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CHRODIS+
IMPLEMENTING GOOD PRACTICES FOR CHRONIC DISEASES

GUIDE FOR THE IMPLEMENTATION OF GOOD PRACTICES

based on results of JA CHRODIS PLUS from 8 countries using
JA CHRODIS RECOMMENDATIONS AND CRITERIA (QCR), a short version

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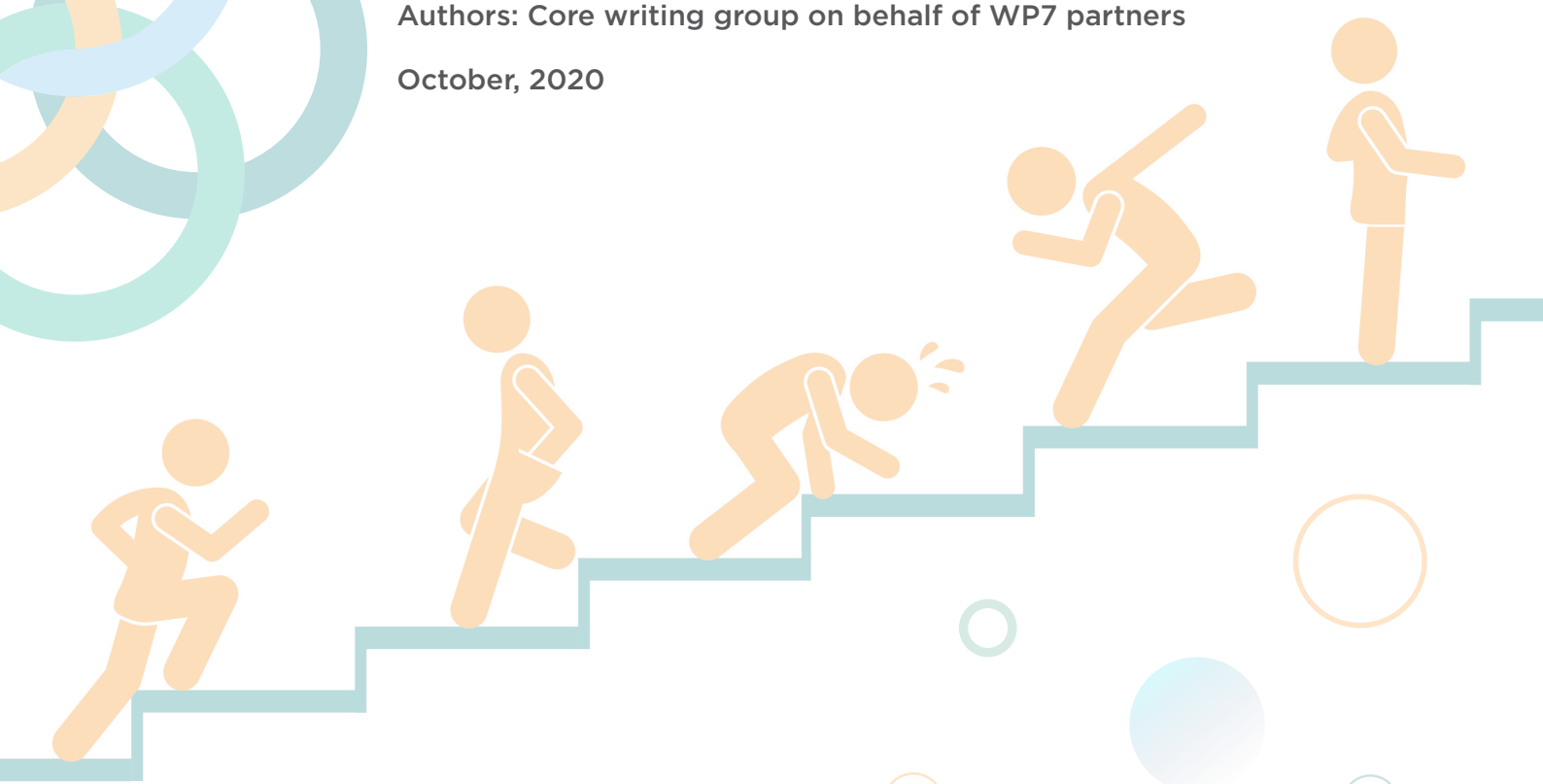

INTRODUCTION

This booklet is a short version of the **Guide for the implementation of JA CHRODIS Recommendations and criteria** (In short: The Guide), that was developed in Joint action **CHRODIS PLUS**, a three-year initiative (2017-2020) funded by the European Commission and participating organisations with 42 beneficiaries representing 20 European countries. The purpose of CHRODIS PLUS was to tackle the increasing burden of chronic diseases by promoting the implementation of policies and practices in this field.

The Guide provides a step-by-step tutorial for the implementation of JA CHRODIS Recommendations and criteria. The latter were originally developed in Joint Action CHRODIS (2014-2017) using Type 2 Diabetes (T2DM) as a model disease, but were subsequently applied and tested in CHRODIS PLUS - Work Package 7: Fostering quality of care for people with chronic diseases. They were implemented in a variety of settings through pilot actions in Bulgaria, Croatia, Finland, Germany, Greece, Serbia, Slovenia and Spain. Pilot actions developed innovative practices in the fields of disease prevention, health promotion and healthcare, focusing on Type 1 and Type 2 diabetes, tinnitus and complex chronic conditions. The experiences show the potential for applicability of JA CHRODIS Recommendations and criteria to settings outside T2DM.

Based on these experiences we developed the Guide for the implementation of JA CHRODIS Recommendations and criteria to provide practical support to those who are going to lead the development, implementation, monitoring and evaluation of the practices in the field of health promotion, disease prevention and care for chronic diseases. It was concluded that it is suited to be used as a 'top-down' framework, when the broad horizon of the implementation has to be taken into account, and is therefore most useful for the core leadership group. Nevertheless, as experienced by partners with pilot actions, its use fosters active and meaningful participation of a wide variety of stakeholders who are or will be in any way affected by the practice, and/or are involved in its sustainability and scalability.

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CORE ELEMENTS OF THE GUIDE

JA CHRODIS Recommendations and criteria	• List of JA CHRODIS Recommendations and criteria with visual representation of the framework
Steps of the implementation process	• Establishment of the core leadership group and the implementation working group • Scope of the practice • Baseline analysis of situation and context • Design of pilot action plan • Monitoring and evaluation of the implementation • Reporting of the results • Planning for sustainability of the practice and to increase the potential for scale-up

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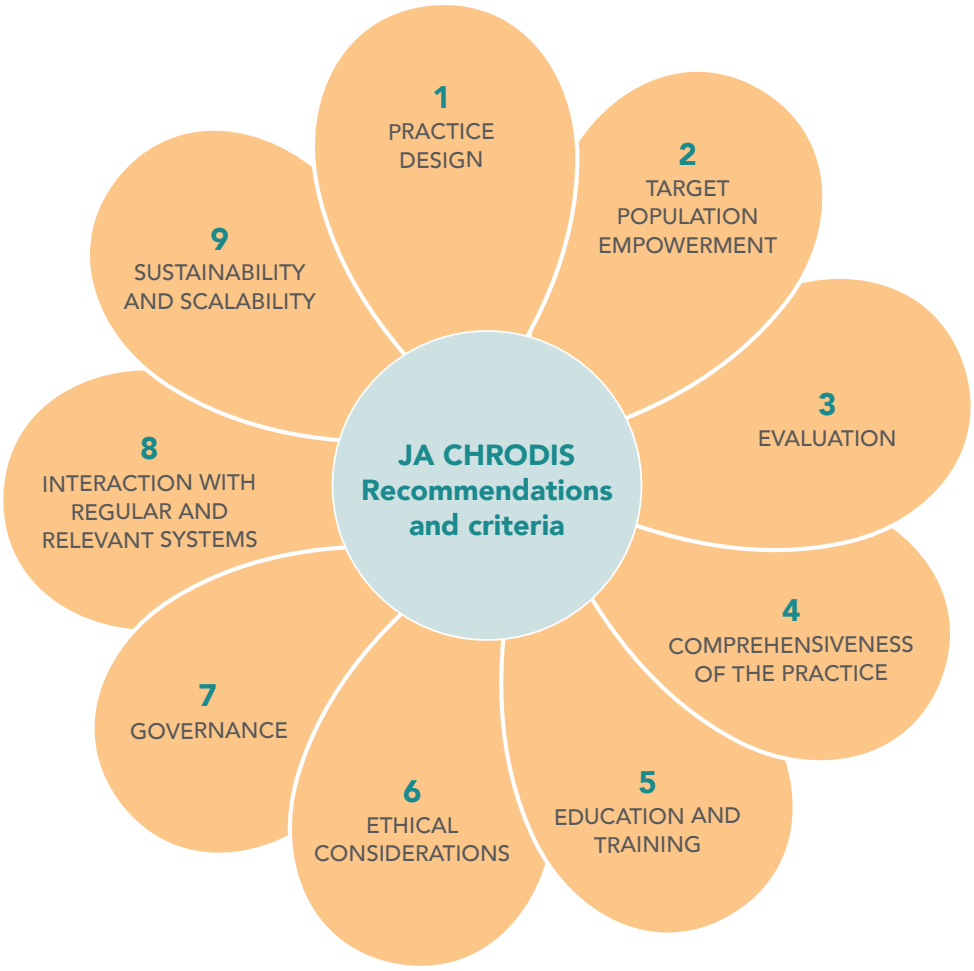
JA CHRODIS RECOMMENDATIONS AND CRITERIA

The following section presents JA CHRODIS Recommendations and criteria (QCR). They include in-depth descriptions of different aspects that were found to be useful in developing, implementing, monitoring and evaluating the good practices. They are represented visually as a nine leaved clover, since they all characterise a good practice.



Design of the Practice

The design should clearly specify aims, objectives, and methods, and rely upon relevant data, theory, context, evidence, and previous practices including pilot studies. The structure, organization, and content of the practice is defined and established together with the clearly described target population (i.e., exclusion and inclusion criteria and the estimated number of participants). Human and material resources should be adequately estimated in relation with committed tasks. Relevant dimensions of equity have to be adequately taken into consideration and targeted.

Promote the Empowerment of the Target Population

The practice should actively promote the empowerment of the target population by using appropriate mechanisms, such as self-management support, shared decision-making, education-information, value clarification, active participation in the planning process, active participation in professional training, and considering stakeholder needs in terms of enhancing/acquiring the right skills, knowledge, and behavior.

Define an Evaluation and Monitoring Plan

The evaluation outcomes should be linked to action to foster continuous learning and/or improvement,

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and/or to reshape the practice. Evaluation and monitoring outcomes should be shared among relevant stakeholders and linked to the stated goals and objectives, taking into account social and economic aspects from both the target population and formal and informal caregiver perspectives.

Comprehensiveness of the Practice

The practice should consider relevant evidence on effectiveness, cost-effectiveness, quality, safety, the main contextual indicators, and underlying risks of the target population using validated tools to individual risk assessment.

Include Education and Training

The practice should include educational elements 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, and trainers/educators are qualified in terms of knowledge, techniques, and approaches.

Ethical Considerations

The practice should be implemented equitably (i.e., proportional to needs). The objectives and strategy are transparent to the target population and stakeholders involved. Potential burdens (i.e., psychosocial, affordability, accessibility, etc.) should be addressed to achieve a balance between benefit and burden. The target population has the right to be informed, to decide about their care, and participation. Their right to confidentiality should be respected and enhanced.

Governance Approach

The practice should include organizational elements, identifying the necessary actions to remove legal, managerial, financial, or skill barriers, with the contribution of the target population, caregivers, and professionals planned for, supported, and resourced. There is a defined strategy to align staff incentives and motivation with the practice objectives. The practice should offer a model of efficient leadership and should create ownership among the target population and several stakeholders considering multidisciplinary, multi-/intersectoral, partnerships and alliances, if appropriate. The best evidence and documentation supporting the practice (guidelines, protocols, etc.) should be easily available for relevant stakeholders (e.g., professionals and target populations), which should support the multidisciplinary approach for practices. The practice should be supported by different information and communication technologies (e.g., medical record system, dedicated software supporting the implementation of screening, social media etc.), defining a policy to ensure acceptability of information technologies among users (professionals and target population) to enable their involvement in the process of change.

Interaction with Regular and Relevant Systems

The practice should be integrated or interactive with regular healthcare and/or further relevant systems, enabling effective linkages between all relevant decision makers and stakeholders, and enhancing and supporting the target populations' ability to effectively interact with the regular relevant systems.

Sustainability and Scalability

The continuation of the practice should be ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities, as well as supported by those who implemented it. The sustainability strategy should consider a range of contextual factors (e.g., health and social policies, sex and gender issues, innovation, cultural trends, general economy, and epidemiological trends) that assesses the potential impact on the population targeted.

The JA CHRODIS Recommendations may as well be described as JA CHRODIS Criteria with defined specific categories per each criterion to support the implementation process. Please, refer to page 15.

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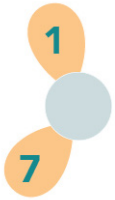
STEPS OF THE IMPLEMENTATION PROCESS

Establishment of the core leadership group and the implementation working group

The first step of the implementation process needs to consider various aspects of governance and leadership. In this step it needs to be defined who will be leading and coordinating the practice development and implementation. ***The core leadership group*** is central in identifying relevant stakeholders to be involved in the various stages of the process, outlining their roles and responsibilities. It is a group that plans, organises, monitors, shares, reports and provides support during the pursuit of practice objectives. This is where an efficient leadership has to be established and foundations are laid to later on create shared ownership among the target population and all collaborating stakeholders. That is why this group puts a particular emphasis on sharing the information or enabling an easy access to relevant information and evidence that supports the pilot implementation (e.g. guidelines, documents, protocols etc.). Establishing opportunities for continuous information exchange fosters multidisciplinary approach and incentivises those involved.

When establishing the ***implementation working group***, core leadership group has to identify stakeholders to be included and at which level – individuals, institutions or organizations that are in any way involved or affected by the activity, programme, intervention or policy implemented, or are important for the sustainability or scalability of the implemented action. The stakeholders may represent institutions, organizations or individuals with distinctive knowledge and experiences in health, education, social, employment, research and Information and Communication Technology (ICT) sectors, NGOs, patient associations and civil society. Although teams can vary in size and composition, the implementation would benefit most from the persons that can ensure that relevant perspectives are represented. Members may be engaged as organizers, experts, decision-makers, frontline stakeholders, implementers and target group representatives. Other stakeholders identified may not be included in the implementation working group, but can be consulted on specific issues, actively informed and asked for feedback, or only informed.

Depending on the specifics of the practice, new objectives, needs and activities might emerge over time. The core leadership group should be able to identify them timely, and then adjust the implementation working group according to the situation and context. Usually patients and other users of healthcare services are the ones who are directly or indirectly affected by health practices the most. If possible (and depending on the context), consider involving vocal target population representatives in the implementation working group. This can substantially influence the group dynamics, make it more constructive with clearer language and more patient-centred. This is also how focus on target population involvement can be maintained throughout the development and implementation of the practice.



1. *Governance*
7. *Practice design*

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Scope of the practice

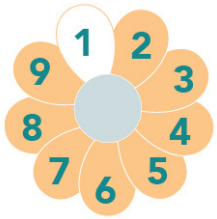
The next step is to define the scope of the practice. The implementation working group, led by core leadership group, in this phase outlines the problem that the practice will be addressing, defines its purpose and involvement of target population and selects the JA CHRODIS Recommendations and criteria (1) that are core to the successful implementation.

Problem description: the nature and significance of the local problem is outlined, based on the available knowledge. It summarizes what is currently known about the problem with reference to relevant previous studies. It was experienced by the partners that the published literature in implementation area is scarce.

General purpose: general purpose has to be clear and established together with all members of implementation working group; it should reflect the needs of the target population.

Target population: when defining the target population, relevant dimensions of equity should be adequately taken into consideration and targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area and vulnerable groups).Their characteristics (i.e. exclusion and inclusion criteria and the estimated number of participants) and roles in the intervention are to be clearly specified.

First implementation outline: the implementation is briefly described, considering each criterion. It is advisable to take into account all of the criteria, but some may not apply to the specific implementation. In that case, it is a good double-check exercise to try to describe, why some of the criteria may not be addressed.



1. – 9. *All*
1. *particular emphasis to Practice design*

Baseline analysis of situation and context

Before the action plan is developed in detail, relevant contextual factors that might affect the implementation should be identified. Quantitative, qualitative or mixed methodology can be used to perform baseline analysis. Same principles can be applied for the monitoring and evaluation of the implementation.

Quantitative methodology: data is can be collected from data registries, questionnaires, and forms which produce numeric data. Data analysis includes statistical procedures (descriptive, unvariate, multilevel, multivariate) or score construction. Products are inferential statistics, multilevel models and /or multivariate classification. In many instances secondary data is being used to analyse the context.

Qualitative methodology: data is usually collected with open-ended questionnaires, semi-structured interviews, participatory observation and interactive sessions (e.g. workshops, SWOT analysis (2), 'World cafe' (3)) or by extraction of data from written sources. Data (mostly in the

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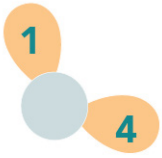
form of transcripts and researchers' memos) is usually analysed using coding, content analysis or grounded theory (4).

SWOT analysis is a qualitative method that can be used to describe the context from the perspective of the implementation working group. It engages all group participants and does not require elaborate expert knowledge to perform the analysis. It enables a structured discussion among the group participants which is synthesized in a SWOT diagram. Describe strengths, weaknesses, opportunities, and threats of the implementation activity you are trying to develop, change or improve.

SWOT analysis could be performed from the focus of all of the JA CHRODIS Recommendations and criteria (1), or only taking into account the selected criteria that are found as most relevant. However, it is advisable to report the arguments, why other criteria were not seen as relevant.



1. *Practice design*
4. *Comprehensiveness of the practice*

Design of pilot action plan

Baseline (situation and context) analysis helps to outline the specific local problem in more detail. At this point, it is advisable to check again the scope of the intervention and make adjustments, based on the information acquired from the analysis.

Next step is to define pilot action plan. In pilot action plan, specific objectives, activities, responsibilities, timeline and key performance indicators are defined.

Specific objectives: formulation of specific objectives has to be coherent. The practice objectives and strategy have to be transparent to the target population and stakeholders involved.

Activities: per each specific objective, one or more activities are defined.

Responsibilities: it has to be clear, who is responsible for a particular activity implementation and who is involved. The action plan has to create ownership among the target population and several stakeholders considering multidisciplinary, multi-/inter-sectorial partnerships and alliances, as appropriate.

Timeline: implementation of each activity should be realistic in terms of duration. Usually, the activity took more time than planned.

Key performance indicators: indicators are used to measure processes (implemented activities), outputs (results of the activities) and outcomes (changes obtained by the activity).

The practice should be implemented equitably (i.e. proportional to needs) and efforts should be made to assure transparency of objectives and strategy to the target population and stakeholders involved. Consider the potential burdens of the practice (i.e. psychosocial, affordability, accessibility,

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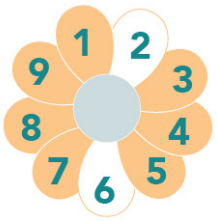
etc.) and balance between benefit and burden. The rights of the target population to be informed (regularly and after the practice has been put in place), to decide about their care and to actively participate have to be respected and supported, and the confidentiality is taken into account.



1. - 9. *All, particular emphasis to Target population empowerment*
6. *Ethical consideration*

Monitoring and evaluation of the implementation

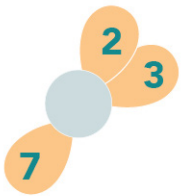
Day one of the implementation process has to be defined. Use of Gantt chart (see 5) or other visual methods is advisable to describe the timeline and identify potential failures in planning.

PDSA (plan-do-study-act) methodology (6) can be adopted to outline one or more implementation cycles. This method supports further changes of the primary plan, based on the information collected and analysed. PDSA cycle this includes intermediary evaluation of the intervention.

Intermediary evaluation of the intervention can be performed using JA CHRODIS Recommendations and criteria (1), in JA CHRODIS PLUS it was used for self-assessment. The partners assessed the implementation of the practice after several months, describing in detail if and how the categories of the criteria are a fulfilled at that time point, providing justification/explanation for the answer, and describing the ideas/plans/concrete actions for the changes in the primary action plan. The intermediary evaluation also includes the assessment of key performance indicators, and results in adaptation of the plan if needed. More than one PDSA cycles can be rolled out.

Final evaluation at the conclusion of the intervention may have the same structure.

The outcomes of the evaluation should be at every point linked to action to foster continuous learning and/or improvement and/or to further reshape the practice. They are to be shared among relevant stakeholders, showing the link to the defined goals and objectives. Evaluation has to address social and economic aspects from both target population, and formal and informal caregiver perspectives, if applicable.



2. *Target population empowerment*
3. *Evaluation*
7. *Governance*

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Reporting of the results

When intervention is concluded, it is very useful for the implementation working group to reflect on the job done, and to write a report on the entire implementation process. Reporting also conveys core information and messages the scientific, professional and lay communities as well as to the decision-makers, and is an essential building element for the sustainability and scalability.

The report of the implementation process should be structured and aligned to the guidelines that are used in scientific and professional publications. Partners in JA CHRODOS PLUS were using SQUIRE 2.0 Guidelines (7). The following elements are to be included into the report:

- Title
- Abstract
- Short summary
- Introduction *(Why did you start?)*
    - Problem description
    - Available knowledge
    - Rationale
    - Specific aims
- Methods *(What did you do?)*
    - Context
    - Intervention(s)
    - Study of the Intervention(s)
    - Measures
    - Pilot action plan
    - Analysis
    - Ethical considerations
- Results *(What did you find?)*
- Discussion *(What does this mean?)*
    - Implementation process
    - Summary
    - Interpretation
    - Limitations
- Conclusions

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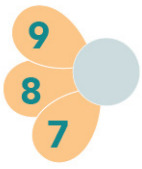
Planning for sustainability of the practice and to increase the potential for scale-up

Sustainability and scalability aspects of the practice should be considered at all stages of the implementation: at baseline situation and context analysis, at planning phase of the activities, and during intermediary and final evaluations, with special emphasis at the reporting. The experiences of our partners with pilot actions show that sometimes major adjustments to the primary planned activities are needed to increase the potential for sustainability.

For achieving sustainability, there should be a broad support to the implemented practice amongst those who have implemented it, or by those who intend to. Continuation of the practice can be ensured through institutional anchoring and/or ownership by the relevant stakeholders or communities, facilitated by implementation working group and/or core leadership group. The sustainability strategy should be defined, that considers contextual factors (e.g. health and social policies, innovation, cultural trends and general economy, epidemiological trends). Potential impact on the population targeted (if scaled up) has to be assessed.

Establishing and/or fostering connections with decision-makers and the local community is another important mechanism for building the sustainability and the potential for scalability. Where possible, those stakeholders have to be involved in the implementation process and the results (meaningful information) should be shared with them. Their reflection on the results can be sought, for example by organising a 'policy dialogue' – a structured discussion with decision-makers, experts and target population representatives about the intervention. Common expectations have to be identified, support sought among the stakeholders, and the possible next steps should be outlined together. Patient representatives/representatives of the target population should be continuously and meaningfully involved. The owner and carer of the future process have to be defined and supported by all stakeholders, as experienced by our partners with pilot actions.



7. Governance
8. Interaction with regular and relevant systems
9. Sustainability and scalability

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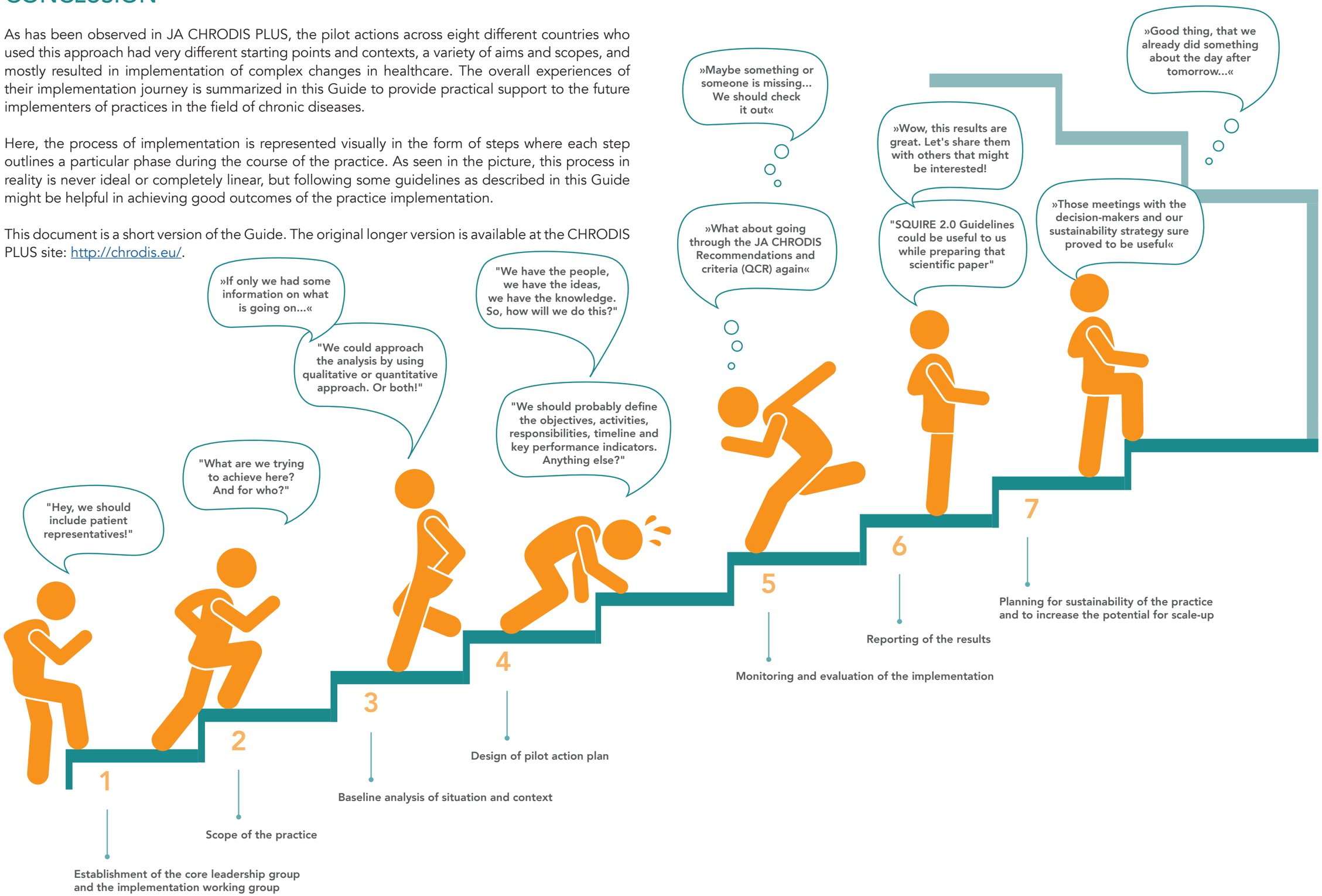
CONCLUSION

As has been observed in JA CHRODIS PLUS, the pilot actions across eight different countries who used this approach had very different starting points and contexts, a variety of aims and scopes, and mostly resulted in implementation of complex changes in healthcare. The overall experiences of their implementation journey is summarized in this Guide to provide practical support to the future implementers of practices in the field of chronic diseases.

Here, the process of implementation is represented visually in the form of steps where each step outlines a particular phase during the course of the practice. As seen in the picture, this process in reality is never ideal or completely linear, but following some guidelines as described in this Guide might be helpful in achieving good outcomes of the practice implementation.

This document is a short version of the Guide. The original longer version is available at the CHRODIS PLUS site: http://chrodis.eu/.



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JA CHRODIS Criteria

Criterion 1: 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)

Criterion 2: 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.)

Criterion 3: 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

Criterion 4: 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)

Criterion 5: 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

Criterion 6: 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

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- 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

Criterion 7: 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

Criterion 8: 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

Criterion 9: 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.

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Contributors and Acknowledgements

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