Deliverable 7.1

WP7

Pilot action design: a blueprint for action

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Contents

Page number

Abbreviations...4

Executive summary ...5

Introduction ...7

Aim and scope of the report...7

Methodology ...8

Results ...9

Planning the pilot actions using the QCR tool ...11

Local Implementation Working Group definition ...11

Stakeholders identification ...12

Scope definition ...13

SWOT analysis using QCR tool ...15

Identification of improvement areas ...17

Pilot action plan in Improvement area (s) ...18

Individual Pilot Action Plan Report, in summary table ...20

Table 1 – QCR to improve care for people with chronic diseases ...22

References ...25

Annex 1 - Guideline on implementation strategy Module 1: Pre-Implementation phase

Annex 2 - Guideline on implementation strategy Module 1: Pre-Implementation phase Reference Material: SWOT Analysis

Annex 3 – Individual Pilot Action Plan Summary Reports

Abbreviations

AUTH	Aristotelio Panepistimio Thessalonikis, Greece
CERTH	Centre for Research & Technology Hellas
CD	Chronic Disease
CIPH	Croatian Institute of Public Health
CSC	Cantabrian Health Service
EB	Executive Board
EPF	European Patient Forum
EU	European Union
ICT	Information and Communication Technology
ISS	National Institute of Health, Italy
JA	Joint Action
LIWG	Local Implementation Working Group
mHealth	Mobile Health
NCD	Non Communicable Diseases
NCPHA	National Center of Public Health and Analyses
NIJZ	National Institute of Public Health, Slovenia
OVGU	University of Magdeburg
NGO	Non-governmental organizations
QCR	Quality Criteria and Recommendations
SWOT	Strengths, Weaknesses, Opportunities, Threats
TC	Tele Conference
THL	National Institute for Health and Welfare, Finland
UBEO	Faculty of Medicine, University of Belgrade, Serbia
UHREG	University Hospital Regensburg
UULM	Ulm University
WP	Work Package

Executive summary

Introduction to JA CHRODIS PLUS

CHRODIS PLUS main purpose is the collaboration of EU countries on implementing pilot projects and generating practical lessons in the field of chronic diseases. The very core of the Action includes 21 pilot implementations and 17 policy dialogues. The pilot projects focus on the 3 following areas:

1. health promotion & primary prevention (WP5)
2. an Integrated Multimorbidity Care Model, fostering the quality of care for people with chronic diseases (WP6)
3. ICT-based patient empowerment and employment & chronic diseases (WP7)

The present report refers to pilots of the third area.

Aim and scope of the report

This report aims to provide a framework for the implementation of actions using JA-CHRODIS QCR tool across European countries to develop/improve/monitor practices for prevention of chronic disease and to improve of the quality of care for people with chronic diseases.

Pre-implementation

The approach taken to define the framework for the implementation of actions using QCR tool presented in this report involved several steps based in particular on:

- Definition of a short version of the QCR defined in the JA-CHRODIS.
- Collaboration to the development of the first Module on Pre-Implementation phase of the "Guideline on implementation strategy" for the pilot sites (Annex 1).
- Organization of a Pre-Implementation workshop to build the capacity of partners with pilot actions to perform and report in a uniform way the steps of pre-implementation phase,
- Definition of a series of templates on: stakeholder identification, SCOPE definition, SWOT analysis, identification of improvement areas, pilot plan elaboration, and individual PILOT ACTION PLAN report adapted to specific objectives of WP7.

Implementation activity

Croatia (Croatian Institute of Public Health in collaboration with the Primary Health Care Centres): to pilot an intervention to increase the use of diabetes control check-list for improvement of health care quality in diabetes as well as to identify barriers for their full implementation in primary health care settings. Study will enable quantification of availability and quality of diabetes care indicators and impact of structured education and performance feedback on their quality.

Finland (National Institute for Health and Welfare in collaboration with Primary health care and Family Federation of Finland): to develop and pilot a lifestyle intervention specifically tailored to the Somali population using the StopDia model, and to examine the effects and suitability of the StopDia-concept on this specific population.

Greece (Aristotle University of Thessaloniki, AHEPA University Hospital, Alexander" Technological Educational Institute of Thessaloniki): to improve self-management of people with hypertension and diabetes through education and training; to improve capacities of involved professionals (medical and paramedical healthcare personnel) for the management of hypertension and diabetes and for patient's education on lifestyles and self-management.

Serbia (Faculty of Medicine of the University of Belgrade, Primary Health Care Centres with close cooperation with Republic Institute of Public Health and Ministry of Health): to implement at PHCC, in each Serbian municipalities, a stepwise screening procedure and preventive intervention in high-risk individuals for diabetes T2, additional care for people with T2D, and training and education of physicians working in DCUs.

Slovenia (General Hospital Novo Mesto, and the Primary Healthcare Centre Novo Mesto): to develop a model for integration of care for people with complex state (model state is a chronic wound) across primary and secondary level of care including social care, structured by QCR and transferable to other domains of healthcare. Patients were actively involved in the practice development (patient case studies are used to analyse the current pathways and identify unmet needs; patient representative involved in the LIWG).

Spain (Regional Ministry of Health of Cantabria & Cantabrian Health Service), **Bulgaria** (National Center of Public Health and Analyses)**, Germany** (University Hospital Regensburg): to implement mHealth tools to foster quality of care for patients with chronic diseases. The pilots on mHealth tools aim to assess the contribution of various self-management and patient empowerment features (i.e. ecological momentary assessments [EMAs], personalised feedback and education) in patient control over their chronic disease (tinnitus and diabetes).

Conclusions - A Framework for the implementation of actions for fostering quality of care for NCD using QCR Tool

The procedure described above resulted in a framework for the implementation of pilot actions using the QCR tool, and in a series of operational elements, methodological details, and practical indications to:

- define the LIWG and identify key stakeholders
- describe the scope of intervention by selecting, from QCR tool, the recommendations and related quality criteria, to be considered as the components of the intervention
- conduct the SWOT analysis of the context of Pilot action using QCR tool
- identify and prioritise improvement areas using the QCR tool
- plan actions for each identified improvement areas
- define the key performance indicators
- design the Pilot implementation plan.

The usefulness of JA CHRODIS QCR Tool has been proven to be useful in the planning phase for the development of a good practice, and is being tested to serve as a monitoring tool to support PDSA cycles of the pilot actions.

Introduction

In the frame of JA-CHRODIS (http://chrodis.eu/outcomes-results/) an extensive process at EU level was carried out to identify a core set of quality criteria and formulate recommendations to improve prevention, early detection, and quality of care for people with diabetes (case study), but general enough to be applied to any of the CDs (http://chrodis.eu/wp-content/uploads/2017/02/wp7-deliverable-recommendations-final-draft.pdf).

The QCR tool consists of 9 criteria, subdivided in 39 categories, which are ranked and weighted (Table 1). This is supportive towards assessing whether an intervention, policy, strategy, program as well as processes and practices, can be regarded as a "good practice" in the field of chronic disease prevention and care.

The core set of quality criteria may be applied to develop and improve practices, programs, strategies and policies in various domains (prevention, care, health promotion, education, and training), they are general enough to be applied in countries with different political, administrative, social and health care organization, and could be used in any of the chronic diseases.

The QCR constitutes a tool for decision makers, health care providers, health care personnel and patients to improve the existing practices when used as an evaluation tool as well as to support new implementation of good practices, when using the tool as a guide, aiming to improve the quality of care for people with chronic diseases.

The adoption of an agreed core set of quality criteria, as defined by the QCR tool, can help to decrease inequalities in health within and across European countries, and can contribute to the cultural shift needed to redesign the care systems with and around the needs of people with CDs.

QCR tool will be tested in a series of pilot actions within the Joint Acton CHRODIS PLUS (http://chrodis.eu/), to improve and evaluate existing practices. For better tool's applicability evaluation across the EU, different tool domains will be implemented in different countries. This will provide rich information on the barriers and facilitators related to any of the specific QCR as well as the contextual elements of each of the health care systems where they are to be implemented.

For this, a total of 15 partners representing 9 European countries will collaborate to implement pilots and generate practical lessons that could contribute to the uptake and use of QCR tool. Overall, all participant countries will explore the sustainability and scalability in longer terms of the intended changes, learning from these pilot actions to foster high quality care for people with chronic diseases.

Aim and scope of the report

This report aims to provide a framework for the implementation of actions using QCR tool across European countries to develop/improve/monitor practices for prevention of chronic disease and to improve of the quality of care for people with chronic diseases. In particular, it aims to provide operational elements, methodological details, and practical indications to:

- define the LIWG and identify key stakeholders;
- describe the scope of intervention selecting, from the QCR tool, the recommendations and related quality criteria, to be considered as the components of the intervention;
- conduct the SWOT analysis of the context of Pilot action using QCR tool;
- identify and prioritise improvement areas using QCR tool;
- plan actions for each identified improvement areas;
- define the key performance indicators;
- design the Pilot implementation plan.

Methodology

The approach taken to define the framework for the implementation of actions using JA-CHRODIS QCR tool presented in this report involved several steps:

- Definition of a short version of the QCR defined in the JA-CHRODIS that can be easily translated, to facilitate the dissemination and sharing of the QCR tool with LIWG, and with other stakeholders involved in the implementation process. (http://chrodis.eu/wp-content/uploads/2018/05/qcr-tool-short.pdf)
- Collaboration to the development of the first Module on Pre-Implementation phase of the "Guideline on implementation strategy" (First module) for the pilot sites (Annex 1). The strategy provides a series of methods and techniques to enhance the adoption and sustainability of practices and the use of tools developed in JA-CHRODIS that can be applied in different settings and contexts. The document is the result of a productive collaborative work between the Authors and JA CHRODIS PLUS partners.
- Tailoring the SWOT analysis to the specificity of WP7 partners using the SWOT short guidelines for LIWGs (Annex 2). The guidelines include a section on theory and methods and a second part on the recommended steps to conduct a SWOT analysis at Local Level. Practical examples on the SWOT analysis and how from the SWOT outcomes it is possible to draft the Implementation Plan.
- Organization of a Pre-Implementation workshop (June 4-5, Ljubljana, Slovenia) to build the capacity of WP7 partners with pilot actions to perform and report in a uniform way the steps of pre-implementation phase, as defined by the "Guideline on implementation strategy" with the use of QCR tool. The aims of the overall experience were to build, using a blend of participatory approaches, a common methodology helping LIWGs to replicate the pre implementation workshop in other countries, in order to perform the SWOT analysis (Annex 2), identify Strategic Actions and Priorities and drafting the Pilot Implementation Plans, tailored to the needs of each pilot site. The workshop offered also the opportunity to provide further operational support to WP7 LIWGs through the definition of the framework for the implementation - structure, content, methodology - of QCR that can be applied in different settings and contexts.
- Definition of a series of template on: stakeholder identification, scope definition, SWOT analysis,

identification of improvement areas, pilot plan elaboration, and individual pilot action plan report adapted to specific objectives of WP7.

Results

The procedure described above resulted in a framework for the implementation of pilot actions using the QCR tool, and in a series of templates aimed to further support partners in the definition of the pilot plans.

In each participating country a LIWG has to be established. The LIWG is composed by the local relevant stakeholders as well as by local WP7 team, and is the responsible to plan the pilot action and conduct the pilot implementation.

Each participating Country implements at least four quality criteria: Practice design, Target population empowerment, Education and training to promote empowerment, and Sustainability and scalability. Moreover, at least one of the three criteria from the management perspective (Governance, Interaction with regular and relevant systems or Evaluation) is to be included.

LIWGs perform the SWOT analysis (Annex 2) to reveal gaps, key enablers and positive forces that support the applicability of the QCR tool and actual/potential barriers that need to be recognized and addressed, and to evaluate their transferability across countries. It will also enable partners of WP to share their vision, ideas, knowledge, expertise and experiences in a structured way.

The structure, organization and content of the practice is defined, and established together with the target population, that should be clearly described. Human and material resources will have to be adequately estimated in relation with committed tasks. Relevant dimensions of equity have to be adequately taken into consideration, and targeted.

The plan/design of the interventions is reported using SQUIRE 2.0 Guidelines which are intended for reports that describe level work to improve healthcare (https://qualitysafety.bmj.com/content/25/12/e7).

Summary reports of pilot action plan defined by CIPH, THL, AUTH, UBEO, NIJZ are reported in Annex 3.

In synthesis, WP7 partners with pilot are using QCR tool as follows:

Croatia (Croatian Institute of Public Health in collaboration with the Primary Health Care Centres): to pilot an intervention to increase the use of diabetes control check-list for improvement of health care quality in diabetes as well as to identify barriers for their full implementation in primary health care settings. Study will enable quantification of availability and quality of diabetes care indicators and impact of structured education and performance feedback on their quality.

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paramedical healthcare personnel) for the management of hypertension and diabetes and for patient's education on lifestyles and self-management.

Serbia (Faculty of Medicine of the University of Belgrade, Primary Health Care Centres with close cooperation with Republic Institute of Public Health and Ministry of Health): to implement at PHCC, in each Serbian municipalities, a stepwise screening procedure and preventive intervention in high-risk individuals for diabetes T2, additional care for people with T2D, and training and education of physicians working in DCUs

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Spain (Regional Ministry of Health of Cantabria & Cantabrian Health Service), **Bulgaria** (National Center of Public Health and Analyses)**, Germany** (University Hospital Regensburg): to implement mHealth tools to foster quality of care for patients with chronic diseases. The pilots on mHealth tools aim to assess the contribution of various self-management and patient empowerment features (i.e. ecological momentary assessments [EMAs], personalised feedback and education) in patient control over their chronic disease (tinnitus and diabetes).

Planning the pilot actions using Quality Criteria and Recommendations (QCR tool)

Local Implementation Working Group definition

The LIWG is composed by the local relevant stakeholders as well as by local WP7 team, and is the responsible to plan and conduct the implementation activities. Populations target of the intervention (citizens, people with chronic diseases, health professionals, ...) should be actively involved in the planning process and decision making. Functions and roles preferably covered by the LIWG are stated using the following table. If certain function/role is not represented in LIWG, the argument why should be presented.

Functions/roles	Institution, name and surname
Organizer Plan, prepare, chair and run the group workshops Run the secretariat (prepare agendas and minutes) Write reports	
Experts Provide knowledge and faculty on specific matters depending on the intervention selected	
Decision makers Provide strategic vision Support and sponsorship of the implementation process Eliminate bottlenecks during the implementation process	
Front-line stakeholders Give knowledge and expertise on real-life practice experience Choose the right type of subject to implement Motivate and empower implementers Equip and support implementers to deal with the implementation	

Implementers (can be same individuals as the front-line professionals) Implement the intervention following the agreed plan Continuously assess the implementation process Provide input and feedback to the LIWG	
Patient representatives Give the input during the pilot action development, implementation, monitoring and evaluation	

Stakeholders identification

Stakeholders are individuals, institutions or organizations that are in any way interested by the activity, program, intervention or policy promoted. In JA CHRODIS PLUS, the stakeholders are interested parties that can include institutions or organizations that come from different fields and distinct expertise and experience (health, education, social, employment, research and ICT sectors, NGOs, patients and their associations and civil society, to be as enriching and comprehensive as possible. Although teams can vary in size and composition, each implementation site needs to include the appropriate persons in the group to ensure that all perspectives are covered.

According to the interest, influence and importance for success, the LIWG can consider different levels of involvement of the stakeholders:

- Full participation. The stakeholder is fully involved in the decision-making process, but not as part of LIWG.
- Consultation. The stakeholder is consulted during the decision-making process and its opinions are then discussed within the LIWG.
- Information. The stakeholder is fully informed on decisions and decision-making process.
- Passivity. The stakeholder is briefly informed.

Stakeholder	Level of involvement (full participation, consultation, information, passive recipient of the information)

Scope definition

The problem can be described through data and information on population health, organizational and regulatory aspects. As an example:

- Data on population health: morbidity, mortality, adherence to therapies, hospitalization and readmissions (quantitative); beneficiaries and actors' opinions (qualitative).
- Organizational aspects: integration through levels of care, information systems, interprofessional collaboration, intersectoral approach.

Identification of the target population includes a description of the main characteristics of the population: type, age groups, estimated number …

The purpose of the intervention defines how the identified problem will be addressed. It refers to the general objective of the project and describes the changes the intervention should produce (institutional, organizational, behavioural, others). As an example: to improve the prevention and management of obesity and diabetes 2 in youths, by strengthening primary care services, inter-professional and intersectoral collaboration

Criteria from QCR Tool (Table 1) are the basis for the definition of the scope of the intervention. The focus might be on all of the criteria, or only on selected criteria most useful for the specific intervention. However, arguments why other criteria were not seen as useful should be reported.

Practice design, Target population empowerment, Education and training to promote empowerment and Sustainability and scalability are obligatory for all the pilot plans. Moreover, the plan should include at least one of the three criteria from the management perspective (Governance, Interaction with regular and relevant systems or Evaluation).

Item	Description
Problem/challenge	
General purpose of the intervention	
Target population	
Quality criteria	**1. Practice design** - **2. Target population empowerment** - **3. Evaluation** - **4. Comprehensiveness of the practice**

	- **5. Education and training** - **6. Ethical considerations** - **7. Governance** - **8. Interaction with regular and relevant systems** - **9. Sustainability and scalability** -

SWOT analysis using QCR tool

Based on the scope as defined previously, LIWG perform SWOT analysis of the context of pilot action using criteria from QCR (Table 1). The SWOT can focus on all of the criteria, or only on the selected criteria considered the most useful. However, arguments why other criteria were not seen as useful should be reported.

Practice design, Target population empowerment, Education and training to promote empowerment and Sustainability and scalability are obligatory for all the pilot plans. Moreover, the plan should include at least one of the three criteria from the management perspective (Governance, Interaction with regular and relevant systems or Evaluation).

	STRENGHTS	**WEAKNESSES**
INTERNAL	Practice design - ..... Target population empowerment - ..... Evaluation - ..... Comprehensiveness of the practice - ..... Education and training - ..... Ethical considerations - ..... Governance - ..... Interaction with regular and relevant systems - ..... Sustainability and scalability -	Practice design - ..... Target population empowerment - ..... Evaluation - ..... Comprehensiveness of the practice - ..... Education and training - ..... Ethical considerations - ..... Governance - ..... Interaction with regular and relevant systems - ..... Sustainability and scalability - .....

	OPPORTUNITIES	THREATS
EXTERNAL	Practice design - ..... Target population empowerment - ..... Evaluation - ..... Comprehensiveness of the practice - ..... Education and training - ..... Ethical considerations - ..... Governance - ..... Interaction with regular and relevant systems - ..... Sustainability and scalability -	Practice design - ..... Target population empowerment - ..... Evaluation - ..... Comprehensiveness of the practice - ..... Education and training - ..... Ethical considerations - ..... Governance - ..... Interaction with regular and relevant systems - ..... Sustainability and scalability - .....

Identification of improvement areas

Based on the SWOT analysis, LIWG:

- Identify potential improvement areas (strategic actions) that will be included in the Pilot plan using criteria from QCR (Table 1). They usually stem out of identified weaknesses of the practice, having in mind the threats as barriers that are outside the control of the LIWG. Improvement areas build on identified strengths as well as on opportunities; although the latest are beyond control of the LIWG, but are potentially helpful.
    - identify improvement areas from the focus of all of the criteria, or only the selected criteria considered the most useful. However, arguments why other criteria were not seen as useful should be reported. Practice design, Target population empowerment, Education and training to promote empowerment and Sustainability and scalability are obligatory for all Pilot actions. Please check, that at least one of the three criteria from the management perspective (Governance, Interaction with regular and relevant systems or Evaluation) is included.
- List the potential improvement areas found to be important.
- Score the improvement areas according to their priority (1 = lowest priority, 3= highest priority).
- Rank according to the importance those with the highest priority.
- Agree which of the improvement areas with highest priority and with high rank of importance will be addresses in the Pilot Action Plan (key priorities).

Improvement areas	Priority score (1-3)	Ranking
➔		
➔		
➔		
➔		

Pilot action plan in Improvement area (s)

Based on the improvement areas identified in the previous step, LIWG design the Pilot action plan:

a) Describe the improvement area

b) Define the objective (s)

c) List the activities (Change package) necessary and feasible to reach the objective(s)

d) Identify the person(s) involved and the one that is responsible

e) Define timeline for all the activities

f) Define the Key performance indicator(s)

LIWG define elements of pilot action plan from the focus of all of the criteria, or only the selected criteria considered the most useful. However, arguments why other criteria were not seen as useful should be reported.

Practice design, Target population empowerment, Education and training to promote empowerment and Sustainability and scalability are obligatory for all Pilot actions. Please check, that at least one of the three criteria from the management perspective (Governance, Interaction with regular and relevant systems or Evaluation) is included. Evaluation criteria may support the definition of key performance indicator(s).

Important:

- Several improvement areas may have the same objectives
- It would be advisable that Pilot action plan includes maximum 2 objectives
- The same objective may be related to more improvement areas and to several different criteria
- Each objective may have one or more related activities in the change package

Improvement area(s)	Objective(s)	Change Package Describe the activities	Person(s) involved /responsible	Timeline (months)	Key performance indicator(s)
Description 1		Activity 1 Activity 2	XX, WW Responsible: AA XX, WW Responsible: AA		KPI 1 KPI 2 KPI 3
Description 2		....	....		....

Individual Pilot Action Plan - Summary report

The report on the Pilot action plans will follow the adapted version of SQUIRE 2.0 Guidelines (https://qualitysafety.bmj.com/content/25/12/e7) which are intended for reports that describe system level work to improve healthcare.

Introduction	***Why did you start?***
1. Problem description	Nature and significance of the local problem *"Problem/challenge" from the Scope definition*
2. Available knowledge	Summary of what is currently known about the problem, including relevant previous studies
3. Rationale	Informal or formal frameworks, models, concepts, and/or theories used to explain the problem, any reasons or assumptions that were used to develop the intervention(s), and reasons why the intervention(s) was expected to work
4. Specific aims	Purpose of the project and of this report *"General purpose of the intervention" and "Quality criteria" from the Scope definition (Guideline 5.1)*
Methods	***What will you do?***
5. Context	Contextual elements considered important at the outset of introducing the intervention(s) *Main output of the SWOT analysis*
6. Intervention(s)	Specifics of the team involved in the work *Description of the LIWG (such as number, profiles, roles) from LIWG definition and stakeholders identification, if deemed relevant* Description of the intervention(s) in sufficient detail that others could reproduce it *"Target population" from the Scope definition* *Pilot action plan with defined Improvement areas (Guideline 5.3)*
7. Study of the Intervention(s)	Approach chosen for assessing the impact of the intervention(s) (quantitative or qualitative analyses) *Pilot action plan with defined Improvement areas (Guideline 5.3) with special focus to key performance indicators* Approach used to establish whether the observed outcomes were due to the intervention(s)
8. Measures	Measures chosen for studying processes and outcomes of the intervention(s), including rationale for choosing them, their operational definitions, and their validity and reliability

	Pilot action plan with defined Improvement areas (Guideline 5.3) with special focus to key performance indicators
9. Chronogram	Expected timing of the activities of the Change package, scheduling the start and end month *Pilot action plan with defined Improvement areas (Guideline 5.3) with special focus to timeline(s)*

Table 1

QCR Tool - Quality Criteria and Recommendations to improve care for people with chronic diseases

http://chrodis.eu/wp-content/uploads/2017/02/wp7-deliverable-recommendations-final-draft.pdf

Criteria	Categories
Practice design	The practice aims, objectives and methods were clearly specified
	The design builds upon relevant data, theory, context, evidence, previous practice including pilot studies
	The structure, organization and content of the practice were defined, and established together with the target population
	There was a clear description of the target population (i.e. exclusion and inclusion criteria and the estimated number of participants)
	The practice includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks
	There was a clear description of the target population, carers and professionals specific role
	In design, relevant dimensions of equity are adequately taken into consideration, and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups)
Target population empowerment	The practice actively promotes target population empowerment by using appropriate mechanisms (e.g. self-management support, shared decision making, education-information or value clarification, active participation in the planning process and in professional training).
	The practice considered all stakeholders needs in terms of enhancing/acquiring the right skills, knowledge and behaviour to promote target population empowerment (target population, carers, health and care professionals, policy makers, etc.)
Evaluation	The evaluation outcomes were linked to action to foster continuous learning and/or improvement and/or to reshape the practice
	Evaluation outcomes and monitoring were shared among relevant stakeholders
	Evaluation outcomes were linked to the stated goals and objectives
	Evaluation took into account social and economic aspects from both target population, and formal and informal caregiver perspectives
Comprehensiveness of the practice	The practice has considered relevant evidence on effectiveness, cost-effectiveness, quality, safety, etc.
	The practice has considered the main contextual indicators
	The practice has considered the underlying risks of the target population (i.e. validated tools to individual risk assessment)

Education and training	Educational elements are included in the practice to promote the empowerment of the target population (e.g. strengthen their health literacy, self-management, stress management….etc.)
	Relevant professionals and experts are trained to support target population empowerment
	Trainers/educators are qualified in terms of knowledge, techniques and approaches
Ethical considerations	The practice is implemented equitably (i.e. proportional to needs)
	The practice objectives and strategy are transparent to the target population and stakeholders involved
	Potential burdens of the practice (i.e. psychosocial, affordability, accessibility, etc.) are addressed, and there is a balance between benefit and burden
	Target population rights to be informed, to decide about their care, participation and issues regarding confidentiality, were respected and enhanced
Governance	The practice included organizational elements, identifying the necessary actions to remove legal, managerial, and financial or skill barriers
	The contribution of the target population, carers and professionals was appropriately planned, supported and resourced
	The practice offers a model of efficient leadership
	The practice creates ownership among the target population and several stakeholders considering multidisciplinary, multi-/inter-sectorial, partnerships and alliances, if appropriate.
	There was a defined strategy to align staff incentives and motivation with the practice objectives
	The best evidence and documentation supporting the practice (guidelines, protocols, etc.) was easily available for relevant stakeholders (e.g. professionals and target populations)
	Multidisciplinary approach for practices is supported by the appropriate stakeholders (e.g. professionals associations, institutions etc.)
	The practice is supported by different information and communication technologies (e.g. medical record system, dedicated software supporting the implementation of screening, social media etc.)
	There was a defined policy to ensure acceptability of information technologies among users (professionals and target population) i.e., enable their involvement in the process of change
Interaction with regular and relevant systems	The practice was integrated or fully interacting with the regular health, care and/or further relevant systems
	The practice enables effective linkages across all relevant decision makers and stakeholders
	The practice enhances and supports the target populations ability to effectively interact with the regular, relevant systems

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

References

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