criteria to evaluate all GPs could adapted to the CHRODIS Platform, but the mechanism and reviewers should be kept.

In order to stimulate the proactive inclusion of GPs to the CHRODIS Platform, the evaluation process itself with the report on the results and the contact with a community of practices of health professionals could be an incentive, also the granting of an EU stamp of best practice could motivate owners to upload practices at the Platform. **ES** indicated the potential synergisms with the national methodology and indicatedthat when using also the EU common set of criteria for GPs, the added value would be to have your GP evaluated at EU level. It is also interesting the identification and implementation of a continuous evaluation process in order to ensure the updated of the GPs. In addition, it could prove an extra value to identify if the GP has been already scaled up. ES also suggested avoiding the use of any EU stamp of best practices in order to elude any confusion with the national accreditation systems.

Skills and competencies for case management training programmes. The curricula of case manager (WP6)

Graziano Onder, co-leader of WP6 explained that the work was performed by a literature review, a questionnaire to partners on case management training programmes, and a consensus expert meeting last 4th of November with the participation of the European patient Forum. He pointed out that only 15 answers to the questionnaire were received, indicating the low rate of existing case management training programmes.

The most relevant conclusions from the questionnaire where that:

- Nurses were the principal targets.
- In a 50% of the cases, formal training is needed to act as case manager
- Individual-care plans are one core element of the training programmes.

Regarding the literature review completed by WP6 on this relevant topic, from 600 studies only 3 of them could provide relevant evidence although some studies in the U.S.A system.

Experts were provided with additional information regarding the skills to become a case manager (CM) in Europe, specific competences and how should the training be delivered. As a result of the experts meeting, a definition of case manager was drafted, experts identified a list of 11 potential skills and competences for case managers and a basic structure of the training programme was elaborated during the 4th November meeting. As future steps, the developed case management training programme being drafted in WP6 should be tested in different countries for improvement. Additionally higher acknowledgement of this health professional at national and EU level should be formally recognized as a specific new role in the health care system.

Discussion

BE: The case manager definition is complex and a high topic in the agenda for Belgium. In different settings, different definitions are used. At the moment there is no uniform function description in Belgium or in the regions. There are several good practices available and the policy makers are trying to define a uniform definition (and in some regions also a function description- linked to certification or profession). Therefore the presented skills and competences are helpful for them. BE MoH considered that for complex patients with chronic diseases it is appropriate to have a reference professional that would be the case manager (Kaiser Permanent maximum top 5% of complex patients).

Coordinator: In Spain most of these competences are already performed by general practitioners. The Coordinator indicated that we should be careful not to generate a new role that may fragment the system and led the discussion towards the topic of contracting/salary rather than definition of the role. In a multidisciplinary team, all the members might perform part of the case manager's functions and the general practitioner is, in Spain, the reference professional for the patient →WP6: Although Spain might not benefit from the work completed as the role of the case manager is primarily completed by the General Practitioner, WP6 elaborated a more general definition for case manager because some countries do not have these skills described. Moreover, WP6 have worked towards the definition of functions and not of the position with salary matters. However it depends on how much time it is taken to those functions, if it is 100% of the professional time, then we might be talking of a contractual position. Moreover, at multi-disciplinary teams, normally there is one person designated with the case manager role or functions.

ES: It can be useful to know the required skills as in certain cases nurses have to be specially trained (i.e. rare diseases…)

Dissemination JA-CHRODIS and Final Conference (WP2)

Anne Pierson, leader of the WP on dissemination explained progress on the web page, currently in change and considering if it will be maintained for the next JA.

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Anne updated with last activities regarding the newsletter, monthly updates, publications performed, press release, webinars, activities in social medias, 2nd video of JA-CHRODIS, latest events including participation in EPHA session in Vienna and pre-session, and different promotional material available (posters, updated brochure,…).
Regarding the Final Conference (27th, 28th February 2017), Anne explained that invitations have already been sent to Minister of Health of Finland, Germany, Bulgaria, Malta and Spain. WP2 expected to have around 250 people attending the Final Conference in Brussels.
WP7 and WP3 asked if there would be some space for poster exhibition → WP2 answered that there will be a small place for poster display.

Impact Plan and Evaluation JA-CHRODIS (WP3)
Rogerio Ribeiro, co-leader of WP3 summarised the already finished work on the mid-term evaluation report and the work in progress on the final evaluation of the JA-CHRODIS, explaining the differences of aims for the final evaluation report and the impact plan.
The final evaluation report refers to the actual monitoring of the JA-CHRODIS including the development of a help tool to ease reports by the WPs leaders.
On the other hand, the impact plan aims at knowing what are the medium/long term consequences and the ultimate expected impact of JA-CHRODIS. It has been elaborated based on different documents (internal from JA-CHRODIS and EU documents) and will be circulated to the GB for their comments.

Discussion
NL: Is interested in the final evaluation report for the final conference as it will have pan European conclusions and findings.
FI: Asked if the WP initial tasks were defined clearly enough and if the WP's results have gone beyond what was initially stated. → WP3: Task, milestones and deliverables were clearly stated but many differences were found when monitoring the results and that is why they have developed a help tool for collecting data for the final evaluation report.
FR: As the field of chronic disease is very broad it could be useful to assess the perception/use by stakeholders of CHRODIS contributions/outcomes and their understanding of the scope of the JA: chronic diseases or focus on Non Communicable Diseases (NCD) targets.
WP7: It can be interesting that for next JA to interview different partners in order to see how to manage the partnerships (responsibilities, communication pathways…). Moreover, also a reflection on how our work has changed, if there has been an aptitude or cultural change it could also be considered a result. This can be done with a global satisfactory survey at the beginning and at the end of the JA → WP3: the survey and final evaluation report will briefly reflect the evolution on how we have worked, however deeper analysis is not possible at the time being. It can be taken into account for next JA.

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Closed session

Terms of use of the JA-CHRODIS Platform

This item was introduced at the WP4 presentation. Comments from the German MoH were taken into account, where appropriate, for the last version of the Terms of Use (ToU) of the JA-CHRODIS Platform. The ToU must be acknowledged and accepted to proceed with the user account creation. A deeper discussion among GB members took place:

DE: In general terms, Germany agreed with the proposed ToU and the development of an editorial policy separately that would cover the remaining concern: DE MoH still has the concern that, even though the intention of the Platform is not to provide medical advice to individuals, documents found in the Digital Library could generate misleading messages on scientific or medical recommendations/guidelines (for example, if information is uploaded on the use of genetic tests for screening of NCD it could be understood that this kind of test are "recommended".).

FR: Asked about the reviewers in charge for the content of the Digital Library (DL) and if it would be necessary to define the type of document that would be accepted as good evidence support. If it is not established from the beginning FR recommended having a strong reminder to the reviewers in checking what is being uploaded in the DL in order to keep control of the quality of the content. MoHs might agree on the usefulness of strategic documents from public institutions/bodies but there is much more uncertainty on others sources. The principal product of the JA-CHRODIS Platform is the Clearinghouse of GPs, we must be careful not to create confusion for users because of double standard between GPs and DL on the same website.

IT: indicated that the German comments should be included in a different document (i.e. Editorial policy) and not in the ToU which only addresses the user's relationship with the platform as a contractual document but not the content per se. In that other document (editorial policy), issues such as procedures when the content is not adequate should be also included (i.e. avoid the publication or even deny access to a user). For IT, it was a bit confusing the differences in the level of restriction to upload content in between the Clearinghouse (for GPs a whole process of evaluation with Delphi criteria) and the DL (none restriction at all). Therefore, in addition to the ToU, the editorial policy document should also apply for CH and DL. Regarding the criteria to define quality of the evidence, IT recommended that GB should not comment on what is accepted as good evidence and GB should be careful with the requirements to apply, because sometimes the fact that a document has been issued by a public body does not mean that it does not have any conflict of interest.

NL: suggested to look for editorial policy documents in other platforms.

FI: FI MoH was also concerned about the quality of content if the DL is open with permissive requirements, for example low quality in literacy material, etc. FI MoH suggested to start with a set-up approach limiting the DL content to documents from official and public bodies and wider to other type of documents at a later stage.

PT: said that PT MoH has already elaborated a similar document for national use that can be distributed as a proposal to JA CHRODIS. PT MoH also proposed that a control on the documents to

be uploaded in the DL could be performed at national level when the "federation of platforms" is established. However, if the control is too restrictive the DL may not be successful.
NO: also thinks that the important product of the platform are the GPs; still, limiting the DL content to only documents from official and public bodies would also be a good solution at this stage.
Coordinator answered the comments and summarized the conclusion reached: The idea was not to limit the content of the material to be uploaded in the DL at the beginning and if the help desk manager identifies any irregular aspect, then adequate measures can be taken. Additional would be 1 or 2 persons as help desk managers to review the content of DL. Regarding the type of evidence there would be a great variety of documents and it would be difficult to determine a set of common criteria to fit all possible type of documents. Therefore, and after this discussion, GB members could agree to adopt the proposed ToU and to review the Editorial policy when developed. Additionally, an instruction should be issued to the helpdesk reviewers, indicating that content to be uploaded in the DL should be limited to documents, web sites, etc. only from public institutions until the editorial policy document is developed.

Intervention of the GB in the Final Conference of JA-CHRODIS (27/28 Feb 2017)
Regarding participation of the Minister of Health from Spain, Finland, Germany and Bulgaria, members of the current Governing Board, it should be good to avoid duplication on topics to be approached.
ES: The proposed participation of the Spanish Minister of Health would be at the welcome. Therefore, it would be a general intervention on the challenge of chronic diseases and the different approaches carried out by Spain including the work and results of JA-CHRODIS which can support our National Policy or Programme on chronic diseases.
FI: indicated that a possible topic for their participation would be the implementation of GPs uploaded at the JA-CHRODIS Platform.
DE: would need to confirm their participation and could not give any preliminary comments.

Member States' plans to implement products of the JA-CHRODIS
Coordinator noted that it is of great importance that deliverables produced in JA-CHRODIS could be used and implemented in the Member States. This is also a priority for next JA and Carlos invited members of GB to indicate, here or in writing, which deliverables GB members would like to see as a result for the implementation in their respective countries.
HR: Told that for their MoH actions in prevention and diabetes are a priority. HR MoH found the JA-CHRODIS Platform is a very good tool but HR MoH needs to think on the option of a customised platform. Croatia announced that they will participate, not only at the GB but as an associated partner in next JA and enquired on the pilot study HR associated partner will work in and the number of person days.

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BE: would be very interested in using the case manager training programme, once BE MoH reviews the actual report (not jet available). Moreover if any pilot study on the case manager training programme is performed at the next JA CHRODIS Plus, BE would also value this information. →EC referred that there are ongoing works at EU level on curricula for the health workforce and may be it would be interested to have EU CV for case managers. EC also indicated that for further piloting of specific deliverables from JA-CHRODIS (as the case manager training programme), representatives from MoHs in the GB would have to express their interest in order to guarantee that it can be performed at the next JA. Rokas Navickas said that he would confirm if any pilot on this is already proposed for the next JA as a part of the deliverable of MultiMorbidity care Model (MMM) and Rokas thought that if not already proposed, it could be possible to look into it.
FI: asked for a more horizontal approach for all NCDs and not so focus on Diabetes. Health promotion and prevention is very important for FI.
FR: France has a national strategy for health with focus on chronic diseases prevention and care, reinforcement of primary care, patient's rights, and tackling health inequalities that is consistent with JA CHRODIS outcomes. FR is promoting the GP platform to national bodies, as European resource and opportunity for national needs. References to comprehensive NCD prevention and management tools would help for dissemination, independently of disease-specific targets choices, in national policies.
The French MoH will participate, likely; only in the GB and would find interesting the link with the WHO Global Plan for NCD. →EC commented that the National Institute of Cancer from France will also be an associated partner.

ES: Told that the MM care Model was in line with the national Strategy to address chronic diseases but ES MoH would like to have specific examples of good practices on multimorbidity management that could illustrate how this conceptual MM care model can be implemented on the ground.

Similarly, on the Guideline for National Diabetes Plans, ES indicated that this initial document was adequate and in line with our National Diabetes Strategy, but ES MoH would appreciate further development with specific details and GPs for the efficient implementation of a whole National Diabetes Plan.

The uploading of the GPs at the CHRODIS Platform would be also of interest for ES.

Finally, ES said that key issues on the scalability of good practices developed at WP5 would be also used and taken into account at national level.

NL: pointed out the presentation from the Netherland at the final conference on Dutch implementation of the JA-CHRODIS MM care model as an example of a JA-CHRODIS deliverable implemented. NL MoH has participated at the WP5 study visit "Well London/Communities" London and was actually discussing with municipalities at NL how to implement it.

The NL found very fruitful the discussion on the JA-CHRODIS platform and would work on it with their professionals.

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For next JA NL MoH was very interested on the interaction of health promotion and the cure/treatment side, how to link them and where to allocate the promotion (i.e. NL has physical activity included as a treatment).

NO: explained that since 2013, the NO Health System began the re-orientation towards a primary care team for care and follow up of chronic patients, in line with the product from JA-CHRODIS. However, structural changes are necessary for the actual implementation of some deliverables which require political support and time.

NO shared the generic way of thinking on a general team with a coordinator in charge of each patient using a risk stratification tool (ASSES). However, a flexible and quick implementation is a trouble for NO as their Health System was not organised in this way. → EC noted that NO is not an associated partner in the next JA and pointed out that implementation is the focus for the next JA; EC encouraged NO to participate in the GB of the next JA.

RS: will participate at the new JA (as associated and collaborating partners) and are very interested in the upcoming products.

BG: expressed BG MoH interest in the Work Package of prevention and promotion because for them, it is difficult to include new recommendation and practices and any help is good. BG MoH would also participate in the case study on m-health.

Update on the 2nd JA on Chronic Diseases

Coordinator explained a summary of the 2nd JA on Chronic Diseases (JA-CHRODIS PLUS):

The objective is to develop a common methodology for the actual implementation (including monitoring and evaluation) of Good Practices. The JA will perform several pilots (ICT based patient empowerment, health prevention and promotion, multimorbidity, management of chronic disease, etc.) and will also provide specific support to people implementing GPs. Management, governance and sustainability aspects were also noticed. It would be helpful to know what MoHs need to improve in order to provide genuine and useful products.

Ingid Keller from EC pointed out that the EU added value is an essential requirement for the Commission as it could be the implementation of specific products from CHRODIS in a different Member State. Next JA foresees a tool of policy dialogues that can also help to implement products at regional level if more feasible. Additionally implementation of products can help MoH to reach targets stablished at WHO Global Plan for NCD but a minimum of political interest is needed. EC mentioned that there are many projects working on chronic diseases (last heard selfie2020) that should be taken into account and some of them had a small budget but have obtained good results (EIP-AHA, twinning programmes).

Rokas Navickas, Scientific Coordinator of the next JA, explained that with the implementation and piloting activities the next JA expects to answer the queries from the GB in the JA-CHRODIS regarding "how to do things". He expected that in turn the GB in the next JA will promote the integration of products into policies. He announced a new mandate for the GB in CHRODIS Plus.

IT wondered why this has not happened in JA-CHRODIS, where partners may be have developed documents that where familiar to them but were not interesting enough for MoHs, in addition to a lack of political impact.

FI indicated that many factors influence the implementation of GPs (legislation, financial, political..) and believed that it is critical to involve local agents. Therefore FI hesitated if the ministerial representatives at the GB would be the right representatives. Another problem is that for the finance aspect the cost-effectiveness can only be known at a long term.

DE and NL said that because there are many layers of decision and many sectors involved it is very slow to go from the ministerial level to the local ground and it is difficult to transmit messages across levels.

FR: Recommended to clarify the orientations of the JA, within the framework of the WHO Euro action Plan for NCD. FR observed that some topics are more successful that others, according to national agendas. FR suggested increasing the participation of patients, pushing for change and on products that documents are issued not only for health professionals, but also adapted to broader audience/stakeholders.

Rokas Navickas thinks that GB can boost products in local policies and this can encourage professionals to look for more information. Moreover, GB can highlight the results to institutions and offer CHRODIS+ to help when starting to implementing GPs. Coordinator, Carlos Segovia, indicated that collaborating with stakeholders can help to be more flexible, taking into account their different priorities, and believed that pilots can give good practical examples.

How to improve the work of the GB in the next JA on Chronic Diseases

Some items already mentioned during this meeting were reminded:

- Work with summaries of the deliverables
- Improved the feedback from the GB
- Use ICTs as communication pathways (webinars…)

HR agreed on the usefulness of summaries and proposed to develop more surveys to the GB including questions on change in policies in their countries.

NO would have liked to have the purpose of the meetings more clearly formulated and to know more exactly what was expected from their comments as GB members and feedback.

ES suggested to improve the dialogue in between the GB and leaders of the WPs and to increase EB awareness on the relevance of GB's opinions for their work. ES believed that in order to stimulate the issue of opinions and feedbacks from the Ministries of Health a quality threshold of the WPs' deliverables has to be guarantee. Additionally the organization of some logistic details (i.e. time frames, and communication pathways among EB and GB before deliverables are sent to CHAFEA) should be checked for next JA. Finally, ES found very interesting the creation of a new Steering Group on Promotion and Prevention by the EC; however a fluent dialogue should be kept in order to avoid duplications and enhance synergies.

IT made a request to get more benefit from the CHRODIS Platform and proposed to collect national papers and documents to upload them.

EC briefly explained the objective of the Steering Group in promotion and prevention as to coordinate EU work in this field by expert groups, projects and Committees. This Steering Group will develop a common set of quality criteria for GPs to identify GPs from different EU funded projects. Then prioritise those best Practices and support for their implementation at the Member States. EC pointed out that some countries will participate at the WP4 of CHRODIS + (SK, IT and BE), dealing among other issues with the sustainability of the JA, and called for the respective MoH collaboration in this regard.

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Annex 3. Feedbacks received from members of the GB

This annex contains the written comments received via email from the Members of the GB to deliverables/milestones identified for feedback in the GB Framework Plan, approved by Executive Board in June 2015 and sent to the GB members in September 2015. The GB Framework Plan was further updated in May 2016.
The Framework Plan of the GB also establishes the criteria for reviewing JA-CHRODIS deliverables and milestones which are listed below.
Additional comments to the deliverables completed during the Governing Board meetings are included in the minutes of those sessions.

Criteria for reviewing JA-CHRODIS deliverables and milestones
The following criteria were suggested to the GB members when giving feedback to the deliverables:

- Do you think that this deliverable aligns with the interests of your country in addressing chronicity?
- Which barriers would you find for the application of this deliverable in your country?
- Which facilitators would you find for the application of this deliverable in your country?
- Would it be feasible to apply this deliverable in your country?

Deliverables/milestones for feedback of Governing Board members
The following JA-CHRODIS deliverables were selected to receive feedback from the GB members *(in order on when they were produced and circulated to the Governing Board)*:

- D07-02 Report on care pathways approaches for multimorbid chronic patients (included the meetings with experts to assess accuracy of collected evidence and select good practices, identify commonalities for care management of multimorbid patients).
- D04-03 Recommendations to improve the quality of care of people with diabetes: minimum set of indicators.
- D04-02 Guide for National Diabetes Plan - Lessons learnt from the National Diabetes Plan to support development and implementation of National plans for chronic diseases
- D06-03 Recommendation report on applicability and transferability of practices into different settings and countries
- D07-03 Reports on meetings with experts for designing multimorbidity case management programmes

D07-02 Report on care pathways approaches for multimorbid chronic patients (included the meetings with experts to assess accuracy of collected evidence and select good practices, identify commonalities for care management of multimorbid patients)

This deliverable was circulated for feedback to the GB members on 11th of March 2016. The Governing Board members from Spain and France provided written feedbacks that were sent to the Coordination of the JA-CHRODIS who forwarded them to the Work Package Leaders responsible for this deliverable (WP6).

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1. **France feedback to D07-02 Report on care pathways approaches for multimorbid chronic patients (included the meetings with experts to assess accuracy of collected evidence and select good practices, identify commonalities for care management of multimorbid patients)**

"It shows that this care model is well related with the public health issues in France. Interestingly, the key points underscored by the French National Authority for Health (HAS): ageing (and multi-risk) patients, patients centered care, patient involvement (education and support), inappropriate care (especially for ageing people) are relevant to prevention issues, beyond multimorbidity context."

The following information was attached with the email received where 3 annexes to the feedback to the deliverable were included:

HAS' comments and replies on the CHRODIS WP6 – model care for multimorbidity - proposals

Nathalie Riolacci[1], Emmanuel Corbillon[1], Anne Françoise Pauchet-Traversat[1], Marie Hélène Rodde-Dunet[1], Caroline Abelman[2], Juliette Dubois[2] & Catherine Grenier[3] MD, MPh, MBA

1. Department of care coordination, appropriateness and quality of care; 2. Legal department; 3. Director, Quality and security improvement direction (DAQSS), French National Authority for Health

Do you think that deliverable or milestone aligns with the interests of your country?

The French National Authority for Health (HAS) is an independent public scientific authority with an overall mission of contributing to the regulation of the healthcare system by improving health quality and efficiency. HAS helps public health decision makers to work on new quality challenges of health system. Care of the multimorbidity is a key issue for the HAS; the multimorbidity is considered as the most common chronic disease. So, the CHRODIS work on the multimorbidity care model aligns with the main health key issues in France.

The main characteristics of the multimorbidity in France were recalled in the document "the note méthodologique sur la polypathologie" (French version only available). http://www.has-sante.fr/portail/jcms/c_2028194/fr/prendre-en-charge-une-personne-agee-polypathologique-en-soins-primaires; http://www.has-sante.fr/portail/upload/docs/application/pdf/2015-04/note_methodologique_polypathologie_de_la_personne_agee.pdf

From the HAS thinking and work on this topic 3 main issues may arise:

1. *The multimorbidity is associated with advanced age or functional disability (somatic, cognitive, or psychological disease or the social vulnerability or a combination of any of three). These 3 associated factors should be considered in thinking about the care model. That means that geriatric, social and psychological skills should be a key part in the model and so be available and appropriate. These populations are referred to as "people in complex situations"*
2. *The role of the patient and informal care-givers should be considered. A lot work should be done (i) to develop educational supports and services to improve the patient education, (ii) to support patients along the care process. Comments on the patient education are provided in the annex 2.*
3. *These populations are often exposed to inappropriate cares. The HAS worked since 2005 to reduce inappropriate prescriptions (Annex 1: works undertaken with Pr. Sylvie Legrain to optimize the medicine prescription in the annex 1) and works on the detection and discharge of the frail people or/ and people in a complex clinical situations (Annex 3).*

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Which facilitators for the application of these recommendations?

Many legal devices or approaches for collaborative multidisciplinary care have been adopted: network, mobile team, PAERPA2, CLIC3 or MAIA 4; their effects on the care routine practices and benefits for the patients are not generalized. Working on these issues through the promotion of thematic programs could be an effective mean to heighten awareness and skill of all actors (examples: how to reduce readmissions of patients with heart failure, how to promote the rehabilitation for patients with broncho -neumopathy exacerbation etc.). The HAS could help public decision makers to launch and evaluate services dedicated to these issues. The HAS provided legal devices dealing with issues with tools (PAERPA tools).

The assessment of PAERPA could provide the HAS with information on facilitators and barriers.

Which barriers for the application of these recommendations?

The initial medical education does meet the needs of the people requiring the care which today challenges our health system. The question is how to switch from a disease management to a care/ patient centered care. Multidisciplinary approaches are still too little supported through the continuous medical education. New approaches may lead to revising the relationship between medical practitioners and other health or social provider and help to redefine the skills for each professional. Lastly the place and role of the patient and relatives should be revised, promoted and supported. Skills for leading multidisciplinary approaches are not enough available to support this purpose. Financing the collaborative approach and patient centered care is not enough/ insufficiently developed.

Which conditions for implantation these recommendations?

The promotion of cooperative care with specific fees for each professional and health sectors could have a leverage effect on the dissemination of these recommendations.

Consumers and the patient organizations may put pressure on the system and professionals to a more effective collaboration.

Annex 1. Synthetic overview of the HAS production on Polypharmacy /multimorbidity / iatrogenicity (2005-2015). Rational

Many elderly people take multiple medications, usually for multiple health disorders. This "polymedication" increases the risk of iatrogenic disorders, may affect adherence to treatment, and represents an economic burden for society. It is therefore essential to optimize drug prescription to the elderly. The general practitioner is most involved in treating the elderly, who tend not to consult specialists as frequently as younger adults do. Most elderly subjects with comorbidities and

[2] **PAERPA**: **P**ersonnes **A**gées **E**n **R**isque de **P**erte d'**A**utonomie: Elderly at risk of losing autonomyhttp://social-sante.gouv.fr/IMG/pdf/1.brochure_generale.pdf.

[3] **CLIC : C**entre Local d'**I**nformation et de **C**oordination (des soins et aides pour les personnes âgées). Local Information and Consultation Committee for the aids and cares aged people. The role of the CLICK was reaffirmed by the law n°2015-1776 of December 28th, 2015 relative to the adaptation of the society to the ageing

[4] **MAIA** ; **M**éthode d'**A**ction pour l'**I**ntégration des services d'aides et de soins pour l'**A**utonomie des personnes Method of action for the integration of help services and care in the field of the autonomy http://www.cnsa.fr/documentation/CNSA_CahierPe_dagogique_MAIA_HD.pdf

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polymedication are excluded from clinical trials, and geriatrics is not considered a priority during medical training. Three suboptimal prescription modalities have been described in the elderly population: "overuse", "misuse", and "underuse".

Adverse drug reactions are frequent in the elderly and have a major economic cost. They are behind about 10 % of hospital admissions over the age of 65, and 20 % over 80. Yet most adverse drug reactions are preventable. The public health consequences of non- adherence to drug therapy are poorly documented. Elderly people may have several risk factors for non-adherence and a combination of measures may be necessary to improve the situation.

Disease-management programs are effective in preventing readmissions to the hospital of elderly adults, particularly those with chronic heart failure. Such programs include multifaceted and multidisciplinary interventions for individuals with a single (or preponderant) disease. These programs combine evidence-based drug prescription /optimization, patient education, and enhanced coordination between health professionals, but they are not suitable for elderly adults with multiple chronic conditions. Such individuals' enrollment in several programs may lead to multiple guidelines without any comprehensive assessment, resulting in inappropriate prescribing, contradictory educational messages, and fragmented care. A few trials of patient-centered multifaceted interventions have shown decreased readmissions of elderly adults admitted in different hospital departments, but the trials were unicentric or included selected elderly participants.

Courtney M, Edwards H, Chang A et al. Fewer emergency readmissions and better quality of life for older adults at risk of hospital readmission: A randomized controlled trial to determine the effectiveness of a 24-weekexercise and telephone follow-up program. J Am Geriatr Soc 2009; 57:395–402.

Coleman EA, Parry C, Chalmers S et al. The care transitions intervention: Results of a randomized controlled trial. Arch Intern Med 2006; 166:1822–1828.

Naylor MD, Brooten D, Campbell R et al. Comprehensive discharge planning and home follow-up of hospitalized elders: A randomized clinical trial. JAMA 1999; 281:613–620.

The HAS publications 2005-2015

The multimorbidity has always been a major topic for the HAS. This theme was worked on through different issue: how to improve the prescription of drugs in elderly (PMSA), how to reduce the drug iatrogenicity more frequent with polymedication more severe in the elderly people, how to manage elderly people with multiple chronic diseases.

2006- 2013: Conception and dissemination of the program for improving the drug prescription (MPAS) for Medicine Prescription Aged Subject) and reducing the drug iatrogenicity in the elderly population (AMI program for Alert & Mastering drug Iatrogenicity), how to involve the elderly people in their care

2006-2013: the HAS developed in 2005 with Prof Sylvie Legrain, a program to improve the quality and security of drug prescriptions in elderly person (PMSA).The drug revision is based on a comprehensive review of the diagnosis and symptoms. http://www.has-

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sante.fr/portail/jcms/c_675707/fr/prescription-medicamenteuse-chez-le-sujet-age-pmsa-programme-pilote-2006-2013.
A Key Points & Solution leaflet on the drug prescription has been produced in 2014 and an English version will be soon available. http://www.has-sante.fr/portail/jcms/c_1771468/fr/comment-ameliorer-la-qualite-et-la-securite-des-prescriptions-de-medicaments-chez-la-personne-agee
2011: This program is one of the 3 components of the multifaceted intervention in the clinical trial OMAGE (2011). The PMSA in the OMAGE intervention is combined with a patient therapeutic education program and a enhanced communication with the practitioner in charge of the patient medical monitoring. This intervention was shown efficient with a reduction of mortality and readmissions. Sylvie Legrain, MD, Florence Tubach, MD, PhD, Dominique Bonnet-Zamponi, MD,* § and coll. Aur lie Lemaire, MD, Jean-Pierre Aquino, New Multimodal Geriatric Discharge-Planning Interventionto Prevent Emergency Visits and Rehospitalizations of Older Adults: The Optimization of Medication in AGEd Multicenter Randomized Controlled Trial. JAGS 59:2017–2028, 201
The HAS is keeping on the PMSA dissemination by producing a program focused on the reduction of the drug iatrogenicity: Alert and Mastering the drug Iatrogenicity (AMI). This program was applied for reducing the overuse of sleeping pills or for limiting antipsychotics in dementia. More than 50% of the Alzheimer population in France has several chronic diseases.
http://www.alcove-project.eu/index.php?option=com_content&view=article&id=69&Itemid=208;
http://www.has-sante.fr/portail/upload/docs/application/pdf/2011-03/brochure_programme_ami_alzh_vf_2011-03-03_11-35-59_520.pdfhttp://www.has-sante.fr/portail/jcms/c_1055540/alzheimer-s-disease-and-iatrogenicity-of-antipsychoticshttp://www.has-sante.fr/portail/jcms/c_860624/en/a-workshop-on-psychotropic-drug-prescriptions-in-the-elderly
2012-2015: Evolution of the ambulatory setting and practices for improving care of patients at risk of the independence loss".http://social-sante.gouv.fr/IMG/pdf/professionnels_sante_ville.pdf
PAERPA: The HAS contributed to develop good practices for caring elderly persons with multiple illnesses and a high risk of the loss of autonomy by producing tools for the PAERPA. A summary of tools is described in the "Key Points and Solution leaflet "Managing elderly persons with multiple illnesses in the primary care. The caring process includes tolls for the therapeutic educational program for elderly people at risk a loss of the autonomy.

2015: A Key Points & Solution leaflet on managing multimorbidity in outpatient setting has been published in April 2015. Strategy and tools for managing multimorbidity are presented in this leaflet.
http://www.has-sante.fr/portail/jcms/c_2028194/fr/prendre-en-charge-une-personne-agee-polypathologique-en-soins-primaires
2017 and further The HAS would pursue on this issue by working on the observance and the patients' role for improving care and cure.

Annex 2. Self-management and support: THE HAS feedback on the 3rd section
Component 8.Training of care providers to tailor self-management support based on patient preferences and competencies:

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Relevance to multimorbidity patients:
The implementation of patient therapeutic education (TPE) requires prior optimization of drug and non -drug treatments and prioritization of therapeutic and educational goals.
Component 9. Providing options for patients and families to improve their self-management
In multiple illnesses, the patient is confronted with daily monitoring of health status, changing symptoms or diseases, the need to cope with crises, acute episodes , to treat and learn to take initiatives to constantly adapt to the situation and find a balance , to associate close to the daily management . He needs to acquire and frequently mobilize self-care and coping skills, and maintain over time.

French guidelines 2007 the patient on self-management
http://www.has-sante.fr/portail/jcms/c_601290/fr/structuration-d-un-programme-d-education-therapeutique-du-patient-dans-le-champ-des-maladies-chroniques
This document describes the patient centered approach. http://www.has-sante.fr/portail/jcms/c_2040144/fr/demarche-centree-sur-le-patient-information-conseil-education-therapeutique-suivi (currently a French version only available)
Self-management and support for older people. http://www.has-sante.fr/portail/upload/docs/application/pdf/2015-03/adaptations_de_letp_chez_les_personnes_agees_en_risque_de_perte_dautonomie.pdf

Annex 3. Discharge of frail people or people in a complex clinical situation
These programs were developed to contribute to a reduction of hospital readmissions.
Almost 50% of patients with chronic heart failure or chronic respiratory heart failure have multimorbidity and should be considered in a “complex clinical situations” at the hospital discharge.
Multimorbidity associated with polymedication on aged people increases the risk of hospitalisations and readmissions.
http://www.has-sante.fr/portail/jcms/c_2041354/fr/comment-organiser-la-sortie-des-patients-hospitalises-pour-insuffisance-cardiaque
Comment prévenir les ré-hospitalisations après une exacerbation de bronchopneumopathie chronique obstructive ? http://www.has-sante.fr/portail/jcms/c_1744728/fr/comment-prevenir-les-re-hospitalisations-apres-une-exacerbation-de-bronchopneumopathie-chronique-obstructive
Comment prévenir les réhospitalisations d’un patient diabétique avec une plaie du pied http://www.has-sante.fr/portail/jcms/c_2001222/fr/comment-prevenir-les-rehospitalisations-d-un-patient-diabetique-avec-plaie-du-pied
Comment réduire les hospitalisations évitables chez la personne âgée http://www.has-sante.fr/portail/jcms/c_1602735/fr/comment-reduire-les-rehospitalisations-evitables-des-personnes-agees
Comment réduire les réadmissions non programmées des résidents d’EHPAD http://www.has-sante.fr/portail/upload/docs/application/pdf/2015-07/fpc_reduire_hospit_residents_ehpad.pdf

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2. Spain feedback to D07-02 Report on care pathways approaches for multimorbid chronic patients (included the meetings with experts to assess accuracy of collected evidence and select good practices, identify commonalities for care management of multimorbid patients)

Based on the criteria for the revision of the work packages deliverables stablished in the Governing Board Frame work plan, the Spanish Ministry of Health, Social Services and Equality has the following comments on the "Multimorbidity (MM) care model" described at the deliverable 7-02 of the WP6:

Do you think that this key deliverable is aligned with the interests of your country in addressing chronicity?

Many of the components stated at the MM care model are shared with the recommendations and guiding principles established at the Spanish Strategy for Addressing Chronicity in the National Health System (NHS) adopted in 2012.

People are the center of the NHS, the continuity of care, avoiding fragmentation, duplication and improving communication and coordination, Primary health care is the core of patient care for those with chronic health conditions and activity limitations, and to share responsibility in health care and in the appropriate use of health and social service resources in between professionals and with all citizens, are some of these guiding principles.

The Strategic lines of the Spanish Strategy for Addressing Chronicity in the NHS are:

1. *Health promotion: A large proportion of chronic health conditions and their risk factors are preventable. In this regard, the promotion of healthy lifestyles is an essential course of action to improve the health of the population that involves actions to modify the personal, social, environmental, and economic conditions in which we live.*
2. *Prevention of Health Conditions and Chronic Limitations of Activity: To effectively address the wide range of health determinants associated with chronicity, it is necessary to go beyond the health sector and adopt a multisectoral approach in prevention that integrates health in other areas such as education, social services, the workplace, the environment, research and others.*
3. *Continuity of Care: It is necessary to develop instruments and channels of co-ordination between different levels of health care and social services in order to progressively achieve comprehensive care for health problems. Home care should be strengthened to ensure continuity in the caregiving process*
4. *Reorientation of Health Care: Comprehensive care requires, first, stratifying the population according to the situation of each person and his or her needs. It is necessary to promote the systematic implementation of individualized care plans that result of the comprehensive assessment of medical needs, and functional and social care.*
5. *Health Equity and Equal Treatment: Equity in health implies that resources are allocated according to the needs of people.*
6. *Research and Innovation: Integrating research with clinical practice promotes a higher quality of health services. Health systems must interact closely with health research systems to generate and use knowledge relevant for their own improvement. Health innovation includes not only technological innovation but also organizational innovation and innovation in services, and should be understood as a process of continuous improvement of the capacity to respond to the needs of the population and professionals. The role of Information and Communication*

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Technologies (ICT) as drivers of competitiveness and development of public health and social services is stressed.

Therefore this key deliverable aligns with the interests of Spain in addressing chronicity.

Which barriers would you find for the application of this key deliverable in your country?

We do not see any barrier to the application of this conceptual MM care model a priori, as the recommendations in this Spanish Strategy for Addressing Chronicity in the National Health System (NHS), will complement and enhance the initiatives that are already being developed by the Autonomous Regions, and will form a cohesive framework to guide common goals across the NHS.
However in Spain the National Health System has a decentralized management and the autonomous regions are the Authorities responsible for Health Planning, Public health and Healthcare services management, and further implementation of specific good practices in MM might be jeopardized by this fact.

Which facilitators would you find for the application of this key deliverable in your country?

As part of the Strategy for Addressing Chronicity in the NHS, various projects and areas of work are being developed in order to carry out the implementation, monitoring and evaluation of the Strategy. Therefore these would be facilitators of the application of this key deliverable in Spain:

1. *A Project of Stratification of the Population in the NHS, with the aim of establishing a tool that permits identification of subgroups with different levels of care needs. Currently, 13 out of 17, Autonomous regions have implemented this tool for the stratification of the Population.*
2. *We have developed a first step of the System Indicator Project that with state vision describes a common minimum set of indicators that will enable following up on the care for patients with chronic diseases.*
3. *A Network of Health Schools for Citizens has been set up, in order to promote, share and develop training tools to improve self-management of health and disease of citizens.*
4. *A Frame document for the Improvement of chronic pain in the NHS has been elaborated, to approach its impact on the quality of life of people and the subsequent impact on health outcomes.*
5. *Different Strategies have been elaborated to approach risk factors and other determinants in order to prevent chronic diseases and promote health: NAOS Strategy (Strategy for Nutrition, Physical Activity and the Prevention of Obesity) and Strategy for Health Promotion and Diseases Prevention.*
6. *A project regarding the analysis of the situation and proposals for improvement of home care programs in the NHS is envisaged to determine minimum criteria for uniform quality throughout the national territory which will contribute to enhance the continuity of care.*
7. *The Chronic diseases management project (GEC) is an IT tool for the clinical decision support which contributes to the research and innovation and facilitates the implementation of evidence-based medicine.*

Would it be feasible to apply this key deliverable in your country?

According to the previous, the answer is yes, however, we would like to comment that a general assessment component, apart from that of the regular comprehensive assessment of patients, is missing.

We considered that the assessment of any intervention on multimorbidity care is essential to ensure the efficiency and continuous improvement. Consequently, we are missing an assessment plan as an additional component of the MM Care Model.

Additionally we would find useful for the applicability of this key deliverable to have specific examples of good practices on multimorbidity management that could illustrate how this conceptual MM care model can be implemented on the ground.

Details on the scalability of these good practices would be also of critical relevance.

D04-03 Recommendations to improve the quality of care people with diabetes: minimum set of indicators

This deliverable was circulated for feedback to the Governing Board on the 27th July 2016. Feedback was received from the Governing Board member from Finland, Croatia and France. The Croatian and French feedbacks to this deliverable D04-03 were provided together with feedbacks on Deliverable 04-02 "Guide for National Diabetes Plan". These feedbacks were sent to the Coordination of the JA-CHRODIS who forwarded them to the Work Package Leaders responsible for this deliverable (WP7).

1. **Finland feedback to Deliverable 04-03 Recommendations to improve the quality of care people with diabetes: minimum set of indicators**

A huge and important work has been done. The key is, however, how this is going to be implemented. Countries across Europe are in different phases what it comes to prevention and quality of care of people with diabetes. Some general comments:

- In our interest in Finland is to promote integration of the diabetes into daily life with people with diabetes and to support their self-management ability and well-being. This document gives very little support to deliver that.

- Most of this we have already done in some extent in Finland, some points are applicable and should be considered to take into action. The most of work done hasn't been scientific so that is why the evidence is missing when performing literature search.

- It is said that this is patient-centered… still everything is more or less defined and written from the organizational structure or healthcare professional point of view. For example: "The quality criteria/indicators and the recommendations presented in this report constitute a tool for decision makers, health care providers and health care personnel to support implementation of good practices, and to improve, monitor, and evaluate the quality of diabetes prevention and care." in this people with diabetes are turned into objects instead they should be subjects if patient centered care really is what we want.

- The European platform sound very interesting. That could really add some value to work across Europe.

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Finland Governing Board representative also included the deliverable in question with some comments in accordance with the remarks made above. This deliverable with the comments included is available at request.

2. **Croatia feedback to Deliverable 04-03 Recommendations to improve the quality of care people with diabetes: minimum set of indicators**

See below Croatia feedback given to the deliverable D04-02 "Guide for National Diabetes Plan".

3. **France feedback to Deliverable 04-03 Recommendations to improve the quality of care people with diabetes: minimum set of indicators**

Do you think that deliverable or milestone aligns with the interests of your country?

In September, 2013, the French Government launched a comprehensive national health strategy to address financial issues under national health insurance, health-care reform, public health issues, and social aspects of health inequalities. This strategy is being implemented through a health law that passed in January 2016. The main components are;

- *Addressing prevention first*
- *Organization of health care for chronic diseases management*
- *Democracy in health*
- *To reduce health inequalities*

Furthermore, the health strategy, as well as strategic targets of the general directorate for health (in the MOH) for 2017-2019, promotes good practices and innovation for health promotion, prevention and care.

The French National Authority for Health published various guidelines for type 2 diabetes and obesity management.

The French public health agency disseminates evaluation tools for health promotion interventions.

Which barriers would you find for the application of this key deliverable in your country? Which facilitators would you find for the application of this key deliverable in your country?

The deliverable will be made available to French National Authority for Health, the French public health agency and regional health agencies.

Would it be feasible to apply this key deliverable in your country?

Yes, with regard to previous tools.

D04-02 Guide for National Diabetes Plan - Lessons learnt from National Diabetes Plan to support development and implementation of National plans for chronic diseases

The Guide for National Diabetes Plan was circulated to the Governing Board members on the 30th September 2016. Feedbacks in this occasion was provided by Croatia and France that were sent to the Coordination of the JA-CHRODIS who forwarded them to the Work Package Leaders responsible for this deliverable (WP7).

1. **Croatia feedback to deliverables:**

   D04-02 Guide for National Diabetes Plan - Lessons learnt from National Diabetes Plan to support development and implementation of National plans for chronic diseases

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D04-03 Recommendations to improve the quality of care people with diabetes: minimum set of indicators

Regarding the "Guide for National Diabetes Plan - Lessons learnt from National Diabetes Plan to support development and implementation of National plans for chronic diseases" and "Recommendations to improve early detection, preventive interventions, and the quality of care for people with diabetes. Definition and agreement on a common minimum set of indicators." I would like to confirm that both deliverables aligns with the interest in our country addressing chronic diseases. Potential barriers are resources, both human and financial, and further JA an EU project facilitating this topic could be beneficial and potential good facilitator of the further changes and application of the deliverables. Political commitment is very important so all the activities that will reflect Governments directly from the EU Parliament and/or other relevant EU bodies could be excellent facilitators. Regarding the feasibility of implementation of the deliverables in our country, I believe it is partially possible but level of implementation will depend on the mentioned obstacles/ facilitators.

2. **France feedback to Deliverable D04-02 Guide for National Diabetes Plan - Lessons learnt from National Diabetes Plan to support development and implementation of National plans for chronic diseases**

Do you think that deliverable or milestone aligns with the interests of your country?

In September, 2013, the French Government launched a comprehensive national health strategy to address financial issues under national health insurance, health-care reform, public health issues, and social aspects of health inequalities. This strategy is being implemented through a health law that passed in January 2016. The main components are:

- *Addressing prevention first*
- *Organization of health care for chronic diseases management*
- *Democracy in health*
- *To reduce health inequalities*

Therefore, diabetes as non-communicable diseases at large is clearly on the foreground of the political agenda (Ref: Touraine, Marisol. Health inequalities and France's national health strategy; The Lancet, Volume 383, Issue 9923, 1101 – 1102).

Which barriers would you find for the application of this key deliverable in your country? Which facilitators would you find for the application of this key deliverable in your country?

Facilitators would be:

- *to provide a directory (or synthesis) on resources choices among successive CHRODIS deliverables on diabetes plans (swot analysis, policy brief).*
- *to bridge the gap in the policy scope of WP7 deliverable from diabetes to cardio-metabolic risk (cf WHO action plan for NCD prevention in Europe)*

Overall the deliverables of WP7 provide a thoughtful and comprehensive assessment of diabetes plans, overview of strategies and factors that may influence the implementation and impact. The link between obesity, T2 diabetes, and other RF and CVD is well documented.

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The policy brief had rightly reminded the diversity of NDP framework: specific NDP, NCD plan or chronic disease strategic framework.
Regional health strategies in France reflect altogether differences in policy design and common features whatever for health promotion - nutrition and physical activity, obesity prevention, diabetes and CVD diseases management.
Therefore, to complete the NDP design for cardio-metabolic prevention would significantly enhance dissemination of CHRODIS deliverables.

Would it be feasible to apply this key deliverable in your country?

Regional health agencies design their own health strategies according to population needs. The deliverables will be disseminated to regional agencies.

D06-03 Recommendation report on applicability and transferability of practices into different settings and countries

This deliverable was circulated to the Governing Board members on the 9th January 2017. Feedbacks in this occasion was provided by Belgium, Croatia, Spain and Germany, that were sent to the Coordination of the JA-CHRODIS who forwarded them to the Work Package Leaders responsible for this deliverable (WP5).

1. **Belgium feedback to deliverable D06-03 Recommendation report on applicability and transferability of practices into different settings and countries.**

Do you think that deliverable or milestone aligns with the interests of your country?

At the moment regional projects of integrated care are being conceptualized; they must include innovative actions that can reshape the health (and) social healthcare system towards more integrated care. The proposed actions should be scalable towards their whole region (100 000 -150 000 inhabitants), therefore criteria for scalability of approaches are useful.

Which barriers would you find for the application of this key deliverable in your country? Which facilitators would you find for the application of this key deliverable in your country?

This is an opportunity to disseminate this information, as the projects are just in the conceptualization phase.

Would it be feasible to apply this key deliverable in your country?

This deliverable will be disseminated towards the project regions and can help to evaluate the proposed innovative actions.

2. **Croatia feedback to deliverable D06-03 Recommendation report on applicability and transferability of practices into different settings and countries**

Do you think that deliverable or milestone aligns with the interests of your country?

Deliverable aligns with the interest in the country addressing chronic diseases.

Which barriers would you find for the application of this key deliverable in your country? Which facilitators would you find for the application of this key deliverable in your country?

There are no real barriers but we need to increase the knowledge and level of implementation of that findings/recommendation in our country; good facilitators could be workshops or pilot joint action on specific topic on the nation level.

Would it be feasible to apply this key deliverable in your country?

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I believe that is feasible to apply the deliverable in Croatia.

3. **Spain feedback to deliverable D06-03 Recommendation report on applicability and transferability of practices into different settings and countries.**

Do you think that deliverable or milestone aligns with the interests of your country?

During the last few years, the Spanish Ministry of Health has coordinated the process for the identification, selection and evaluation of good practices in different chronic diseases in the National Health System (NHS). There is collaboration among public health administrations at the regional and the national level. For the last two years, the MoH has been working in the development of a guide of transferability of good practices within the NHS, and we are in the final stage of its development. The MoH will coordinate the transfer process also.

Which barriers would you find for the application of this key deliverable in your country? Which facilitators would you find for the application of this key deliverable in your country?

The fact that the Ministry of Health coordinates these processes at the national level facilitates the application of this deliverable.

This report would be a first step for the transfer of a good practice. It needs to develop into a more specific and concrete document, like a methodological manual to better orient health professionals interested in transferability.

The previous experience in transferability is a key element to consider for the success of the transfer process, as well as the commitment of the team and the organisation where the good practice to be transferred was developed with the team that it is going to transfer it, in order to facilitate the training. These aspects are not contemplated in the document, and they are important to take into account because the transferability of good practices produces knowledge, financial and innovative returns for the original team and its organisation as well as for the team and organisation that will transfer the good practice. Consequently, this process promotes motivation for both.

Would it be feasible to apply this key deliverable in your country?

Only partially because, and although the effort has been made to develop a kind of checklist in the form of questions, it is not clear how to use the results of those responses when making the decision to transfer or not a good practice. We find interesting and more concrete the records of the study visits where key success factors of the experiences are specified.

4. **German feedback to deliverable D06-03 Recommendation report on applicability and transferability of practices into different settings and countries.**

From the point of view of the German Ministry of Health, the recommendations report is a very useful approach to scaling up the implementation of good practices and to creating new synergies.

Few comments and amendments were suggested to the text in the sense of:

- *Make it clear from the outset that the document is about good practice examples and their transferability and not the concept of transferability per se.*
- *It would be helpful to include an executive summary with key messages.*

One important factor to facilitate dissemination/implementation of the document would be its availability in the German language.

D07-03 Reports on meetings with experts for designing multimorbidity case management programmes

This deliverable was circulated to the Governing Board members on the 29th December 2016. Feedback in this occasion was provided by Belgium, Croatia and Spain that were sent to the Coordination of the JA-CHRODIS who forwarded them to the Work Package Leaders responsible for this deliverable (WP6).

1. **Belgium feedback to deliverable D07-03 Reports on meetings with experts for designing multimorbidity case management programmes**

Do you think that deliverable or milestone aligns with the interests of your country?
Yes, case management is an important aspect of integrated care and necessary in order to provide adequate care for complex patients.

Which barriers would you find for the application of this key deliverable in your country? Which facilitators would you find for the application of this key deliverable in your country? *Barrier: there is no consensus on whether or not case management deserves a qualification as a profession or whether it is a role (with specific salary scale).*
Facilitator: this report clarifies that a specific training addressing different skills is necessary.
Would it be feasible to apply this key deliverable in your country?
We could install an additional training program based on the reported skills for people who are educated in health or social care and have already experience these settings, but at the moment there is no consensus. This report could help the discussion.

2. **Croatia feedback to deliverable D07-03 Reports on meetings with experts for designing multimorbidity case management programmes**

Deliverable aligns with the interest in the country addressing chronic diseases, however:

- *There are barriers and*
- *I am not sure if it would be feasible to apply the deliverable in our country at this moment or in the near future*

In Croatia General practitioners are perceived as health care workers that are supposed to address that role in National health care system although their skills in general are not enough to fulfil all requirements for Multimorbidity Case Manager. I believe that we need to sensitize health authorities (JA-CHRODIS is excellent activity in that direction), persist in activities long enough to initiate changes in perception, organisation and education and during that time organise extra education for potential Multimorbidity Case Manager.

3. **Spanish feedback to deliverable D07-03 Reports on meetings with experts for designing multimorbidity case management programmes**

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The comments below are made by Health Authorities of two Autonomous Regions of Spain, País Vasco and Generalitat de Cataluña. These are two out of the 18 Competent Authorities that in Spain are responsible for Health Planning, Public Health and Healthcare services management, and therefore with competences in the actual implementation of case management programmes, and thus of this specific deliverable.

Answer from País Vasco:

Do you think that deliverable or milestone aligns with the interests of your country/Region?

Yes, País Vasco thinks it is feasible and believes that the deployment of this figure is important for the management of fragile patients.

Which barriers would you find for the application of this key deliverable in your country/Region?

First of all, if a professional profile, other than what is formally considered a health professional, is allowed, a tuff debate on competencies would take place, and therefore this aspect of the deliverable would be a barrier.

Additionally the economic issue would be another barrier to solve (both at the level of training, i.e. how long that training would last, who would take charge of the cost; and at the level of management of post).

Which facilitators would you find for the application of this key deliverable in your country/Region?

There are nurses that currently are taking the role of case managers which is a priority for the system and it is seen important by the society.

Would it be feasible to apply this key deliverable in your country/Region?

País Vasco believes that it would be feasible but many operational aspects would be necessary to defined and the document does not clearly describe the guidelines and procedures (i.e. who would provide the training health systems or universities? who would supervise the on-the-job practical sessions? In addition, would this training be adequate without the provision of specific posts at the portfolio of services?)

Answer from Generalitat de Cataluña:

Do you think that deliverable or milestone aligns with the interests of your country/Region?

Generalitat de Cataluña considers the deliverable provided is a good and useful work, both in the definition of competences of case managers and in the training elements needed, based not only on technical elements but also on other competencies, in particular in the relational field (as team work, communication, etc.) closely related to the weighting between technical and relational skills that these professionals must have.

Which barriers would you find for the application of this key deliverable in your country/Region?

Which facilitators would you find for the application of this key deliverable in your country/Region?

It will be necessary that budgets allow the creation and incorporation of these professionals. It would be also needed to incorporate training modules that approach these elements and critical

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competencies. The deliverable provides a very modern and updated profile of competencies. It is a good job.

Some current Masters (postgraduate trainings) could incorporate this training and development of skills.

Would it be feasible to apply this key deliverable in your country/Region?

Training modules for the case management profile could be made, although in Cataluña we are thinking about the design and implementation of a training program in the format of a Massive Open Online Course (MOOC), in which thematic contents and also elements of leadership and non-relational skills are incorporated.

One of the aspects to be assessed is the need to consider case management as a model of care beyond multimorbility (MM). In Cataluña we speak of "people in complex situation" beyond the MM, but this deliverable focuses more on the population group with multimorbidity and associates the case management model to this group.

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