

WP 4 PLATFORM FOR KNOWLEDGE EXCHANGE

Task 1: selecting JA-CHRODIS criteria to assess good practice in interventions related to chronic conditions

**INTERIM REPORT 1: Delphi Panel on interventions
in the area of health promotion and primary
prevention of chronic diseases**



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Intended use of this publication

The content of this publication is the result of a consensus process among experts from a variety of domains and profiles. The criteria and indicators agreed under this consensus process are meant to be used as a whole, not being recommended the selection of a subset of criteria and categories for a purpose different to which they were agreed for (ie. assessment of practices involving chronic patients under a peer review process). Be aware that other uses may compromise the reliability of the instrument and are out of the scope of the CHRODIS project.



Introduction

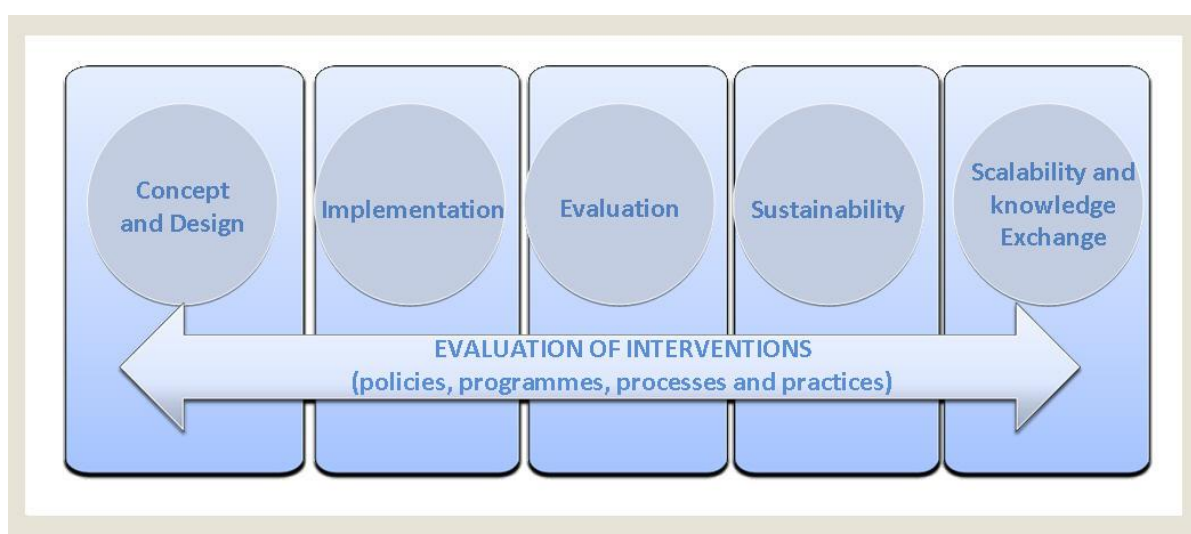
The CHRODIS Delphi consultation gathered an expert panel to decide on the suitability and priority of a series of criteria to assess whether an intervention -policy, strategy, programme/service, as well as processes and practices- can be regarded as ‘good practice’ in the field of **Health Promotion and Primary Prevention of Chronic Conditions**.

Following the RAND modified Delphi methodology, the consultation entailed two online rounds using a web-based questionnaire, followed by a face to face meeting. The number of participants was restricted to a maximum of 30 and a minimum of 15, allowing for eventual drop offs.

The first web-based questionnaire included the criteria identified through a search and appraisal of primary and secondary documents from different sources.

Two main bodies of information were identified. The first came from the country reviews conducted by JA-CHRODIS Work Package 5. The second was made up of the conceptual models, assessment tools, frameworks and procedures identified at national and international level for the evaluation of good practice related to chronic conditions, in particular -but not exclusively- those focused on health promotion and primary prevention. In addition, a reverse search was undertaken based on the identified and reviewed sources.

The complete list of sources consulted and retained to elaborate the criteria is displayed in annex 1 and annex 2 includes the summary of the evidence compiled. The search for criteria was guided by the model depicted below, with a view to cover all those aspects of evaluation.



Methodology

- **Online Round 1 (R1)**

Round 1 was launched in December 2nd 2014 and closed on January 25th 2015. The initial number of European experts invited to join the panel was 34. Twenty six of them actually completed the questionnaire in the first round: men=12 (46%) and women=14 (52%), the age-range included 23% within 35-44 years old, 26 % ages 45-54 and 38% in the range 55-65 years old.

They came from different countries in Europe (Belgium, Bulgaria, Denmark, Estonia, Germany, Greece, Iceland, Ireland, Italy, Netherlands, Portugal, Serbia, Sweden and United Kingdom); covering a variety of health system models as well as diverse individual expertise (academic, clinician, policy, advocacy). Their common feature was holding knowledge and experience in the field of health promotion and primary prevention of chronic diseases.

The online questionnaire included all items in the exhaustive list extracted from the review: 57 items clustered into 16 thematic drivers. Experts were asked to judge how relevant each item was in assessing health promotion and primary prevention practices using a scale of 1 (not relevant at all) to 9 (highly relevant). In this round they were able to suggest additional criteria.

The relevance of each item was determined by the median score achieved. The scale was divided into 3 brackets for this analysis: scores 1-3 were interpreted as 'irrelevant criterion', 4-6 'not clearly relevant' and 7-9 'relevant criterion' (fig 1).

In order to establish the degree of agreement, the median and the distribution of votes for each score was examined. When the median and the votes fitted within the same bracket, it was concluded that there was an agreement among the experts about that particular item. Only those items for which agreement converged around 'relevant' were kept for priority setting in the following round; agreements on irrelevance or not clearly relevant led to dropping the item. Those items that did not reach any agreement were kept for reassessment in the second round (fig 2).

Figure1: answers range and possibilities of agreement

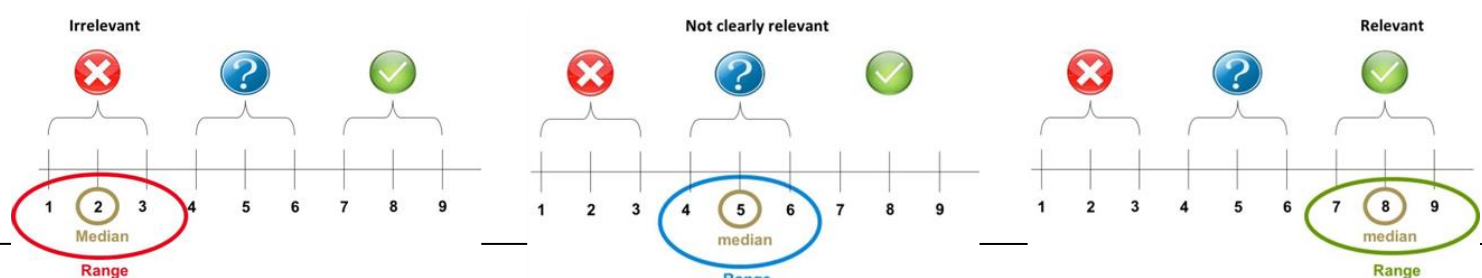
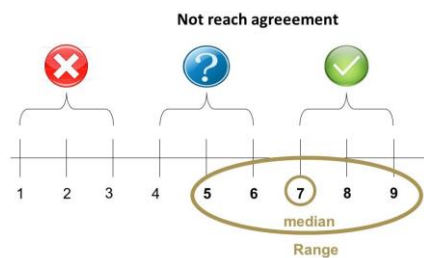


Figure 2: answers rate that did not reach agreement

- **Online Round 2 (R2)**

The Delphi round 2 was launched to last from February 16th to March 16th 2015. The 26 panellists completing the first round were invited to participate in the second round. Only Twenty-three of them were finally able to contribute. They were men=10 (43, 5%) and women= 13 (56, 3 %). Participants' age-range included 35-44 (26%), 45-54 (26%) and 55-65 (39%) years old. The range of countries represented (Belgium, Bulgaria, Estonia, Germany, Greece, Iceland, Ireland, Italy, Netherlands, Serbia and United Kingdom) was still a good sample for the variety of health systems in Europe; the range in expertise was also well covered (academic, clinician, policy and advocacy).

The 40 items on which experts had agreed as being relevant (7-9 score) in the first round were presented for rating on a priority scale from 1=lowest priority to 9=highest priority. The higher the value the participant chose, the more priority was attaching to the item to assess interventions in the area of health promotion and primary prevention of chronic disease.

Likewise the first round, the median and interquartile range, as well as the distribution of votes per score, were examined to determine whether experts agreed on the level of priority (1-3 low priority; 4-6 moderate priority; 7-9 high priority).

To give a sense of the relative priority assigned to each item, the individual values of expert's marks were summed up to build an item score. Drivers were then ranked according to the average score across the items they gathered.

The items on which the panel had not reached agreement in the first round were presented again, this time alongside with the median and range of variation of experts' marks in the previous round. In light of this information, panellists were asked to rate again each item according to the proposed relevance scale (from 1=not relevant at all to 9=highly relevant).

- **Face to face**

The expert meeting to refine and prioritise criteria to assess practices on health promotion and primary prevention of chronic diseases was held on April 23rd and 24th in Brussels.

Fourteen out of the 23 experts that completed the 2nd round were able to attend. They were men=3 (21,5%) and women=11 (92,9%). The range of countries represented (Estonia, Belgium, Germany, Iceland, Ireland, Italy, Portugal, Serbia, Netherlands and United Kingdom) still showed a good sample of the variety of health systems in Europe; the range in expertise was also covered (academic, clinician, policy and advocacy).

A trained facilitator conducted the discussions following a structured consensus methodology. Two rapporteurs provided support in recording voting processes and modifications in phrasing and allocation accorded by experts' consensus. In addition, sessions were tape-recorded (with experts' consent) to enable an accurate account for discussions.

Each retained driver and the items clustered under it were presented following the priority order obtained from the 2nd online round. Reacting to a proposal by the CHRODIS Delphi Team, experts agreed to consider each driver as a criterion for intervention assessment, which was further specified into categories (the items composing each driver) as shown in table 6.

Priority-setting and weighting of criteria took place in two stages:

In the first step experts allocated relative weight to each category within a criterion.

Criteria were presented one at a time and at this stage, merging, rephrasing and reallocating of categories across criteria were allowed. Once consensus on the formulation of criterion and categories was reached, experts proceeded to weight categories on a scale of 100.

Whenever group discussions did not yield consensus about weights distribution among categories, experts individual voting was called to allocate the 100 points using ballots. The final weight for each category was calculated averaging total points by the number of voters (dividing total points by 14 experts and multiplying by 100, so the sum of categories' weight within a criterion was always 100). In 8 out of the 10 criteria, experts agreed in open discussion on the relative weight of categories. Individual voting was needed just for two criteria.

Table 6. Relevant criteria for intervention's assessment obtained from online round 2

Note: categories coloured in pink correspond to items selected in the second round

Criterion-ID	Criterion	Categories
1	Equity	Different dimensions of equity are taken into consideration and are targeted (i.e. gender, socioeconomic status, education level, ethnicity, rural-urban area, vulnerable groups)
		Efforts are made to facilitate vulnerable group's access to relevant services ("low threshold" approach)
2	Sustainability	The continuation of the project is ensured e.g. through ownership, structural continuity and/or institutional anchoring
		There is broad support for the intervention amongst those who implement it
		There is broad support for the intervention amongst the intended target populations

Criterion-ID	Criterion	Categories
		:: The continuation of the project is ensured through follow-up funding and human resources
3	Aims & Objectives	The concept includes a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed)
4	Description of intervention strategies and methods of implementation	The design is theoretically justified and addresses the sequence, frequency, intensity, duration, recruitment method and location of the intervention
		The method of the intervention is thoroughly described in concrete activities including time frame or chronograms
5	Evaluation	Evaluation results are linked to the stated goals and objectives at each stage of implementation process
		The results of evaluation are linked to actions to reshape the implementation accordingly
		Information /monitoring systems are in place to deliver data aligned with evaluation and reporting needs
		Use of validated evaluation methods and/or tools
		The intervention is assessed for impact (i.e. health impact and in a broader sense, any consequences derived from the implementation of the intervention such as raising specific taboos among certain groups, unforeseen resistances in the implementation, etc.)
		Defined evaluation framework assessing structure, process and outcome
		The intervention is assessed for efficiency
6	Empowerment and Participation	The intervention has been designed in consultation with the target population
		The intervention aims to support the target population(s) in an autonomy-developing process
		The intervention creates ownership among the target population and stakeholders
		Strengths and resources of the target population are developed (salutogenetic approach)
7	Multi-Stakeholder Approach	Different dimensions of a multi-stakeholder approach are taken into consideration (i.e multidisciplinary, multi-/ inter-sector, partnerships and alliances)
8	Target population	Target population/s are defined on the basis of needs assessment
		Methods used for selection of target population/s are documented

Criterion-ID	Criterion	Categories
		<p>There is a communication strategy which includes intermediaries/multipliers addressing stakeholders that are of relevance to promote the use of /participation in the intervention (e.g. community doctors and local school teachers are made aware of the existence of a community counselling service)</p> <p>The intervention aims to create a health promoting environment through a "setting approach"</p> <p>:: Specific characteristics and strengths of target population/s are documented</p>
9	Ethical Considerations	<p>The intervention's objectives and strategy are transparent to all individuals and stakeholders involved</p> <p>The intervention is implemented equitably, following the principle of proportional universalism: universal provision with a scale and intensity that is proportional to needs</p> <p>Benefits and burdens of the intervention are fairly balanced</p> <p>Potential burdens of the intervention for the target population are addressed</p>
10	Comprehensiveness of the intervention	<p>The intervention is aligned with a comprehensive approach to health promotion</p> <p>The intervention is aligned with a policy plan at the local, national, institutional or international level</p>
11	Context and Determinants analysis / Evidence	<p>Empirical data has been collected regarding the nature, size and distribution of the problem</p> <p>:: Theoretical basis of the intervention are provided: description of the chain of causation</p>
12	Adequacy, capacity and resources	<p>The concept includes an adequate estimation of the human resources, material, non-material and budget requirements</p> <p>Sources of funding are specified in regards to stability and commitment</p>
13	Participation and structural commitment	<p>Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities)</p> <p>Human resource needs assessed, defined and in clear relation with committed tasks</p>
14	Scalability	<p>There are specific knowledge transfer strategies in place (evidence into practice)</p> <p>Intervention scalability is assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring)</p>

Criterion-ID	Criterion	Categories
		Intervention scalability is assessed in terms of potential size of the population targeted if scaled up
		Intervention scalability is assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators

Note: categories coloured in pink correspond to items selected in the second round

In the second stage panellists' discussions were steered to obtain relative weights for the criteria consolidated in the previous stage. The dynamic entailed 15 minutes of group discussion about the relative importance of the criteria, followed by experts' individual rating using ballots. The criteria relative weight was also rated in a 100 points scale.

To determine the relative weight finally allocated to each criterion, experts' votes were processed to obtain the average score per criterion (total sum of points divided by the number of voters and multiply by 100).

Results

- **Online Round 1 (R1)**

The review produced 57 potential criteria clustered into 16 drivers.

In this first round, Experts agreed on deeming **forty** items as relevant (7-9 score) for assessing practices and, thus, they passed onto the second round (table 1) for priority assessment.

The panellists also reached agreement as to the relative irrelevance of **six** out of the 57 items; therefore these were discarded from the second round (table 2).

As for the remaining **eleven** questions, there was no consensus among the experts, with opinions evenly split between the "not clearly relevant" and "relevant" brackets of the scale. Those questions passed onto the second round for reassessment by the experts, this time in light of the median and range of the valuations assigned by their colleagues in the first round.

Table 1. Relevant drivers and items for interventions' assessment (Round 1)

ID	Driver	Item
1	Comprehensiveness of the intervention	:: The intervention is aligned with a comprehensive approach to health promotion
		:: The intervention is aligned with a policy plan at the local, national, institutional or international level
2	Context and Determinants analysis / Evidence	:: Empirical data has been collected regarding the nature, size and distribution of the problem
3	Aims & Objectives	:: The concept includes a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed)
4	Description of intervention strategies and methods of implementation	:: The design is theoretically justified and addresses the sequence, frequency, intensity, duration, recruitment method and location of the intervention
		:: The method of the intervention is thoroughly described in concrete activities including time frame or chronograms
5	Equity	:: Different dimensions of equity are taken into consideration and are targeted (i.e. gender, socioeconomic status, education level, ethnicity, rural-urban area, vulnerable groups)
		:: Efforts are made to facilitate vulnerable group's access to relevant services ("low threshold" approach)
6	Target population	:: Target population/s are defined on the basis of needs assessment
		Methods used for selection of target population/s are documented
		:: The intervention aims to create a health promoting environment through a "setting approach"
		:: There is a communication strategy which includes intermediaries/multipliers addressing stakeholders that are of relevance to promote the use of /participation in the intervention (e.g. community doctors and local school teachers are made aware of the existence of a community counselling service)
7	Empowerment and Participation	:: The intervention aims to support the target population(s) in an autonomy-developing process
		:: The intervention has been designed in consultation with the target population
		:: The intervention creates ownership among the target population and stakeholders
		:: Strengths and resources of the target population are developed (salutogenetic approach)
8	Multi-Stakeholder Approach	:: Different dimensions of a multi-stakeholder approach are taken into consideration (i.e multidisciplinary, multi-/ inter-sector, partnerships and alliances)

ID	Driver	Item
9	Ethical Considerations	:: Potential burdens of the intervention for the target population are addressed
		:: Benefits and burdens of the intervention are fairly balanced
		:: The intervention is implemented equitably, following the principle of proportional universalism: universal provision with a scale and intensity that is proportional to needs
		:: The intervention's objectives and strategy are transparent to all individuals and stakeholders involved
10	Adequacy, capacity and resources	:: The concept includes an adequate estimation of the human resources, material, non-material and budget requirements [in clear relation with committed tasks?]
		:: Sources of funding are specified in regards to stability and commitment
11	Participation and structural commitment	:: Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities)
		:: Human resource needs assessed, defined and in clear relation with committed tasks
12	Evaluation	:: Defined evaluation framework assessing structure, process and outcome
		:: Use of validated evaluation methods and/or tools
		Information /monitoring systems are in place to deliver data aligned with evaluation and reporting needs
		:: Regularity of monitoring reports
		:: Evaluation results are linked to the stated goals and objectives at each stage of implementation process
		:: The results of evaluation are linked to actions to reshape the implementation accordingly
		:: The intervention is assessed for efficiency
13	Sustainability	:: There is broad support for the intervention amongst those who implement it
		:: There is broad support for the intervention amongst the intended target populations
		:: The continuation of the project is ensured e.g. through ownership, structural continuity and/or institutional anchoring
14	Scalability	:: Intervention scalability is assessed in terms of potential size of the population targeted if scaled up
		:: Intervention scalability is assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators
		:: Intervention scalability is assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring)
		:: There are specific knowledge transfer strategies in place (evidence into practice)

Table 2. Discarded items (Round 1)

Driver-ID	Driver	Item
1	Length of experience threshold	:: The intervention must have been implemented for a minimum length of time (n years) to be eligible for assessment as good practice
3	Context and determinants analysis	:: A comparison to existing alternatives has been carried out and includes economic analysis (e.g. cost effectiveness analysis, cost minimisation analysis, cost utility analysis)
		:: A comparison to existing alternatives has been carried out and includes Health Impact Assessment (HIA)
16	Innovation	:: The intervention implements new ways of funding coordination across key separate institutional and community instances/resources
		:: The intervention implements new ways of coordination for information systems involving key separate institutional and community instances/resources
		:: The intervention includes new (as yet un-trialled) ideas and approaches to resolve known problems

- **Online Round 2(R2)**

Regarding the eleven questions where the panel reached no agreement in the first round, 3 of them were deemed relevant and retained for discussion at the face to face meeting (table 3). The other 8 items considered unclear or not relevant, were dropped from the list (table 4).

As for the 40 items agreed as relevant in the previous round, they all rated in the area of high priority in the second. The scores obtained for each item and the corresponding drivers are summarised in table 5.

The final list of items selected for discussion at the face to face meeting included 14 Drivers with a total of 43 items (table 6).

Table 3. Items assessed as relevant in R2

Driver- ID	Driver	Item
2	Context and Determinants analysis / Evidence	:: Theoretical basis of the intervention are provided: description of the chain of causation
6	Target Population	:: Specific characteristics and strengths of target population/s are documented
13	Sustainability	:: The continuation of the project is ensured through follow-up funding and human resources

Table 4. Items discarded in round 2

Driver-ID	Driver	Item
1	Comprehensiveness of the intervention	The intervention addresses several risk factors or determinants of health at the same time
2	Context and Determinants analysis / Evidence	A systematic review has been conducted to collect evidence on the determinants of health (i.e. Social and economic environment, Physical environment, target population and persons' individual characteristics and behaviours)
		There is an analysis of the budget impact of implementing the intervention (BIA)
		Theoretical basis of the intervention are provided: description of interactions between key stakeholders
		Theoretical basis of the intervention are provided: description of interactions between processes
9	Ethical Considerations	Analysis of conflict of interests among stakeholders and individuals involved
14	Scalability	There are systematic networking efforts to foster the exchange of information, mutual support and cooperation with other community resources
15	Innovation	The intervention implements new ways of coordination for decision making involving key separate institutional and community instances/resources

Table 5. Relevant drivers and items for intervention's assessment ordered by their average priority scores

Driver-ID	Driver	Item	Priority-Weight	
5	Equity	Different dimensions of equity are taken into consideration and are targeted (i.e. gender, socioeconomic status, education level, ethnicity, rural-urban area, vulnerable groups)	183	181.5
		Efforts are made to facilitate vulnerable group's access to relevant services ("low threshold" approach)	180	
13	Sustainability	The continuation of the project is ensured e.g. through ownership, structural continuity and/or institutional anchoring	182	179.33
		There is broad support for the intervention amongst those who implement it	179	
		There is broad support for the intervention amongst the intended target populations	177	
3	Aims & Objectives	The concept includes a SMART specification of the intervention aims and objectives (Specific/Measurable/Acceptable for the target population/Realistic /Time-framed)	179	179
4	Description of intervention strategies and methods of implementation	The design is theoretically justified and addresses the sequence, frequency, intensity, duration, recruitment method and location of the intervention	178	176.5
		The method of the intervention is thoroughly described in concrete activities including time frame or chronograms	175	
12	Evaluation	Evaluation results are linked to the stated goals and objectives at each stage of implementation process	182	176.13
		The results of evaluation are linked to actions to reshape the implementation accordingly	180	
		Information /monitoring systems are in place to deliver data aligned with evaluation and reporting needs	178	
		Use of validated evaluation methods and/or tools	178	
		The intervention is assessed for impact (i.e. health impact and in a broader sense, any consequences derived from the implementation of the intervention such as raising specific taboos among certain groups, unforeseen resistances in the implementation, etc.)	176	

Driver-ID	Driver	Item	Priority-Weight	
		Defined evaluation framework assessing structure, process and outcome	176	
		The intervention is assessed for efficiency	172	
		Regularity of monitoring reports	167	
7	Empowerment and Participation	The intervention has been designed in consultation with the target population	177	175
		The intervention aims to support the target population(s) in an autonomy-developing process	175	
		The intervention creates ownership among the target population and stakeholders	175	
		Strengths and resources of the target population are developed (salutogenetic approach)	173	
8	Multi-Stakeholder Approach	Different dimensions of a multi-stakeholder approach are taken into consideration (i.e multidisciplinary, multi-/ inter-sector, partnerships and alliances)	173	173
6	Target population	Target population/s are defined on the basis of needs assessment	176	172
		Methods used for selection of target population/s are documented	174	
		There is a communication strategy which includes intermediaries/multipliers addressing stakeholders that are of relevance to promote the use of /participation in the intervention (e.g. community doctors and local school teachers are made aware of the existence of a community counselling service)	172	
		The intervention aims to create a health promoting environment through a "setting approach"	166	
9	Ethical Considerations	The intervention's objectives and strategy are transparent to all individuals and stakeholders involved	180	170
		The intervention is implemented equitably, following the principle of proportional universalism: universal provision with a scale and intensity that is proportional to needs	169	
		Benefits and burdens of the intervention are fairly balanced	166	
		Potential burdens of the intervention for the target population are addressed	165	
1	Comprehensiveness of the intervention	The intervention is aligned with a comprehensive approach to health promotion	171	170
		The intervention is aligned with a policy plan at the local, national, institutional or international level	169	

Driver-ID	Driver	Item	Priority-Weight	
2	Context and Determinants analysis / Evidence	Empirical data has been collected regarding the nature, size and distribution of the problem	170	170
10	Adequacy, capacity and resources	The concept includes an adequate estimation of the human resources, material, non-material and budget requirements	177	169.5
		Sources of funding are specified in regards to stability and commitment	162	
11	Participation and structural commitment	Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities)	171	169
		Human resource needs assessed, defined and in clear relation with committed tasks	167	
14	Scalability	There are specific knowledge transfer strategies in place (evidence into practice)	171	162
		Intervention scalability is assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring)	160	
		Intervention scalability is assessed in terms of potential size of the population targeted if scaled up	159	
		Intervention scalability is assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators	158	

- **Comments provide by experts**

In this first round, experts were invited to add any criterion or driver they thought relevant and missing. They were also encouraged to provide comments to individual items, drivers, or the general model. Though no additional items were suggested, those comments proved very informative as to how experts were facing their task and the conceptual difficulties they identified in the process. Three major concerns arise from this material:

The first relates to the assumption that, the feasibility of a good practice in health promotion and prevention will come determined by each country's specific health policy framework, to the point that a practice will be a "good practice" depending on the country's policy rather than the practice *per se*:

["We always have to see that the biggest effects are coming from political decisions"]

["it is very difficult to discriminate "best practice" when the countries' policies are very different among them and they depend on a specific national policy"].



This reliance on health policy as the main drive for good practice and impact leads some experts to underplay the need for further evidence about interventions' effectiveness:

["Prevention and Health Promotion need to be political decisions; if we do more and more science into Public Health we are occupied by research and documentation and loose time and power for Action; "..... Research has to be the second priority and politics has to be the first priority"]

The potential for transferability is also regarded more as matter of national policy than dictated by the intervention requirements of resources or organisational features:

".....the policies of the different countries can differ largely. It is difficult to disseminate a best practice which is very dependent of a specific national policy".

Another concern expressed has to do with assessing a practice by the adequacy of capacity and resources allocated to it. In some experts' view, funding is an *ex-ante* condition, extrinsic to the quality and expected impact of the practice itself, though closely linked to the success and continuation of an intervention:

"Funds are very relevant but differ between countries. So it is difficult to implement this part of the intervention"

Finally, despite their regarding economic analysis as very relevant, some experts showed reservations as to the feasibility of such approach in health promotion and prevention:

"...very hard to demonstrate"

"Difficult to evaluate economic term mentioned but when possible it is highly relevant".

The lack of studies of this sort is argued as a major hurdle to use this type of criteria in assessing the quality of a practice

"..... comparison of cost-effect analysis is very important but there are hardly any studies for cost-effectiveness for health promotion studies and especially studies for the cost-effectiveness for low-income groups are scarce. And very often these are model studies. So this is I think this is a criteria which is difficult to meet"

During the second round experts were also encouraged to provide comments. Those comments were mainly related to the priority that should be assigned to each of the 40 relevant items in deciding whether a practice is good or not, or whether one is better than another.

In line with the first round, some experts' expressed reservations as to attaching high priority to items of adequacy, capacity and resources. Digging a bit further, they argue that such items may penalise practices from those settings under economic constraint; the reasoning seem to go along the lines of potential for misjudgement of otherwise good

practices when resources are increasingly under pressure, limiting the ability of countries to sustain projects despite their relevant results

["High priority and very important criterion in several settings (e.g. countries under austerity)" " it is an important priority no always relevant and in some cases highly costly"].

In addition, sustainability, which experts have considered important criteria for a good practice, is also closely linked to resources

["The funding and the continuation of the funding are very important for criteria within a country. But for a European best practice funding will be different for each country"].

Therefore, according to them, sustainability will depend on the country's economic situation rather than the practice itself (whether it is or not good, its impact on the population, or if the practice can take root into the organization)

["It is a true priority but continuation of the project viability of the funding is uncertain in settings with low resource capacity and under financial crisis"].

Some experts have strong views about the tailoring of practices to the target population needs. The successful adoption of a practice will depend, among other things; on whether different dimensions of the cultural framework are taken into consideration

["Cultural and sub cultural differences among settings may have an impact on the intervention outcomes"].

In this experts' opinion, a comprehensive assessment of the characteristics of the target population, a good method for their selection, and a health promoting setting approach are essential requirements to reach the adequate population

["it has a high agreement that it is a very high priority"].

In spite of that, they also put forward potential pitfalls when assessing target population's needs, claiming that this requirement may be often "unrealistic" due to the diversity of settings and population the practice have to face

["It is highly relevant but not feasible in all cases and in all settings. In several situations, background information and evidence is required that is lacking (e.g. in terms of heterogeneous population)"].

- **Face to Face**

In order to ease discussions at the meeting, the initial 14 criteria obtained in the second online round (table 6) were further elaborated by the CHRODIS Delphi Team to identify redundancies. Thus, the expert panel was presented with a proposal for merging criteria and reallocating categories that was thoroughly discussed at the meeting; the panel finally agreed on a slightly narrowed down set of criteria. Table 7 shows the weighted set of 10 criteria as finally specified by the Expert panel

The following paragraphs provide details on the decisions made by the panel to achieve this final output on the basis of the results obtained from the 2 online rounds (reflected in table 6).

Criterion 1: Equity, Experts kept two categories but rephrasing them for clear distinction between design and implementation:

Criterion 2: Sustainability, the number of categories narrowed down from the initial four to two. Discussions led to the merging of two categories:

- *“The continuation of the project was ensured e.g. through ownership, structural continuity and/or institutional anchoring”*
- *“The continuation of the project is ensured through follow-up funding and human resources”.*

In Experts’ view, the project institutional ownership is the actual key which ensures the human and material resources required.

Experts agreed on merging **Criterion 3 (aims & objectives)** and **4 (Description of intervention strategies and methods of implementation)** were merged and renamed into a new formulation *“Description of the practice” (table 7)*.

This element was considered particularly important in practice transferability. Experts reordered categories differentiating theory basis and context support from purely descriptive elements.

Criterion 5: Evaluation Various categories were merged and rephrased for the criterion to be more concise, clear and measurable. The new formulation included four categories (table7). They term ‘outcomes’ was preferred over health impact, since it is more common in health promotion and prevention field. Experts stressed that both intended and unintended outcomes should be taken into account when assessing a practice

Criterion 6: Empowerment and Participation, The panel identified the overlapping of 2 categories, which were merged into a more comprehensive new category (*The intervention develops strengths, resources and autonomy in the target population(s) (eg. Assets – based, salutogenic approach)*).

Another category (*“The intervention was designed in consultation with the target population”*) was rephrased because experts considered that the involvement of the target population should be both in the design and the implementation phases, resulting in the following wording *“The intervention was designed and implemented in consultation with the target population”*

A third category, related to the creation of ownership among stakeholders and target population was reformulated to focus on target population; the term ownership was replaced by meaningful participation resulting in *“The intervention achieves meaningful participation among the intended target population”*

Criterion 8: Target Population, The panel detected overlapping among three of the categories, all identifying different features for which the target population must be defined. They were merged within a broader and clearer category.

One Category “*Methods used for selection of target population/s were documented*” was dropped since it was thought to be already addressed in Criterion 3 ‘Description of the practice’

The Category “The intervention aimed to create a health promoting environment through a “setting approach”” was considered to better fit within ‘Comprehensiveness’ criterion and was reallocated

Criterion 9: Ethical considerations. This criterion did not experience many changes. Two of the criteria were complementary each other therefore, they merged in a more clarifying category and other one was rephrased to make it more succinct.

Category 26 “*Benefits and burdens of the intervention are fairly balanced*” was dropped and the term harm was included in category 25 to clarify the concept of “burden”.

Category 27 “*The intervention is implemented equitably, following the principle of proportional universalism: universal provision with a scale and intensity that is proportional to needs*” was reworded as follows to make it clear: “The intervention is implemented equitably ie. proportional to needs”

Initially, the coordinator team proposed the inclusion of **criteria 10 and 7 (comprehensiveness of the intervention and multi-stakeholder approach) in Criterion 11: Context and Determinants Analysis**. The proposal argued that they shared features, approaches and dimensions that a good intervention should embrace (policies, partnership, relevant determinants, strategies and settings). The new criterion was renamed as ‘*Comprehensiveness of the intervention*’ (table 7).

Experts considered that context analysis fitted better into Description of the Practice criterion.

The proposal for **Criterion 12: Adequacy, capacity and resources**, was to enhance it by including the elements of **criterion 13: participation and structural commitment**. The experts agreed and considered more appropriate to rename this new criteria as: *governance and project management* assessing the mechanisms required for enhancing the viability of a practice (organisational structures, funding and human resources).

Thus, Experts merged categories 30 (*The concept includes an adequate estimation of the human resources, material, non-material and budget requirements*) and 33 (*Human resource needs assessed, defined and in clear relation with committed tasks*) as considered that estimation of all resources (human, material and budget) has to be related to the committed tasks. They dropped the term non material resources as considered meaningless

Finally, for **criterion 14: Scalability**. In experts' view scalability is a concept difficult to apprehend due to the different policies and economic constrains in different countries in Europe. Therefore, the practice itself should address the potential to scaling-up and transferability that it could have.

Experts pointed out that transferability is a concept widely use in European projects (maybe more frequently than scalability). So the criterion was finally renamed as '*Potential of scalability and transferability*'

Experts merged categories 47 (Intervention scalability was assessed through an analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators) and 48 (Intervention scalability was assessed in terms of sustainability (sufficiency of resources, commitment, ownership and institutional anchoring) as they considered resources and organisational commitment part of the facilitators whereas ownership and institutional anchoring was already taken into account in sustainability criterion

Once the work on new specification was completed, the resulting 10 criteria were submitted to the second stage of assessment by experts. In this second part of the meeting, experts weighted criteria by distributing 100 points among them. The individual voting yielded the following results shown in table 7, second column: Criteria weight.

The highest weight (12 % of the total valuation of a practice) was attached to criterion '*Equity*' while '*Potential for scalability and transferability*' rated the lowest (7% of total), together with '*Governance and project management*'.

Table 7: Final set of weighted criteria recommended for evaluating HPPP interventions

Criteria name	Criteria Weight	Category description	Category Weight
Equity	13	In implementation, specific actions are taken to address the equity dimensions.	60
		In design, relevant dimensions of equity are adequately taken into consideration and are targeted (i.e. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups).	40
Comprehensiveness of the intervention	12	The intervention has a comprehensive approach to health promotion addressing all relevant determinants, (eg. including social determinants) and using different strategies (eg.setting approach).	50
		An effective partnership is in place (eg. multidisciplinary, inter-sector, multi-/ and alliances).	30
		The intervention is aligned with a policy plan at the institutional, local, national and international level.	20
Description of the practice	12	The design is appropriate and builds upon relevant data, theory, context, evidence, previous practice including pilot studies.	50
		The design thoroughly describes the practice in terms of purpose, SMART objectives, methods (eg.recruitment, location of intervention, concrete activities, and timeframe (sequence, frequency and duration)).	50
Ethical Considerations	11	The intervention is implemented equitably, i.e. proportional to needs.	47
		Potential burdens, including harms, of the intervention for the target population are addressed.	31
		The intervention's objectives and strategy are transparent to the target population and stakeholders involved.	22
Evaluation	11	There is a defined and appropriate evaluation framework assessing structure, process and outcomes considering, e.g.: the use of validated tools and/or the results of evaluation are linked to actions to reshape the implementation accordingly and/or the intervention is assessed for efficiency (cost versus outcome).	25
		Evaluation results achieve the stated goals and objectives.	25
		Information /monitoring systems are in place to regularly deliver data aligned with evaluation and reporting needs.	25
		The intervention is assessed for outcomes, intended or unintended	25
Empowerment and Participation	10	The intervention develops strengths, resources and autonomy in the target population(s) (e.g. assets-based, salutogenic approach).	39
		The intervention achieves meaningful participation among the intended target population.	34
		The intervention is designed and implemented in consultation with the target population.	27
Target population	9	Target population/s are defined on the basis of needs assessment including strengths and other characteristics.	60
		The engagement of intermediaries/multipliers is used to promote the meaningful participation of the target population.	40
Sustainability	8	The continuation of the intervention is ensured through institutional ownership that guarantees funding and human resources and/or is mainstreamed.	60
		There is broad support for the intervention amongst those who implement it.	20
		There is broad support for the intervention amongst the intended target populations.	20
Governance and project management	7	The intervention includes an adequate estimation of the human resources, material and budget requirements in clear relation with committed tasks.	40
		Sources of funding are specified in regards to stability and commitment.	30
		Organisational structures are clearly defined and described (i.e. responsibility assignments, flows of communication and work and accountabilities).	30
Potential of scalability and transferability	7	Potential impact on the population targeted (if scaled up) is assessed.	40
		There is a specific knowledge transfer strategy in place (evidence into practice).	30
		An analysis of requirements for eventual scaling up such as foreseen barriers and facilitators (e.g.resources, organisational commitment,etc.) is available.	30
TOTAL	100		

ANNEX1: List of Sources

1. PRACTICE APPRAISAL: TOOLS AND FRAMEWORKS

a) EU level

- SUCCEED tool
- QIP tool
- EQUIP tool
- Public Health Capacity in EU report

b) WHO Non Communicable Diseases (NCD)

- NCD report 2010
- Cost of scaling up action against NCD 2011
- Best buys to prevent NCDs: Discussion Paper Prevention and control of NCDs: Priorities for investment 2011
- Draft comprehensive global monitoring framework and targets for the prevention and control of NCD 2013

c) WP5 collaborators and associated partners: National GP assessment frameworks revised

- | | |
|------------|---------------|
| • Bulgaria | • Italy |
| • Cyprus | • Lithuania |
| • Estonia | • Netherlands |
| • Germany | • Norway |
| • Greece | • Portugal |
| • Iceland | • Spain |
| • Ireland | • UK |

d) International experience

- Canadian best practice portal <http://cbpp-pcpe.phac-aspc.gc.ca/>
- Preventing and Managing Chronic Disease: Ontario's Framework
- Assessment of Chronic Illness Care (ACIC): A Practical Tool to Measure Quality Improvement - MacColl Institute for Healthcare Innovation (USA)
- Patient assessment of chronic illness care (PACIC and PACIC plus)—MacColl Institute for Healthcare Innovation (USA)

- Quint-essenz: Swiss quality criteria for health promotion and prevention programmes www.quint-essenz.ch
- CDC's Framework for Program Evaluation in Public Health, steps and standards. Community Guide US <http://thecommunityguide.org/toolbox/assess-and-evaluate.html>

2. INNOVATION

- WHO Innovative Care for Chronic Conditions: Building blocks for action 2012
- PAHO Innovative Care for Chronic conditions: Organizing and Delivering High Quality Care for
- Chronic Non communicable Diseases in the Americas 2013-Eng
- Excellent Innovation for Ageing a European guide for the Reference sites of the European Innovation Partnership on Active and Healthy Ageing
- Burguess J POSITION PAPER Innovation and efficiency in health care: does anyone really know what they mean? Health Systems (2012) 1, 7–12
- Comino et al. A systematic review of interventions to enhance access to best practice primary health care for chronic disease management, prevention and episodic care BMC Health Services Research 2012, 12:415
- Gagnon et al. Measuring organizational readiness for knowledge translation in chronic care. Implementation Science 2011, 6:72
- García-Goñi et al Pathways towards chronic care-focused healthcare systems: Evidence from Spain Health Policy 108 (2012) 236– 245
- Lacey et al Mixed method evaluation of an innovation to improve secondary prevention of coronary heart disease in primary care. Quality in Primary Care 2004;12:259–66
- Margolis et al Collaborative Chronic Care Networks (C3Ns) to Transform Chronic Illness Care. Pediatrics 2013;131;S219
- Paulus et al. Continuous Innovation In Health Care: Implications Of The Geisinger Experience. Health Affairs, 27, no.5 (2008):1235-1245
- RESINDEX model Regional Social Innovation Index 2013. Innobasque - 2013
- OECD Innovation strategy 2010

3. SCALABILITY

- DG SANCO y DG CONNECT European scaling up strategy for Reference Sites EIP AHA 2014
- Scaling up: a framework and lessons for development effectiveness from literature and practice. Hartman and Linn. Wolfensohn Center for Development Working Paper 5, 2008

ANNEX 2: Summary of Evidence

This document is intended to provide a view of the foundations for the list of drivers and items submitted to experts in the first online round. It summarises the specific contribution of each of the sources analysed and retained as relevant during the literature review (to see a complete list of the sources consulted, please, refer to the document “list of sources”)

There are two main bodies of information: the first comes from the country review conducted by JA-CHRODIS Work Package 5; the second is made up of the conceptual models, assessment tools and procedures identified in Europe and beyond for evaluation of good practice in health promotion and primary prevention of chronic diseases

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

Summary

The objective of CHRODIS WP 5 (Objective N° 2 in CHRODIS work programme) is to promote the exchange, scaling up, and transfers of highly promising, cost-effective and innovative health promotion and primary prevention practices.

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

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

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

Contribution to CHRODIS GP assessment dimensions

From this questionnaire, a new domain have been added:

- Integration and/or interaction with Health delivery system and Community linkages

Plus... Development or reinforcement of the following “criteria”:

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

Other comments

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

Summary

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

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

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

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

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

Contribution to CHRODIS GP assessment dimensions

Criteria reflected in the Bulgarian health strategy:

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

- Equity approach (Commitments and strategies addressing health inequities and supporting socially vulnerable populations)

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

Summary

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

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

Contribution to CHRODIS GP assessment dimensions

Criteria reflected by the Cypriot approach:

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

Indicators:

- Health Impact Assessment
- Theoretical basis of the programme

Other comments

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

Summary

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

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

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

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

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

Contribution to CHRODIS GP assessment dimensions

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

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

Other comments

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

Summary

Information provided through Work Package 5 partner BZgA, Germany.

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

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

Contribution to CHRODIS GP assessment dimensions

The following criteria have been taken into account:

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

Included but in different context:

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

Other comments

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

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

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

Contribution to CHRODIS GP assessment dimensions

See SoE on EQUIHP

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

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

Iceland's public health guidelines follow a life cycle perspective and provide guidelines and information on selected topics for different steps in the life cycle, e.g. healthy ageing.

Topics for public health practices for older people include

Health and wellbeing

- Alcohol and drug abuse and older people
- Mental health and older people
- Health of older people
- Exercise and older people
- Nutrition and older people
- Violence and the prevention of accidents and elderly people
- Dental care and older people
- Nursing and residential - numbers

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

Contribution to CHRODIS GP assessment dimensions

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

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

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

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

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

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

Other comments

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

- Applications must be accompanied by budget.
- Grants are generally awarded to companies, organizations and public authorities.
- Individuals are normally only awarded grants for research projects.
- normally does not exceed the amount allocated to the project by the local or institutions than their own contribution.
- If the applicant has previously received a grant for a project must be submitted for the final report, if continuing work involved shall be available for a progress report on implementation of the project.
- allowances are higher than 500.000kr. are normally paid in two installments and subsequent
- things only from progress reports and other requested data.
- Do supports the general management of institutions or organizations or to purchase furniture or other furnishings.
- No grants are given to conferences.

- No grants are given to projects that are profit applicant.
- Application and supporting documents should be sent within the period mentioned in the ad.
- Applications received after the scheduled deadline are not taken into consideration.

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

Summary

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

Policies include

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

On the implementation level this entails approaches like

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

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

Contribution to CHRODIS GP assessment dimensions

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

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

- *Setting approach*

- *Identifying and addressing the social determinants of health*
- *Equity*
 - *Gender*
- *Comprehensiveness*

Other comments

DOCUMENT

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

Summary

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

Good Practice Criteria provided through a proprietary evaluation framework “Pro.Sa”¹ “Pro.sa” is grounded on the theories of evidence and best practices translation and exchange (knowledge translation and exchange), among different actors (practitioners on health promotion and prevention, stakeholders, decision makers). Through Pro.Sa database the project manager can submit his project to be evaluated as Good Practice. Two independent readers, properly trained in the use of the assessment tool and experts in the field of health promotion, read the project and give it a scaled score. The focus on good practices aims at:

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

Contribution to CHRODIS GP assessment dimensions

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

1. Working group (multidisciplinary, multi-sector, including representatives of target groups)
 - ➔ *Multi-Stakeholder Approach*
2. *Equity in health*
3. *Empowerment*
4. *Involvement/Participation*
5. *Setting*
6. *Theoretical models and theories of design and behaviour change*
7. *Evidence of effectiveness and good practice examples*
8. *Context analysis*
9. *Determinants analysis*
 - ➔ *Context and determinants analysis*
10. *Resources, time and limits*
11. *Partnership and alliances*

¹ <http://www.retepromozionesalute.it>; <http://www.guadagnaresalute.it/progetto/progettoProsa.asp>

12. Objectives
13. Process evaluation
 - ➔ Evaluation
14. Interventions/activities *description*
15. Output and outcome evaluation
 - ➔ Evaluation
16. Sustainability
 - ➔ Upscaled to dimension “Sustainability”
17. Communication
18. Documentation

Other comments

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

Summary

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

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

- Action plan for healthy aging protection in Lithuania 2014-2023
- Action plan approval for reducing health inequalities in Lithuania 2014-2023
- Screening and prevention program funding approval for people attributable to high-risk cardiovascular diseases
- Procedure for the reimbursement of diabetes medicines
- Stroke control and prevention programme 2006-2008

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

It entails the following purposes and tasks:

- To create a safer social environment, reduce health inequalities
 - To reduce poverty and unemployment
 - To reduce socio, economic population differentiation at country and community levels
- To create healthy occupational and living environment

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

Contribution to CHRODIS GP assessment dimensions

Principles related to Good Practice criteria in the template:

- *Comprehensiveness*
 - *Alignment*
- *Context and determinants analysis*
- *Aims and Objectives*
- *Equity*
 - *Socioeconomic status*
 - *Education level*
 - *Vulnerable social groups*

Other comments

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

Norway developed and implemented a comprehensive policy framework with a Public Health Act from 2012 at its core.

The purpose of this act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental living conditions, and contribute to the prevention of mental and somatic illnesses, disorders and injuries. The act establishes a new foundation for strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. It also provides a broad basis for the coordination of public health work across various sectors and actors and between authorities at local, regional and national level.

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

Contribution to CHRODIS GP assessment dimensions

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

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

Principles not reflected in criteria

Precautionary principle ("do no harm")

→ *Diametral to the purpose to identify good practice*

Other comments

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

Summary

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

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

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

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

Contribution to CHRODIS GP assessment dimensions

The following criteria have been taken into consideration:

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

Other comments

Criteria not taken into consideration:

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

Because: Lack of feasibility and applicability to health promotion programmes

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

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

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

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

The procedure entails inclusion criteria for programmes/practices:

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

Contribution to CHRODIS GP assessment dimensions

Prioritization criteria entailed in the approach include:

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

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

Summary

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

Database with life style interventions

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

Procedure for selecting best practices

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

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

Then there are two types of assessment possible:

1. an assessment of the description of the objective, target group, approach and boundary conditions by professional practitioners or other experts from the sector concerned. This happens in the form of a peer review by practice panels. Based on this, interventions can receive the assessment '**Well Described**'.
2. an assessment of the theoretical basis and/or effectiveness of the intervention by an independent expert committee. Interventions that are assessed as good by the Recognition Committee receive a recognition '**Theoretically Sound**' or '**Effective**'. There are several subcommittees for different types of interventions, for example youth health care and health promotion for adults and elderly.

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

Contribution to CHRODIS GP assessment dimensions

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

- Manual of intervention available (*Documentation*)
- *Process evaluation*
- Two way assessment:
 - Description of the project / ,well described'

- *Theoretical basis of the project*

- *Transferability (,Feasibility')*
- *Effectiveness*
- *Relevance*

Other comments

Criteria not included in the template:

- Material for the next 2 years available
- Contact person
- ➔ too specific for the purpose of the template

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

Summary

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

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

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

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

- Lifestyle and wellbeing²
- Diabetes and other endocrinal, nutritional and metabolic conditions³
- Cardiovascular conditions⁴
- Health inequalities⁵
- Value for money⁶

Contribution to CHRODIS GP assessment dimensions

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

- *Comprehensiveness*
 - *Alignment*

² <https://www.nice.org.uk/GuidanceMenu/Lifestyle-and-wellbeingC>

³ <https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Diabetes-and-other-endocrinal--nutritional-and-metabolic-conditions>

⁴ <https://www.nice.org.uk/GuidanceMenu/Conditions-and-diseases/Cardiovascular-conditions>

⁵ <https://www.nice.org.uk/advice/LGB4/chapter/introduction>

⁶ <https://www.nice.org.uk/advice/LGB10B/chapter/introduction>

- *Several risk factors addressed at the same time*
- *Evaluation*
- *Cost effectiveness*
- *Risk assessment*
- *Multi-/Intersectoral approach*
- *Partnerships and alliances*
- *Equity*
- *Documentation*
- *Evidence base*
 - *Theoretical model*
 - *Health Impact Assessment*
- *Aims and Objectives*
- *Community linkage /Networks*
- *Sustainability*

Other comments

DOCUMENT: European Quality Instrument for Health Promotion (EQUIHP)**Summary**

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

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

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

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

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

Contribution to CHRODIS GP assessment dimensions

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

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

The final structure of the questionnaire includes:

I Framework of health promotion principles

II Project development & implementation

- a) Analysis
- b) Aims & objectives
- c) Target group(s)
- d) Intervention (strategies and methods) // Implementation strategy
- e) Evaluation

III Project management

- a) Leadership
- b) Capacity and resources
- c) Participation & commitment
- d) Dissemination // Knowledge transfer
- e) Integration or interaction with the healthcare system
- f) Community linkages // Networks
- g) Ethical implications

IV Sustainability

Other comments

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

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

DOCUMENT: Assessment of Chronic Illness Care (ACIC)**Summary**

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

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

Contribution to CHRODIS GP assessment dimensions

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

- Community linkage between the health delivery system (or providers) and the Community
- Patient's participation in the programme and to consider their empowerment as a final aim of the programme
- The need of evidence based resources available for professionals and patient's

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

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

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

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

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

Contribution to CHRODIS GP assessment dimensions

Two new domains were added from this tool:

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

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

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

Other comments

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

DOCUMENT: Quint-Essenz. Quality criteria

Summary

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

Its objectives are:

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

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

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

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following "criteria":

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

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

Other comments

In the map of dimensions these criteria have not been considered:

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

DOCUMENT: CDC Program Performance and Evaluation Office (PPEO) – Program Evaluation Steps

Summary

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

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

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

The 30 standards are organized into the following four groups:

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

program being evaluated.

Contribution to CHRODIS GP assessment dimensions

Development or reinforcement of the following “criteria”:

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

program (project) when critical circumstances change

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

Other comments

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

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

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

Summary

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

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

The Best Practice Interventions include interventions, programs/services, strategies, or policies which have demonstrated desired changes through the use of appropriate well

documented research or evaluation methodologies and have the ability to be replicated and the potential to be adapted and transferred.

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

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

Contribution to CHRODIS GP assessment dimensions

Reinforcement of the following “criteria”:

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

Other comments

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

Summary

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

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

They draw a number of lessons for the development analyst and practitioner. More than anything else, scaling up is about political and organizational leadership, about vision,

values and mindset, and about incentives and accountability—all oriented to make scaling up a central element of individual, institutional, national and international development efforts. The paper concludes by highlighting some implications for aid and aid donors,

Contribution to CHRODIS GP assessment dimensions

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

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

Other comments

DOCUMENT: European Scaling-up Strategy in Active and Healthy Ageing, 2014

Summary

This document outlines the scaling-up strategy for the good practices identified within the European Innovation Partnership on Active and Healthy Aging (EIP AHA). It relies on WHO Guide for scaling up (which in turn references the Wolfensohn Center for Development Working Paper 5 included in this summary of evidence).

Beyond the quality of the impact, scale and sustainability. They identify four types of scaling up in terms of structures, programs, strategies or resource bases: quantitative, functional, political or organisational. All these dimension of scaling up are conceived as interrelated since quantitative or functional scaling up requires organisational adjustments and further expansion is triggered by political developments.

The approach proposed in this paper focusses on two key elements – "what to scale up" and "how to scale up". The "what" includes identifying practices, projects and innovations to be scaled up, and the "how" focuses on the methods of going to scale. The latter part also discusses the organisational roles involved in scaling up (who and where) in the European context.

Contribution to CHRODIS GP assessment dimensions

The Domain Scalability has drawn on this document incorporating 2 criteria:

- sustainability in the medium term (sufficiency of resources, commitment, ownership and institutional anchoring)

- specific knowledge transfer strategies in place (evidence into practice)

This piece of information also reinforced the other 3 criteria included in the domain:

- size of the population targeted if scaled up
- analysis of requirements for eventual scaling up: key factors, foreseen barriers and facilitators

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

Other comments

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

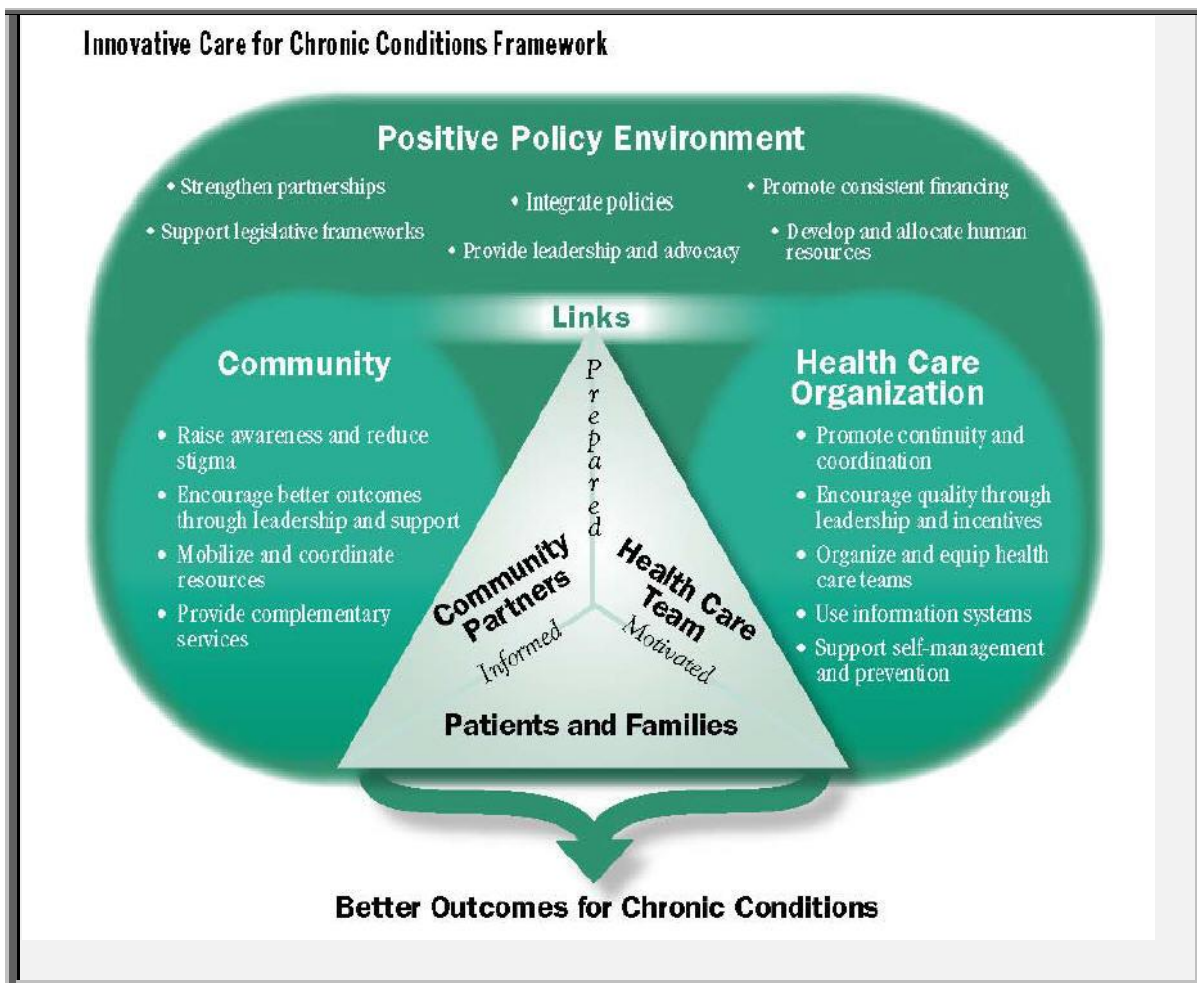
Summary

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

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

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

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



Contribution to CHRODIS GP assessment dimensions

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

- Innovative Care
- Community Linkages
- Leadership and advocacy
- Self-management and prevention
- Sustainability

Other comments

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

DOCUMENT: OECD Innovation strategy 2010.

Summary

It is centred on how to measure Innovation on every different area of progress. It provides an extensive analysis of the situation of the innovation, measured by proxy indicators across the OECD countries and sectors, addressing the need of more research and measurement in how innovation is implemented and how can we promote it to reach new levels of development. It proposes a framework for measuring innovation through their derivative products. Also it promotes people participation and addresses the main challenges to tackle in next years.

Contribution to CHRODIS GP assessment dimensions

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

- Innovation
- Sustainability
- Research Implementation
- Innovation measurement as a method to assess its impact on the healthcare systems

Other comments

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

Summary

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

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

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

Contribution to CHRODIS GP assessment dimensions

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

It also enhances the attention to several domains such as:

- Theory grounds (well specified and measurable main goal and sub-goals)
- Key population and target population
- Community linkages
- Patient Participation and commitment
- Mapping of relevant stakeholders
- Impact of the implementation in current organization
- Regularity of monitoring reports and consequences derived from assessment

- Development of integrated health information systems
- Evaluation framework assessing process and outcomes

Other comments

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