JA-CHRODIS
Final Conference

27th- 28th February 2017

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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Executive Summary

The Join Action addressing chronic diseases and promoting healthy ageing across the life cycle (JA-CHRODIS) started in January 2014. In February 2017 the Final Conference was organised to present the outcomes and achievements of this JA which objective was to promote and facilitate a process of exchange and transfer of good practices between European countries and regions, addressing chronic conditions, with a specific focus on health promotion and prevention of chronic conditions, multimorbidity and diabetes. This report provides a summary of the aims and content on sessions that took place during the 2-day Conference in addition to the results of the evaluation that was completed on the event and the outputs of JA-CHRODIS.

Overview of JA-CHRODIS Final Conference

The JA-CHRODIS Final Conference took place on the 27th and 28th February 2017 at the Thon Hotel in Brussels. The conference was attended by 238 participants and the high profile of speakers made the event a success as one of the final tasks of JA-CHRODIS. During the conference, Carlos Segovia, Coordinator of the JA-CHRODIS, presented the 12 steps towards implementing practices to reduce the burden of chronic disease and the CHRODIS Platform was officially launched to the public.

On Monday 27th February, the Coordinator welcomed participants and then, the work undertaken at the work packages on the Platform for knowledge exchange (WP4), Good practices in the field of health promotion and chronic disease prevention across the life cycle (WP5), Development of common guidance and methodologies for care pathways for multi-morbid patients (WP6) and Diabetes: a case study on strengthening health care for people with chronic disease (WP7) took place in parallel sessions.

On Tuesday 28th February, the European Commissioner Vytenis Andriukaitis, WHO Europe Regional Director, Zsuzsanna Jakab, OECD Health Division Senior Policy Ian Forde and JA-CHRODIS Coordinator, Carlos Segovia, opened the day under the moderation of EuroHealthNet's Senior Policy Advisor Clive Needle. Representatives from several European Ministries of Health continued the day discussing how policy makers can use and plan to use the JA-CHRODIS results. During session 3, the debate was centred on how to better integrate health promotion in comprehensive healthcare systems, while session 4 explored how JA-CHRODIS will leave its mark with examples from practices.

Director General for Health and Food Safety (DG Sante) Xavier Prats Monnè and Deputy Director General for Quality and Cohesion from the Spanish Ministry of Health, Social Services and Equality, Paloma Casado under the moderation of Anne Hendry, Clinical Lead for Integrated Care, closed the conference.

Aims of JA-CHRODIS Final Conference

The aim of the JA-CHRODIS Final Conference was to, whilst presenting the outputs of JA-CHRODIS, discuss the impact and future implementation of these outputs by health policy makers and health professionals.

Content of the Final Conference

The Final Conference of the CHRODIS Joint Action on chronic diseases and promoting healthy ageing across the life cycle was held 27-28 February in Brussels.
A total of 238 participants, including health policymakers, researchers, analysts and representatives of patient groups, attended the day-and-a-half event consisting of keynote presentations from high-level decision-makers, panel discussions and workshops. The event provided a forum for exchanging insights into the successes of the Joint Action and the required next steps for building on positive outcomes and maximising the impact of results.
One of the main outcomes of the three-year initiative was the CHRODIS Platform, an online resource for sharing good practice, and one of the parallel sessions was dedicated to discussing how health professionals, patients and policymakers can make best use of this knowledge-sharing platform.

JA-CHRODIS was led by the National Institute of Health Carlos III, Spain. Carlos Segovia, head of the unit of Accreditation of Health Research Institutes at the institute, was the JA-CHRODIS co-ordinator and welcomed attendees to the conference. He explained that the Joint Action, which was jointly funded by the European Commission and by its 39 associated partners was a far-reaching initiative, addressing health promotion and primary prevention, multimorbidity and, as a case study, type-2 diabetes. Associated partners, along with the 34 collaborating partners, came from 25 countries across Europe and were, for example, national and regional departments of health and research institutions. The objective was to identify, exchange, and provide recommendations for the scale-up and transfer of good practices and effective interventions in these three areas. "Good practice is a practice that is proven to have worked well...and can be a model for others," he said.
Countries across Europe are focused on reducing the burden of chronic diseases – such as diabetes, cardiovascular disease, cancer and mental disorders – that in Europe affect 8 out of 10 people aged over 65. Treating chronic diseases accounts for 70-80% of healthcare budgets, and it is thus vital to ensure that money is well spent in this area. The JA-CHRODIS approach is to promote the exchange of effective and efficient ways to prevent and manage chronic disease.

The final desired outcome of health professionals implementing improved practices can come from either direct policy and clinical intervention and the influence of recommendations and reports. Another option is to access the evaluated examples detailed on the CHRODIS Platform and the guidelines for implementation. The former pathway assumes a scenario in

which those responsible for implementation play a passive role and little attention is paid to the context.

In the scenario envisioned by the JA-CHRODIS approach, however, practitioners have greater room for adjusting good practice to their own particular context. Good practice is multi-directional, explained Dr Segovia. "The practitioners are telling one another how they do it and offering the possibility of learning from each other."

The JA-CHRODIS initiative does not provide definitive answers to how such exchanges should be conducted. It has "simply outlined the possibilities for exchanging good practices", he said. "What we initiated in this Joint Action is not a visible end; it is a wonderful landscape with plenty of different paths to follow."

12 steps towards implementing practices to reduce the burden of chronic diseases

In his welcome address the following day, Dr Segovia provided further detail on the JA-CHRODIS approach, reaffirming that it is very apparent today just how much the Joint Action was needed.

He outlined 12 steps for implementing good practice on chronic disease, which JA-CHRODIS has developed, which are very briefly outlined here (see full document in Annex 2):

1. Design the practice, ensuring that it is based on solid evidence and that monitoring and evaluation are factored in.
2. Empower target population and involve them in this design process.
3. Ensure the provision of adequate investment and resourcing; good practice should not overstretch its reach in trying to cover everyone at the price of losing elements that are essential to be effective, but instead should target specific groups in order to be more effective.
4. Be comprehensive but not too complicated; the full range of determinants of chronic disease should be addressed, like in the multimorbidity care model developed by JA-CHRODIS.
5. Interact regularly with relevant systems, particularly with the social care sector.
6. Educate and train to enable professionals to implement a practice to the highest standard.
7. Respect ethical considerations of the target population and be transparent.
8. Apply good governance by outlining clear responsibilities.
9. Ensure sustainability and scalability: Is the practice value for money and can be up scaled? The acknowledgement of health promotion measures being cost-effective is key here.
10. Make sure equity is addressed; it is not only the overall result that matters but also how the practice benefits vulnerable groups.

11. Evaluate the practice regularly. Ensure there is a defined framework for it at the beginning.
12. Make use of the CHRODIS Platform, which allows a practice to be externally reviewed and feedback to be received.

Parallel Session (WP4): Best use of the CHRODIS Platform

The CHRODIS Platform consists of an up-to-date clearinghouse of evaluated good practices for the prevention and care of patients with chronic diseases. It also includes an online helpdesk to offer guidance and answer questions on implementation and a digital library consisting of a wide range of relevant content.

The Platform was one of the main outcomes of the Joint Action, and the first parallel session focused on how patients, decision-makers, practitioners and researchers can get the best out of this online knowledge-sharing resource. To begin the session, Enrique Bernal-Delgado, senior health services and policy researcher at the Institute for Health Sciences in Aragon, gave a brief overview of the principles behind the Platform.

While diabetes was chosen as a case study to demonstrate how the Platform would function, Dr Bernal-Delgado emphasised that his team were aware that the methods used to evaluate good practice should be applicable for all chronic diseases. Hence the Delphi process was used, "the gold standard methodology", he said, for defining assessment criteria.

JA-CHRODIS asked 100 experts – not only from partners but also patients and representatives of patient organisations – to select the assessment criteria. In line with the Delphi process, the experts were asked to rank the criteria online from 1 to 9 in a series of rounds. After each round of ranking, an independent referee provides an anonymous summary of the experts' scores from the previous round, and the experts are encouraged to revise their earlier answers in light of the replies of other members of their panel. The individual rankings thus converge on an average or single reliable score. Dr Bernal-Delgado explained that the Delphi process avoids polarisation of views and reduces group bias. "No one opinion is allowed to prevail," he said.

Once the assessment criteria were selected, they were incorporated into the Platform for the peer review process. Each practice submitted is reviewed by two independent reviewers and discrepancies are solved by a referee. The JA-CHRODIS method strips down the ranking scores even further to arrive at three assessments: practices are described as 'promising', 'good' and 'excellent', and only these categories are displayed on the Platform.

Given that the JA-CHRODIS vision is "implementation not just to have a collection of practices", this process enables those practices that have the best potential for transfer to stand out. Such formative assessment, Dr Bernal-Delgado said, was a lever of change, facilitating others to learn how, why and when to do things.

The session continued with a demonstration of the Platform by Cristina Blas Miranda, the Help Desk Manager for the CHRODIS Platform. She showed attendees how the search engine allows users to define their criteria to reach the most relevant practices for them. She also outlined the documents and video and audio material accessible from the digital library.

To use the search engine, it is first necessary to create an account. This account allows the user to submit a practice or content to the digital library. The real added value of the Platform is the toolkit, she said, providing guidance on how to implement the good practices.

Another key feature is the helpdesk itself. This function not only helps users with practical questions about the site, but it "puts people in contact with one another and helps with implementation of the practices". Currently, 25 good practices are available on the Platform and 125 content files have been uploaded onto the digital library.
The session then convened a panel of users to share their experiences of the platform: Rogério Tavares Ribeiro, an invited assistant professor at the University of Aveiro; Wil M. de Zwart, Senior Policy Officer, Dutch Ministry of Health, Welfare and Sport and member of the JA-CHRODIS Governing Board; Marieke Hendriksen, a nutritionist at the Dutch National Institute for Public Health and the Environment; and Tamara Poljicanin, Head of the Biostatistics Department at the Croatian Institute of Public Health and member of the JA-CHRODIS Governing Board.

Dr Ribeiro said one of the strengths of the Platform was that it encouraged submitters of good practices to really question why they do what they do. Speaking of his experience as a reviewer, he said that he "had to go back to several members of the team [his colleagues] who were more knowledgeable about the details that had not been recorded in any reports, and I had to go back and question them".

On the subject of reviewing good practice, Dr Hendriksen said of her experience that she was worried at first that it would be time consuming but she actually found the system to be "quite easy". But she added that she found the inability of having direct contact with the submitter of good practice to ask for clarification if needed was a limitation of the system. Nevertheless, she said that she learned a lot as a reviewer.

Ms de Zwart highlighted the challenge of ensuring that information is easily available to professionals, national policymakers and researchers. She said that in the Netherlands they have found it difficult to encourage these stakeholders to visit their national platform. She added that national institutes should consult the CHRODIS Platform to see what is new and make that available on their national websites. The next phase of the JA-CHRODIS initiative is to simply make the Platform better known among its target users.

The benefit of having contributions for such a high number of countries was emphasised by Dr Poljicanin. On a national level, she said, the Platform could be used to show the gaps in public health initiatives. "The potential of the Platform is enormous."

The session also discussed ways of encouraging practitioners to submit best practice. Some attendees were sympathetic to the idea of public funding for an initiative to be conditional to the use of the Platform.

Another key point raised in the session was the facility to re-evaluate good practices, even those that have an 'excellent' status. Such re-evaluation is necessary to ensure that practices remain relevant. It is currently possible to re-submit a good practice. Submitters receive feedback and are able to then make changes to improve their practice. The JA-CHRODIS approach is not to encourage the creation of unchangeable hallmarks of success but to generate continuous improvement to good practice.

Parallel Session (WP5): Factors concerning the exchange and transfer of good practices in health promotion and disease prevention

Moderated by Prof Kenneth Eaton of the Platform for Better Oral Health in Europe, this session focused on health promotion and disease prevention – WP5, which was led by the German federal centre for health education (BZgA) and EuroHealthNet. Anne Pierson from EuroHealthNet began by giving a brief background to the work package. She acknowledged that many chronic diseases are preventable or that at least their onset could be delayed. She said that what is needed are policies and interventions that address the risk factors.

While there is a wealth of knowledge of preventing chronic morbidity in individual countries, this knowledge is not readily shared among them. The objective of WP5 was thus to map and validate good practices on health promotion and disease prevention across Europe and to analyse how these can be transferred. 41 good practices were identified and have either been uploaded onto the CHRODIS Platform or are in the process of being uploaded. Of these practices, seven were selected for study visits to find out more about how they operate.

Analysis of existing practices took the form of questionnaires on policy, practice, assessment of cost effectiveness and the gaps that need to be filled. The team found significant differences in approach across Europe from centralised systems in, for example, Greece and Cyprus, to devolved systems in Spain and the UK. Approaches also differ in the extent that they focus on disease and the social and health determinants. They also found that most countries adopt a partnership approach, involving ministries other than the department of health.

One of the most common gaps identified, however, was the lack of monitoring and evaluation of good practices. Respondents to the questionnaire reported that this was due often to a lack of agreed criteria and funding for evaluation. Furthermore, they also reported a need to develop a larger and better trained workforce. Funding is widely considered to be inadequate for health promotion and disease prevention, Ms Pierson told attendees.

Djoeke van Dale from the National Institute of Public Health and Environment (RIVM), the Netherlands, spoke about how assessment criteria for health promotion practice were

developed. This task was linked to the Delphi process of WP4 (described above) and involved a review of literature and the creation of online questionnaires. This process led to the devising of 16 domains and 57 individual assessment criteria. The relevance of these criteria was scored by a panel of 26 experts, followed by a second round of scoring by 23 experts on the criteria's 'priority'.

After rounds one and two, which led to the discarding of irrelevant criteria, 14 domains and 43 criteria remained to be discussed in a face-to-face meeting with 14 experts. This stage led to the reformulation and merging of some criteria. The process also allowed the criteria to be weighed in terms of priority, and 'equity' was confirmed as being the most important measure. Scalability and sustainability was shown to be less crucial than ethical considerations and evaluation.

The next presentation was given by Teresa Bennett of the Health Service Executive, Ireland, on the Portuguese national programme for healthy eating (PNPAS), which was developed in 2012. The PNPAS is an overarching framework for all healthy eating initiatives in the country. These initiatives are carried out at a local level and are tailored to local needs. But the results of these interventions were required to be presented in a standardised way so that they can be readily fed back into national databases and thus made accessible to all.

Ms Bennett said that there is some indication that PNPAS has achieved a beneficial impact on salt levels of the general public and helped reduce obesity in children. She pointed to the programme's strong governance structure and cross-sectoral collaboration as being crucial to its success. Effective communication among nutritionists across the country was another factor, she said.

The next case study – Well Communities (formerly Well London), a framework for communities and local organisations to work together to improve health and wellbeing, build resilience and reduce inequalities – was presented by Francisco Ruiz, Andalusian Regional Ministry of Health. The value of the initiative lies not only with the provision of "a portfolio of activities" but also in "building community capacity and empowering neighbourhoods". It particularly focuses on deprived areas with high unemployment and unhealthy lifestyles, and research led by the University of East London has already provided quantitative evidence for the initiative's effectiveness: 54% of those reached are now eating more healthily and 82% are more physically active, for example. Other positive impacts include a greater level of connectedness among communities and the building up of trust and relationships, Dr Ruiz said.

The Lombardy Region Workplace Health Promotion Plan was visited by Luciana Costa of the Portuguese National Institute of Health. The plan consists of six programmes for improving lifestyle choices, promoting the environment and preventing chronic disease risk factors. It is a public-private partnership initiative that engages all workplace stakeholders, such as industrial unions, trade unions and regional health systems. Partner companies were tasked with implementing prevention activities in six thematic areas: nutrition, tobacco, road safety,

alcohol and substance abuse and well-being. Companies that introduce a certain number of measures, such as gym membership deals, are allowed to use a logo indicating that they are providing healthy working conditions for their employees.

The Lombardy plan has grown from the initial involvement of two companies in Bergamo to more than 450 companies across the region. Monitoring showed that a reduction in some risk factors has occurred as a result. Its small beginning was heralded by Dr Costa as one of the factors to the success of the plan. Flexibility and the freedom for the company to choose the thematic areas where it would be active were also crucial to the high uptake. Companies moreover appreciated the feedback from the health agency and the voluntary approach of the plan. Finally, the political support and its basis in a national framework were also important.

Alexander Haarmann of BZgA closed the session by summarising the factors that need to be taken into account when seeking to foster the exchange and transfer of good practices in health promotion and disease prevention. The collection of good practices and the study visits have helped drive forward to the ultimate objective of the work package: the drawing up of criteria for transferring and adapting practices to different contexts and regions of Europe. These criteria are mainly intended to be of use to practitioners but they are also helpful for policymakers and other stakeholders.

One of the recommendations is the desirability of performing a 'needs' analysis ahead of attempting to adopt a good practice. It is also valuable to have direct contact with the practitioner that is being learnt from. Dr Haarmann also emphasised that it was important to have a clear understanding of the environment to which the practice is being transferred. Allowing practices to be adaptable to local situations is a common feature of successful initiatives. "Think big but start small," he said. "Don't try to cover everything right from the start."

A further common factor of success indicated by the study visits is the linking of disease prevention initiatives to the goals of other sectors. Being transparent and communicating the reasons behind the practice builds up trust among the public, he added.

Parallel Session (WP6): How can Europe approach the care of persons with multimorbidity?

Multimorbidity is defined as having two or more chronic diseases and its prevalence increases with age. Graziano Onder of the UCSC (Università Cattolica del Sacro Cuore) and AIFA (Agenzia Italiana del Farmaco) in Italy, however, emphasised that addressing multimorbidity is not just a matter of addressing the diseases. "Though some diseases require more care than others and have a higher risk of negative outcomes, other aspects are also very relevant, such as low socio-economic status, poor physical functioning and mental health problems," he said.

In this session, Mieke Rijken, NIVEL, gave a presentation on the review of existing practice in this area that she had conducted under the Joint Action. The task was to identify and analyse integrated care practices and review the evidence of their effectiveness.

She outlined the variety of models and approaches to multimorbidity that have been pioneered across Europe. Most of these approaches are bottom-up initiatives. However, most approaches are not specifically targeted at this group of patients, and due to poor evaluation, their outcomes are not well understood. There is thus a need for studies to be carried out on their effectiveness, she said.

The literature review sought to identify comprehensive care practices (i.e. those that made interventions in two or more components of care), but studies in this area are lacking in Europe, making it difficult to know whether certain types of comprehensive care can be effective. But there is nonetheless some evidence that integrated care programmes can improve patient satisfaction, quality of life and functioning.

In his presentation, Rokas Navickas further examined the 16 components of the multimorbidity care model, which can be divided into five groups. Under the work package, a team of experts from different fields (i.e. research, clinical practice and patient organisations) was brought together to assess these groups. They concluded that a multi-disciplinary co-ordinating team is required to draw up individual care plans that are managed by a professional coordinator of care (potentially a single contact person). The multi-disciplinary team, however, requires training on how to work together. The team also must establish direct links with specialist care experts.

Self-management support is another key part of the care model and concerns the exploring of options for patients and relatives to be active in their care provision. Self-management has been shown to be very effective in improving the quality of care. The multimorbidity care model also anticipates the increasing role that IT will play in healthcare. "We need to work on a better exchange of patient information from one institution to another," Dr Navickas said. The uniform coding of information and the facility for patients to be able to send information to their care providers offer ways to move forward in this area.

The final group of components in the model is social support, particularly informal networks of friends, family and neighbours as well as patient associations and social services. Overall, the aim was to create a broad model that is suitable for all countries across Europe. At the end of this process, the partners of the work package conducted a survey on the relevance of the model developed, receiving 23 responses from 15 countries. All but three countries said that all the components of the model were applicable.

M. João Forjaz of the Institute of Health Carlos III spoke about the task of evaluating how the multimorbidity care model applies to a specific group of patients with multimorbidity. Her team created a 'case study' patient, Maria, who has diabetes, osteoporosis, mild obesity and a mental health problem (including panic attacks). They looked at the care delivery system in

place for Maria, its design, decision support, options for self-management and shared decision making, the clinical information system (i.e. electronic or shared data among doctors) and the community resources available, such as a social support network.

Maria's husband also has multimorbidity and her sister recently died. Though she is fictional case, her story is not untypical and provided a good basis on which to test the multimorbidity care model. This was done by setting up work teams from across Europe to assess how different components of the model could be applied in this case.

The study concluded that the model is feasible and applicable to a complex case such as Maria's. It requires several professional using several rating scales to assess her. It is also important to integrate health and social services, given that some of her problems are social. A case manager is also required to co-ordinate a multi-disciplinary team and the experts agreed that this manager could be a general practitioner, a nurse or a social worker. Patient-operated technologies are also beneficial. Clinical guidelines - even if they are specific for diabetes – should be adapted and considered. Finally, a consultation team could provide additional support and information to the core team of care providers. The next step, Dr Forjaz concluded, is to apply the model to actual case studies under the CHRODIS PLUS programme.

This care model, particularly the role of the case manager, was expanded upon by Federica Mammarella, AIFA, in her presentation. Partners researched multimorbidity care management training programmes, sending out questionnaires across Europe. The second part of the research involved a literature review of such training programmes, but the search only came up with two examples from the US and one from Taiwan of the past 20 years. She said that better evaluation methodologies to assess multimorbidity services and training for case managers were needed. Formal qualifications for those who have received specific training in this area are also required. She concluded by emphasising the importance of the role of the case manager in implementing the multimorbidity care model.
Valentina Strammiello of the European Patients' Forum underlined the need to involve patients in the design of care models, similar to the way that they were included in the creation of the multimorbidity model in the Joint Action. Multimorbid patients require a more tailored approach to care to avoid adverse interaction between different treatments. Patients and patient organisations have a key role to play in promoting the model in their Member States and in their own patient communities. Lack of patient involvement runs the risk of producing a model that does not adequately respond to patients' needs, she cautioned.

<u>Parallel Session (WP7): Lessons for the prevention and care of chronic diseases, taking type-2 diabetes as an example</u>
Diabetes was selected as a case study by the Joint Action in order to demonstrate the benefits of the JA-CHRODIS approach to chronic diseases more generally. The session on the lessons learned through focusing on this condition was opened by Marina Maggini of the National Institute of Health, Italy, who was the leader of this work package.

The task, she explained, was to carry out a thorough analysis of practice on diabetes including a survey on approaches to prevention and management of the condition and a SWOT analysis on national policy programmes. During this stage, several good practices were identified and some of these were uploaded onto the CHRODIS Platform.

Recommendations for prevention and management of diabetes were defined using the Delphi process. "The objective was to define a set of quality criteria for implementing and monitoring good practices... the idea was not to define clinical guidelines, but to produce a report that could be used in policymaking," said Dr Maggini.

From the criteria developed for the diabetes case study, nine recommendations for quality assessment of good practices were drawn up. With clear links to the JA-CHRODIS 12 steps, the first recommendation concerns the design of the practice: "what is well planned is well done". Dr Maggini said that the practice should "empower" the target population through shared decision making. Another recommendation is the need for a clearly defined monitoring and evaluation plan. Practices should also be comprehensive and include aspects of training. Moreover, they should be ethically sensitive and not overburden the target population. Attention should also be made to good governance and the way the good practice interacts with other systems. Finally, consideration should also be placed on its scalability and sustainability.

She concluded by highlighting a few key messages from the diabetes case study, namely that the recommendations mentioned above could constitute a tool for decision-makers, healthcare providers, patients and healthcare personnel when looking to implement and improve good practice. The lessons learned are broad enough to be relevant for countries with very different political situations as well as for other chronic diseases. Furthermore, the adoption of an agreed core set of quality criteria and indicators might help to decrease inequalities in health.

The work package's co-leader, Jelka Zaletel of the National Institute of Public Health, Slovenia, focused on the Joint Action's relevance for National Diabetes Plans (NDPs). Partners looked at what makes a strategy effective and sustainable. She emphasised the importance of leadership, recommending that many stakeholders should be involved and that there should be a balance between centrally defined requirements and regional autonomy. Adequate resources and capacity for implementation are other key considerations.

The Joint Action, moreover, she said, underlined that patients are the best advocates of good practice and any management plan – both in its design and implementation. National plans should also be flexible and be able to accommodate those lessons learned directly as well as those learned from others.

Her presentation was followed by group discussions on the recommendations. These five groups reported back to attendees of the session the results of their conversations on the particular recommendations that they had been assigned. The workshop has to be considered

the starting point for the use, transfer, evaluation and adaptation of WP7 outputs and, in particular, of the recommendations.

KEYNOTE SPEECHES

Vytenis Andriukaitis: JA-CHRODIS's contribution to EU's effort to prevent and address chronic diseases

Vytenis Andriukaitis, the European Commissioner for Health and Food Safety, , in his keynote address, called for more action on health promotion, emphasising that to "foster healthy ageing we need to start at the very beginning: birth (and even before that)".

"It is not just a question of addressing chronic diseases. It is a question first and foremost of promoting good health across the life circle; proactively monitoring children's health in schools; promoting healthy living; protecting children against risk factors to foster healthy children and teenagers and then continue promoting good health among adults," he said.
"We cannot think about healthy ageing only when the first symptoms of chronic diseases start to emerge – that would be too little too late!"

The effect of such health promotion at all stages of life will be a delay in the onset of many chronic diseases, the Commissioner avowed. Keeping people in good health is achieved by addressing the main risk factors: nutrition, lack of physical exercise, alcohol and tobacco consumption, living and working conditions, stress and environmental factors. He cited the recent joint EC/OECD 'Health at a Glance' report that highlighted the number of lives that could be saved by focusing on these risk factors.

But disease prevention must "reach out to everyone" regardless of social background and level of education, he cautioned. "Low social status has a comparable health impact to that of other major risk factors," he said. Owing to poorer diet, unhealthy lifestyles and lower inclination to visit doctors, the less well-off are more likely to develop a range of chronic diseases and to stop working as a result of these diseases.

A report showed that in the European Union more than half a million people of working age die prematurely from chronic diseases every year – representing a cost of €115 billion in lost productivity. "Such figures call once more for a greater focus in promotion across the life cycle reaching out to low social economic groups and for joint work and synergy between the health and employment sectors."

Dr Andriukaitis took the opportunity to praise the achievements of JA-CHRODIS in the area of health promotion. Identifying good practices and the factors affecting their transfer to other areas has been crucial. "The time has come to implement best practices to make a real impact on the ground," he said.

Models are needed for 'holistically' addressing patients with several chronic conditions and the Netherlands is pioneering the way forward in this area. The specific focus of JA-CHRODIS

on diabetes has led to a guide for developing and improving national plans, and the Commissioner encouraged those Member States without national plans to use the guidance established in the Joint Action.

Finally, Dr Andriukaitis told delegates that the Commission would be developing a resource centre on, among other, health promotion and chronic disease prevention that will advance the initiative of the CHRODIS Platform. The Commission has also established a steering group in this area that will specifically focus on how good practices can be transferred and scaled up.

Zsuzsanna Jakab: The link between JA-CHRODIS and WHO Europe's Action Plan on NCD

Zsuzsanna Jakab, Regional Director, WHO Europe, began her keynote address by emphasising that "health and well-being are at the heart of development". Health is thus an essential component of meeting the sustainable development goals (SDGs) by 2030. The roadmap for achieving these goals is fully aligned with European health targets (Health 2020), she said.

The WHO is focusing on the political, economic, environmental and behavioural determinants of disease. In respect of non-communicable chronic disease (NCD), successful approaches need to address all these determinants together with a life cycle perspective and people-centred assistance. This approach to chronic disease was echoed by JA-CHRODIS, according to her.

Greater recognition that health is determined by multiple factors has led to a "momentum for a 'whole of government' response, ensuring greater cooperation and co-ordination of policies outside the reach of the health sector. The broad and interlinked SDGs make collaboration between the sectors more possible and more necessary than ever," she said.

WHO Europe, for example, held a conference at the end of 2016 that brought together the health, education and social policy sectors on the subject of early childhood development. Another example of such an inter-sector approach is the forthcoming ministerial conference on environmental health.

Differences in life expectancy and infant mortalities among countries are decreasing, underlining that WHO strategies are working. Many gains have been made in the area of tobacco, and the EU tobacco control directive was a "landmark achievement". Alcohol consumption is also declining in Europe (11% drop from 1990 to 2014), though huge differences remain between countries. Childhood obesity is a major challenge, however, in Europe.

Europe has developed action plans for all types of NCDs. "The main WHO European Action Plan for the prevention of NCDs is rooted not just in Health 2020 but also in the local and regional strategies for NCDs," said Dr Jakab. The WHO 2016-25 Action Plan builds on previous action plans and focuses on environmental and social determinants of health. Moreover, there are "multiple potential links" between JA-CHRODIS and WHO Europe in the area of

prevention and control of NCDs – owing to its emphasis on evidence-based practice, support for policymakers and ongoing monitoring of health.

Dr Jakab gave the example of promoting physical activity. Her organisation prepared country factsheets with the financial support of the European Commission that highlight progress and success stories. Nevertheless, the WHO recognises that strengthening health systems to achieve better NCD outcomes is difficult. It has carried out country assessments, which should lead to greater support and experience sharing. It moreover has endorsed the European Framework Correction for transforming healthcare systems.

"We are now in the process of developing a European status report that will be launched at our meeting of NCD directors in the European region in June 2017, and we will expect to use this in a global status report," she concluded.

Ian Forde: JA-CHRODIS helping to address the sustainability of healthcare systems

The OECD "really appreciated the depth of innovation that the JA-CHRODIS initiative uncovered, particularly at local and regional level", emphasised Ian Forde, senior policy analyst in the health division of the organisation, at the start of his presentation on sustainable healthcare.

Public spending on health is increasing (along with spending on private healthcare provision), and therefore there is a great need to ensure that we get as much out of this extra spending as possible. We want to see more effective care for people with multiple chronic morbidities, a fast-growing group of patients with complex needs, he said. "It's clear at the moment that we're not doing well enough," he added.

Data shows that often doctors are not informed of specialist care and care records are not regularly passed from one doctor to the other. Dr Forde emphasised that these problems have a clear impact on patients with chronic diseases. This impact is particularly striking for those patients that also have mental health problems. Lower life expectancy in this group is often the result of physical conditions, such as untreated hypertension and poorly managed diabetes. "It's often due to a failure of care co-ordination," he explained. "I hope that some of the insights gained from JA-CHRODIS – such as shared electronic patient records, common coding of conditions, platforms for patients themselves to input their data and questions – will be able to help improve the effectiveness of care for people with chronic and complex conditions."

Efficiency of care ("care at the right place and the right time") is another key area of focus. For example, many patients are treated in emergency departments when it would have been more appropriate for them to have received primary care. But from the data, it is difficult to isolate healthcare systems that do better than others.

Dr Forde also drew attention to the "massive scope" for positive socio-economic impacts. For example, in the developed world around 10-20% of care for over 50s with chronic conditions

is provided by informal carers, who are then unable to contribute in other ways to the economy. "So clearly, we would hope that the JA-CHRODIS recommendations around access to resources, involvement of social networks and psycho-social support will help," he said.

Early retirement and unemployment is also much more common in those with multimorbidity. These trends highlight the "real need to make sure that this group of people are still socially and economically participating in society to the degree that they want".

One of the most striking lessons of the JA-CHRODIS initiative, however, he said, was the lack of knowledge about the impact of health programmes. "The evidence base is extraordinarily thin... [Many] have not been evaluated with a control group, and that's something we really need to fix." The JA-CHRODIS recommendations around assessment are going to be key going forward, he concluded.

Session 2: How can policymakers use JA-CHRODIS results to address the chronic disease and an ageing society?

The 12 steps towards implementing practices to reduce the burden of chronic diseases was one of the defining outcomes of the Joint Action. In his opening remarks, Ranieri Guerra, Director General Prevention, Chief Medical Officer, Italian Ministry of Health, praised the value of the 12 steps. "They give us a procedure and a strong case for what can be done," he said. Such a process is particularly useful at a time of increasingly costly ageing and greater life expectancies. "We need to know these people can be supported," he added.

Another major challenge is the impact of climate change on health. It is important to understand fully how climate impacts will affect everyday practice. A further challenge is the competition for financial resources, particularly in tightened economic circumstances. Treasury departments have to weigh up immediate "substantial" financial gains, such as the revenues from tobacco taxation, against those perhaps longer term benefits deriving from health expenditure.

Joined-up government is required, particularly in Italy, he said, where physical activity is organised at a municipality level and where alcohol consumption is linked to good education. All sectors need to be pulling in the same direction. He concluded by proposing that Member States work together to develop a new model of healthcare provision that will meet increased demand.

Prof Mirosław J. Wysocki, Director General, National Institute of Public Health, Poland (NIH), echoed Dr Guerra's view that the JA-CHRODIS 12 steps will be very practical. Poland, he said, was calling out for new systems to treat those with certain chronic diseases. He cited the example of the 300,000 cases of advanced Alzheimer's in the country.

The next speaker, Gabrijela Korže, Attaché for Public Health and Pharmaceuticals, Permanent Representation of the Republic of Slovenia to the EU, said that her country had identified the need to strengthen primary care as the "cornerstone" for decreasing the burden of chronic

disease. National plans on diabetes, physical activity and general healthcare are boosting the sustainability of the healthcare system in Slovenia, she said.

Since 2011, primary care teams have included registered nurses and act as care co-ordinators for health promotion, early detection and the treatment of chronic diseases. Today, more than two-thirds of the country enjoys such coverage. Healthcare centres are also reaching out locally to empower patients and special programmes have focused on the less well-off.

Ms Korže also highlighted that the JA-CHRODIS initiative was regularly presented to the Minister of Health and the experiences of Slovenia were fed into the Joint Action's outcomes, especially good practices in the prevention and treatment of diabetes. Moreover, the country's integrative approach to addressing risk factors will mean that it will continue to play a role in JA-CHRODIS in the future.

Alain Brunot, Medical Advisor for Public Health, French Ministry of Health, opened his presentation by observing that Europe seems to share a strategic vision for health. France's national strategy, he said, is also focused on health promotion and recently a roadmap was introduced for investing in health promotion. "There is a striking similarity between the conclusions of JA-CHRODIS and what we have in the national framework," he said.

France also has a national initiative for increasing the exchange of experiences and practices. The initiative involves national agencies, regional health authorities and the French Society of Public Health in the creation of a platform for the promotion of good practice similar to the CHRODIS Platform and its support for intervention.

In Belgium, addressing chronic diseases has been national priority since 2008, according to Jolyce Bourgeois of the Belgian Ministry of Health. The Belgian plan focuses on integrated and people-centred care. "This implies a fundamental shift in the way health services are funded, managed and delivered," she said.

The goal of the Belgian joint plan (co-ordinated across all the regional governments) is to bring together different silos and to tackle those silos between primary care, specialised care, home care and welfare. The end result is to improve the quality of care provided by the same healthcare budget. The plan identified 18 action points to be implemented in regions where they would have a great impact in reaching healthcare goals in alignment with the 12 steps of JA-CHRODIS – e.g. addressing equity, empowering the target population, good governance, evaluation and transferability. Following pilot initiatives, the plan will be implemented in the regions this year. She concluded by expressing the hope that the Belgian initiative will lead to good practices being included on the CHRODIS Platform.

Primary prevention is also a priority of the Lithuanian health ministry, said Gintarė Šakalytė, Vice Minister of Health. She emphasised the importance of focussing on multimorbidity, given that 94% of people with a chronic disease in Lithuania suffer from an additional condition. She added that JA-CHRODIS' unified approach must be adaptable to every kind of healthcare

scenario. She reaffirmed the need for an integrated approach across all levels of healthcare. Lithuania, she said, has a working group following the results of the Joint Action and is integrating them into its specific national context.

The session moderator, Clive Needle, Senior Policy Advisor of EuroHealthNet, then asked the panel of speakers whether the practices identified by JA-CHRODIS would prove to be beneficial to their particular contexts. Prof Wysocki responded by highlighting that Poland does not have a national plan for diabetes and that the JA-CHRODIS work in this area, along with the Platform, could be helpful in planning activities to control this disease.

Vice Minister Šakalytė emphasised the need to target prevention initiatives at the young, particular for conditions linked to obesity, while Ranieri Guerra said that his team had been able to apply the lessons of the Joint Action in the redesign of its package of services. Though he added that prevention was not cheap, it is nonetheless needed to make health systems sustainable.

This point was echoed by Prof Wysocki. He added that prevention must not only be cost-effective, however, it must also have an ethical dimension. For example, not introducing prevention measures for cervical cancer was unethical, while, moreover, vaccinating children *is* ethical.

Alain Brunot said that the CHRODIS Platform would benefit from having a broad scope for intervention; the more prevention the better, while Jolyce Bourgeois said that the Platform should not be only a top-down tool, but should be used by health professionals operating at a local level.

Session 3: Integrating health promotion in comprehensive healthcare

In this session, Ellen Nolte, Head of London hubs, European Observatory on Health Systems and Policies, gave a presentation on the implications of the comprehensive healthcare model that was developed by JA-CHRODIS for sustainable healthcare systems. She acknowledged that rising expectations, technological advances and increased life expectancies are placing a strain of healthcare budgets and that ensuring 'value for money' was thus increasingly important.

Focusing on multimorbidity really highlights the key issues that countries are facing, she said. Though the incidence of multimorbidity increases with age, the burden is actually higher under the age of 65. There is evidence to show that deprived communities are disproportionally affected by multimorbidity. But review of evidence on interventions to improve primary care for this group gives a mixed picture – though interventions targeted at specific problems associated with patients with multiple conditions or specific combinations of conditions might be more effective. Guidelines have played a "huge role in improving evidence-based practice", she said, but added that they are disease specific and not always useful for multimorbidity. "The rigorous application of guidelines in some cases can lead to over-treatment."

The JA-CHRODIS has highlighted the need to centre care on the patient. "There is an acceptance that people have to be involved in their care," she said. Though improvements have been made in this area, it is "still not well done". Around 40-50% of multimorbid patients are not involved in their treatment. Diet, physical activity and other underlying factors are not being discussed with healthcare professionals. Risk minimisation and disease prevention remain separate from other activities in the healthcare continuum. There is therefore a need to integrate health promotion into day-to-day practice and provide incentives to healthcare professionals to do so. However, as Anne Hendry, Clinical Lead for Integrated Care, Scottish Government, pointed out, conflicts of interests between different insurance systems abound and, moreover, the political emphasis is often placed on acute care and not prevention. Making prevention a priority requires financial resources and training. Regulatory frameworks must also encourage innovation.

The second keynote presentation was given by Ricardo Baptista Leite, a Member of the Portuguese Parliament, on integrating health promotion in healthcare from different perspectives. He said that his country has been successful in providing a national health system at a lower cost than many countries. But the 6% of GDP that it currently spends on healthcare is predicted to need to rise considerably in the coming years to maintain the same level of service. The emphasis is thus on sustainable spending and that depends of implementing reforms today, he said.

People in Portugal have a comparatively higher life expectancy but 'healthy life years' must be taken into account. An ageing population is putting great pressure of the health system. Other problems include a rising incidence of diabetes and a concentration of doctors in the capital.

Reactive healthcare systems, however, became the norm across the developed world adding to the burden of care. But WHO figures support the need to investment in prevention in order to achieve sustainable systems. Nevertheless, just 3% of healthcare budgets across the EU are being spent on prevention. The days of business as usual are over, Dr Leite argued, due to rising costs and inequalities and demographic changes. "We have to move away from this industrialised view in which we focus on volume and profitability (in which hospital managers are more concerned about the number of hospital visits) to a focus based on patient outcomes."

Such a patient-centred approach takes financial incentives away for hospital figures, for example, and places rewards on outcomes. In Portugal, this approach has already been shown to improve outcomes in studies of type 2 diabetes and hypertension. But to avoid a plateau effect occurring (i.e. more spending while not improving outcomes) requires greater attention to also be paid to how the patient fits into the community. Someone's health status derives 60% from social determinants (30% genomic and 10% clinical).

His prescription for this community value-based care was a four-point plan: stop the health minister thinking like a 'disease' minister; combine health and social services in the same

ministry; strike a risk-sharing deal with the finance minister; and ensure that the prime minister is a champion for health promotion. This approach provides true incentives for the health minister to lower unemployment and early retirement (and other social benefits) due to poor health. Nonetheless, to encourage action on health promotion, concrete 'before and after' figures should be produced. Moreover, in addition to long-term results, timely outcomes are often politically necessary to get the ball rolling.

These presentations were followed by a panel discussion moderated by Anne Hendry. The panel was made up of the two keynote speakers together with Annabel Seebohm, Secretary General of the Standing Committee of European Doctors; Nicoline Tamsma, President of EuroHealthNet and Co-ordinating Advisor International Affairs at the National Institute for Public Health and the Environment (RIVM); and Nicola Bedlington, Secretary General of the European Patients' Forum (EPF).

Ms Tamsma kicked off the discussion by welcoming the speakers' focus on integrated actions. She said that EuroHealthNet's members had looked at the five components of the Ottawa Charter on Health Promotion and found that the least amount of progress had been made in the area of health policies. Health promoters are good at bridge building and creating links with other policies, but less successful has been their influence on health policy. She hoped that CHRODIS PLUS will be able to make a difference here.

"But we shouldn't be looking at competition between health prevention, promotion and patient-centred chronic disease management," said Ms Bedlington. "It is definitely one continuum." She added that EPF is focusing on nutrition, psycho-social support and keeping patients in work. The issue of equity is also crucial to EPF, and the forum is addressing the "massive" inequities across the EU. Her organisation's research has shone a spotlight on the number of patients who are foregoing consultations with doctors due to financial reasons and are weighing up the cost of healthcare against nutrition. Action on healthcare inequities forms part of a wider move to address the full range of social inequalities that exist.

Annabel Seebohm commented on the lack of political commitment on tobacco, food and alcohol. For example, a ban on advertising of alcohol would be desirable, she said. Industrial self-regulation is not functioning well enough, in her view. Furthermore, Ms Seebohm said that a lack of implementation of existing EU legislation is also a problem, e.g. the Czech Republic has only recently banned smoking in public spaces. Progress on plain packaging for tobacco products is also slow, with only a handful of countries in the process of implementing this measure.

Session 4: How does JA-CHRODIS leave its mark, including examples in practice?

Introducing the last of the sessions on putting the tools of JA-CHRODIS into practice, Anne Hendry pointed to the insights to be gained from hearing the experiences of three countries from three different geographical locations of Europe: the Netherlands, Ireland and Serbia.

Mieke Rijken, Research Coordinator at the Netherlands Institute for Health Services Research (NIVEL), gave a presentation on the Dutch implementation of the JA-CHRODIS multimorbidity care model, which was applied on a "small scale" in the country. Even though there is only limited research available in this area, she said that it did not mean that progress could not be made. Hence the model developed was based on expert opinion as well as scientific evidence.

In the Netherlands, the aim was to apply this model on a pilot scale in order to then evaluate the improvements to multimorbidity that can be achieved. The objective was also to transform the model into a self-evaluation tool. Primary care providers would then assess current practice and receive feedback and goals for improving the practice. Assessments of different elements and components are made online on a scale of one to ten according to relevance and more qualitatively on how they relate to the ideal situation that already exists.

Those involved in the pilot cases considered the practices to be all relevant and offering a wider variety of activity than currently practised. The JA-CHRODIS emphasis on collaboration and community resources was also viewed favourably, but respondents were less positive about the "completeness" of the assessments that they had made. "They did not do the comprehensive assessment described by the model," she said. Exchange of patient information was also considered an area for improvement, requiring greater attention to be paid to the type of information to be shared.

Out of this process, a series of suggestions were devised, including creating the right circumstances for tackling the root causes of multimorbidity and for delivering the right messages on what care givers have to offer. The Dutch pilot concluded that the model can be further developed, particularly by making it simpler and more applicable to care professionals not working in the medical setting. The next stage is to work with all the relevant parties to explore how the model can be used nationally as a basis for multimorbidity care.

Next up was the experience of implementation in Ireland, which was presented by Helen McAvoy, Director of Policy at the Institute of Public Health in Ireland. She said that they had taken a team approach to implementation. "When you have the right blend of contributors and structured engagement with your department of health, this is critical for moving forward and really getting the impact of learning from joint actions."

The JA-CHRODIS has brought a "real integration" in service design and delivery, policy work and research nationally as well as network sharing and capacity building across Europe (with "tangible" outcomes, e.g. bicycle use experience sharing with Iceland). The Joint Action has also led the country to take stock of its progress on certain issues such as tobacco control and cardio-vascular disease in comparison with other countries.

The initiative Healthy Ireland has led to the appointment of a Minister for Health Promotion and policies in this area have been introduced. However, community-based programmes have not been rolled out to the same extent in Ireland as some other countries. The experience of Healthy Amsterdam and other city-level initiatives are of particular relevance.

Ireland has specific health challenges such as binge drinking and high overall levels of consumption among those that drink with possible links to high suicide rates among young men. Incidence of respiratory disease is also high. Comparatively, Ireland also has a high level of obesity and it has recently launched an initiative to tackle this problem along with a national physical activity plan. "It is up to us now," she said, "to look at how some of the good practices across Europe fit into its policy frameworks." Furthermore, several healthy workplace initiatives were identified through JA-CHRODIS, and this will be another area where Ireland will explore whether these can be adapted to its policy framework.

Looking ahead, she concluded that databases offered a means of assessing national progress in certain areas in comparison with other countries. She also emphasised the importance of adequate funding. "Unless the investment of resources is written into policy, it's very hard to knit it in later on." Cross-sector funding might point the way forward.

The last national experience of JA-CHRODIS was presented by Vesna Knjeginjic, Assistant Minister at the Serbian Ministry of Health, which created a pilot national chronic disease plan using the tools established by the Joint Action. As a country wishing to join the EU, Serbia has an obligation to adopt good practices, she said. In this context, she echoed the importance of taking action on risk factors and social determinants. "Prevention is an essential response to chronic disease," she stated.

At-risk groups need to be strengthened and early detection supported to reduce incidence levels. "It's important to map and implement existing good practice promoting good health and a common framework for operation," said Dr Knjeginjic.

The session finished with a look ahead to the next Joint Action, CHRODIS PLUS – a €6.2 million initiative engaging 45 partners in 21 countries. Rokas Navickas, the scientific coordinator, said that the co-ordination team had already been working with its partners to shape the direction of this follow-up initiative. His presentation gave a picture of the situation in emerging and developing countries from where great examples can be found of how to achieve increased life expectancies. On effective health expenditure, emerging countries are actually doing better than developed countries because they are following a more ideal path, he said. "The new Joint Action will be very much about sharing knowledge -- from Member States but also from the emerging countries."

The economic dimension to health expenditure should not be overlooked. Studies have shown that reductions in mortality account for about 11% of recent economic growth in low-income and middle-income countries as measured in their national income accounts. "If we spend the money [on healthcare], we actually get a good return on investment," Dr Navickas said.

The chronic diseases requiring attention, however, have not changed since the three years of JA-CHRODIS. In the new Joint Action, the achievements of the first initiative will be built upon.

"We are trying to implement those deliverables to make a change on how we approach patients."

A study by Stanford University has demonstrated that it is possible to delay the onset of disability. It compared a group of 58-79 year-olds from a runners' group with a control group. The researchers recorded a progression to disability in both groups, but the control group was moving to this end at a much faster rate. Dr Navickas concluded his remarks by emphasising that positive preventative measures, such as physical activity in this case, can really make a difference.

Antonio Sarría-Santamera, overall coordinator of CHRODIS PLUS, concluded the session with some specific remarks on the new Joint Action. As previously emphasised, it will focus on implementation of good practices. The challenge is to identify local factors affecting such implementation, he said. The Joint Action will also try to broaden the focus of healthcare to the full range of determinants of chronic diseases, emphasising the benefit of multisectoral action and improving working conditions. He also highlighted the need under the new action to reach out to new stakeholders and to communicate the advantages of the JA-CHRODIS approach. Additionally, evaluating its impact will be crucial to advancing the approach.

The new Joint Action will be divided into three vertical work packages and one horizontal issue. The verticals are health promotion and disease prevention; implementation of the multimorbidity care model; and quality in prevention and care of single chronic disease. The horizontal issue focuses on support for those affected by or living with chronic diseases (employment setting). The outcomes of these work packages will feed into integrative healthcare policies and sustainability. The knowledge gained from the first Joint Action's specific focus on diabetes will be translated under the new Action into developing a model for any chronic disease. Finally, the multimorbidity package will consist of testing the care model in different countries and then finalising it as a ready-to-use tool.

Conference conclusions

The conference was brought to a close by Paloma Casado Durández from the Spanish Health Ministry and Xavier Prats Monné, Director General for Health and Food Safety, (DG SANTE) European Commission. Ms Casado underlined the continued need for action in reducing the burden of chronic disease. She said that the success of the Joint Action CHRODIS was clear and that the initiative was a step towards achieving healthcare systems based on patient needs. The challenge now with CHRODIS PLUS, she added, was to scale up the good practices identified by the Joint Action.

With such wide differences across Europe in healthcare expenditure and life expectancy highlighted by the conference, Mr Prats Monné said that the key task for sustainable healthcare is to ensure that longer life translates into more liveable years – and that this desired outcome depends on how well chronic disease is managed. Moreover, health inequalities within countries are stark. "There is a bigger correlation between health and

poverty than health and obesity," he added. In this light, he expressed his hope that the new Joint Action will indeed reach beyond the commonly acknowledged determinants of chronic diseases to the full range of factors.

Evaluation on the Final Conference

An evaluation of the Final Conference was organised by WP3 who developed a survey for participants divided in four blocks to assess the opinions of the participants with regard to the conference sessions and with reference to some of the main JA-CHRODIS deliverables publicly available at the JA-CHRODIS website at the moment of the conference. The JA-CHRODIS Closing Survey was sent to 238 persons registered at the final conference. Data was collected from 28th February 2017 afternoon to Friday 10th March 2017. The total final number of survey participants was 110. The questionnaire of this survey can be found at Annex IV.

RATIONALE: As part of the evaluation activities of the JA-CHRODIS, work package Evaluation (WP3) has been commissioned to assess the opinions of the participants at the JA-CHRODIS Final Conference (27th and 28th February 2017 in Brussels) with regard to the conference sessions and to assess their opinion with reference to some of the main JA-CHRODIS deliverables publicly available at the JA-CHRODIS website at the moment of the Conference.

OBJECTIVE: To assess both the usability and usefulness of a set of main JA-CHRODIS deliverables and the opinion of the participants of the JA-CHRODIS final conference with regards to the conference sessions.

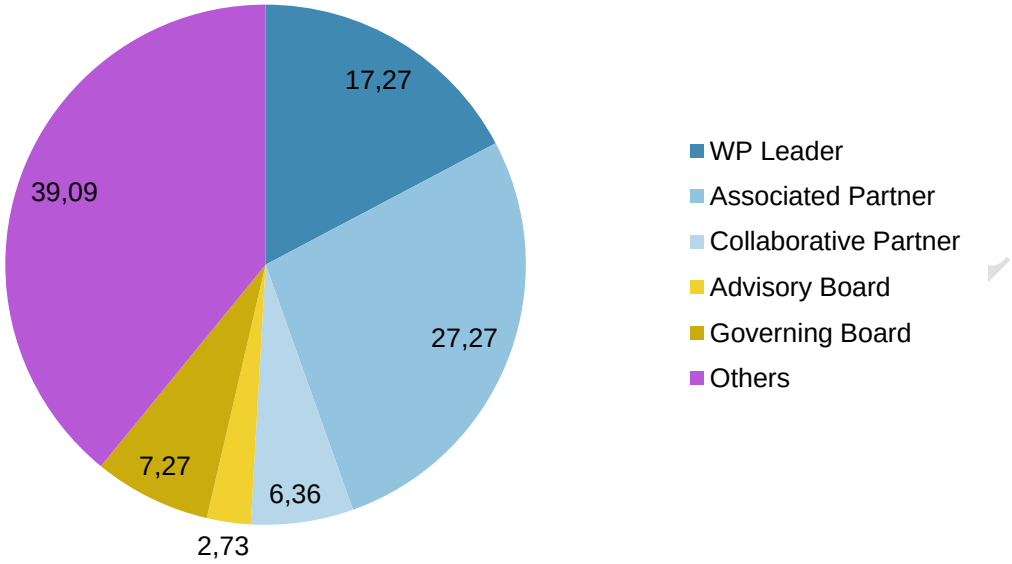
METHODOLOGY: The JA-CHRODIS Closing Survey was sent to 238 persons registered at the final conference. Data was collected from 28th February 2017 afternoon to Friday 10th March 2017.

The JA-CHRODIS Closing Survey was organised in four blocks. Block 1 gathers basic participants' information and block 2 is aimed to assess the Final Conference work package sessions and usability of JA-CHRODIS work packages' outputs. Block 3 focuses on the Final Conference sessions on joining forces and moving forward for better health policies across Europe and, finally, block 4 examines the Final Conference Overall Satisfaction. For more detailed information, see the survey questionnaire in Annex IV.

A statistical descriptive analysis was carried out to summarise the data. 110 people participated in the survey (46.2% of participation). Some of the questions were only asked to some of the survey participants (e.g. only to those survey participants attending the session). See the questionnaire in Annex IV for further details.
BLOCK 1. Basic Closing Survey (at the Final Conference) participants' information

The total final number of survey participants was 110 and the total number of survey participants identifying themselves as partners (work package leaders, associated partners or collaborative partners) was 56 (50.9%) (Figure 1).

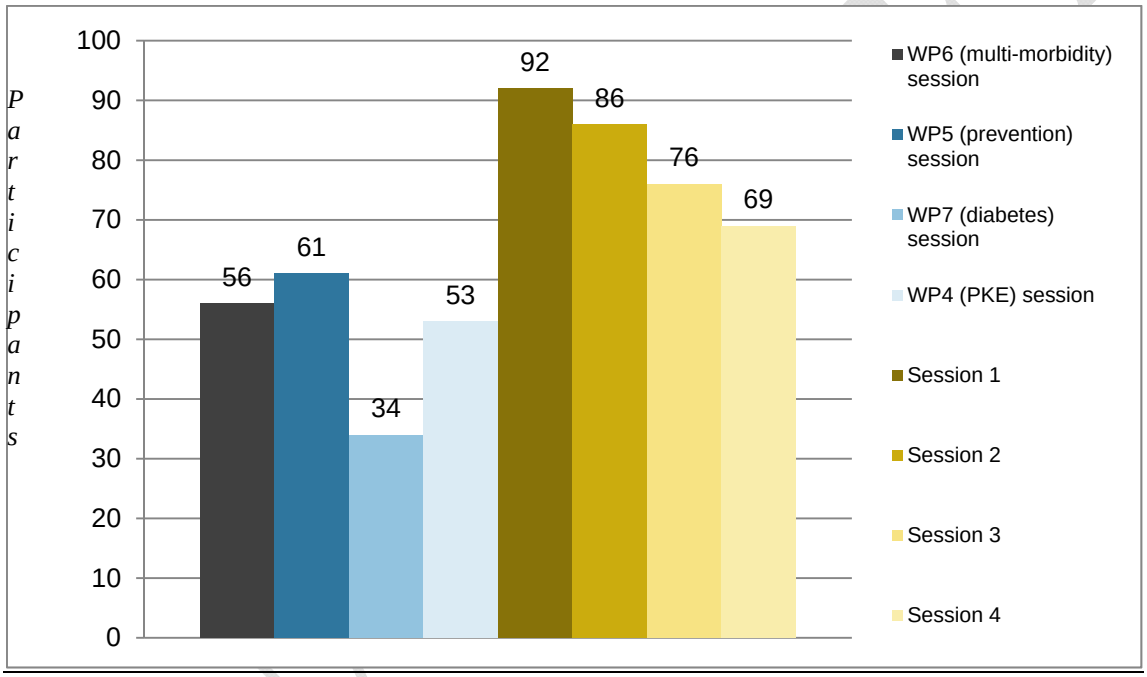
Figure 1: Distribution (%) by JA-CHRODIS Closing Survey participant profile



In terms of involvement of the JA-CHRODIS Closing Survey responders in the Joint Action, 57.3% declared that their institution has been directly involved with the work packages, and 53.6% affirmed that they themselves have been directly involved with the work packages. Moreover, 67.3% stated that their institution has participated in past JA-CRHODIS events and 63.6% affirmed that they directly attended JA-CHRODIS events in the past.

The following figure shows how many of the survey participants indicated that they attended each of the conference sessions. A greater involvement occurred on the second day of the conference.

Figure 2: Number of conference participants attending the JA-CHRODIS Final Conference sessions (Monday 27th (WP sessions); Tuesday 28th (other sessions)) (n=110)



BLOCK 2. Rating Final Conference work package sessions and usability of JA-CHRODIS outputs

The following four figures describe the opinion of the survey participants regarding the sessions attended on February 27th. The patterns of answers were similar across sessions with high response rates evaluating aspects of the sessions as good, very good, or excellent (87% or more at all aspects assessed) in contrast with the rest; fair or poor assessments. Specifically, the WP7 session was the least attended and had higher "fair" or "poor" rates of response assessments (e.g. 32% of respondents considered the session usefulness of the take home messages as "fair" or "poor"). WP5 session is perceived as giving less opportunity for participating and sharing.

Only a few survey participants answered open questions to give feedback on the sessions (number of respondents between 2 and 8 per question). The number of positive and negative feedback comments was similar. Beyond general positive comments, positive qualitative feedback pointed at the WP5 session as useful for real settings and at the WP4 session as relevant, excellent, interesting and undertaken with a style that engaged audience. With regards to negative comments, WP6 and WP5 sessions were described as having too many presentations to keep timetable, WP7 session as confusing because the aim was not clear or the language too technical, and WP4 was said to have contributions not quite on the point, platform future was said to remain unclear, and the session might have been better with a neutral moderator.

A selection of survey participants' comments on the sessions is displayed below:

- WP4: *"The PKE overall has great potential… The key question, sustainability of the PKE was not answered", "This was an excellent workshop and the style and format was excellent".*
- WP5: *"Very useful message to take back home to implement actions on the real settings", "I felt the session was not sufficiently interactive with the audience".*
- WP6: *"Very much has to be done to put care model in practice!".*
- WP7: *"There was lack clarity in a number of presentations possibly due to some of them being too technical".*

Figure 3: Survey participants' opinion of the WP6 (multimorbidity) JA-CHRODIS Final Conference session

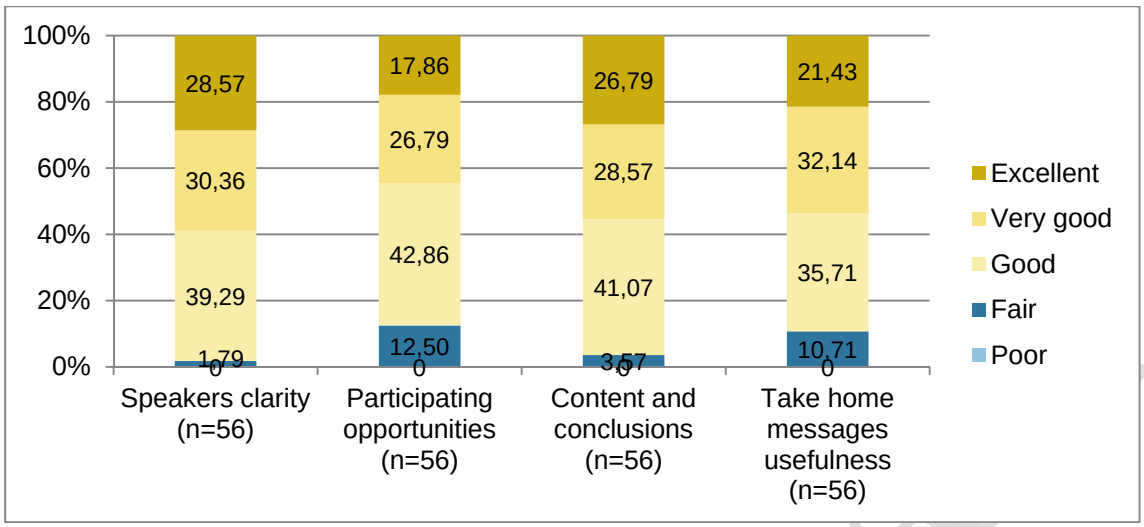


Figure 4: Survey participants' opinion of the WP5 (health promotion and disease prevention) JA-CHRODIS Final Conference session

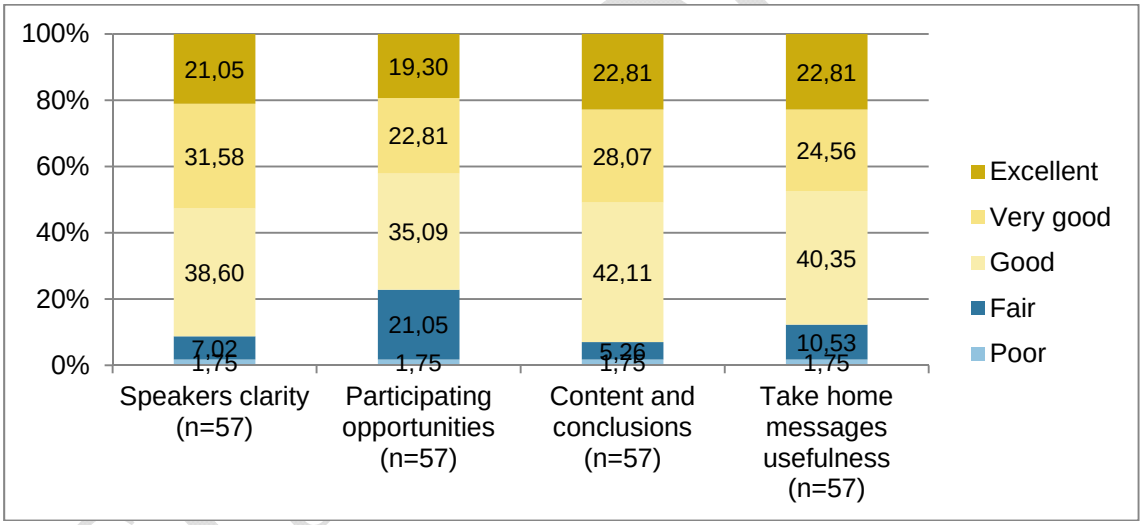


Figure 5: Survey participants' opinion of the WP7 (Diabetes) JA-CHRODIS Final Conference session

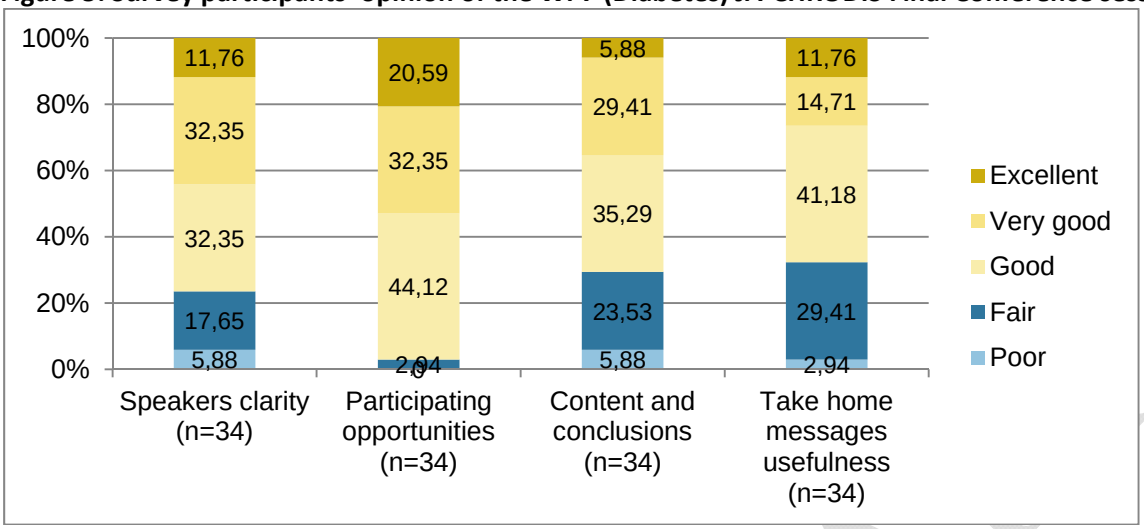


Figure 6: Survey participants' opinion of the WP4 (Platform CHRODIS) JA-CHRODIS Final Conference session

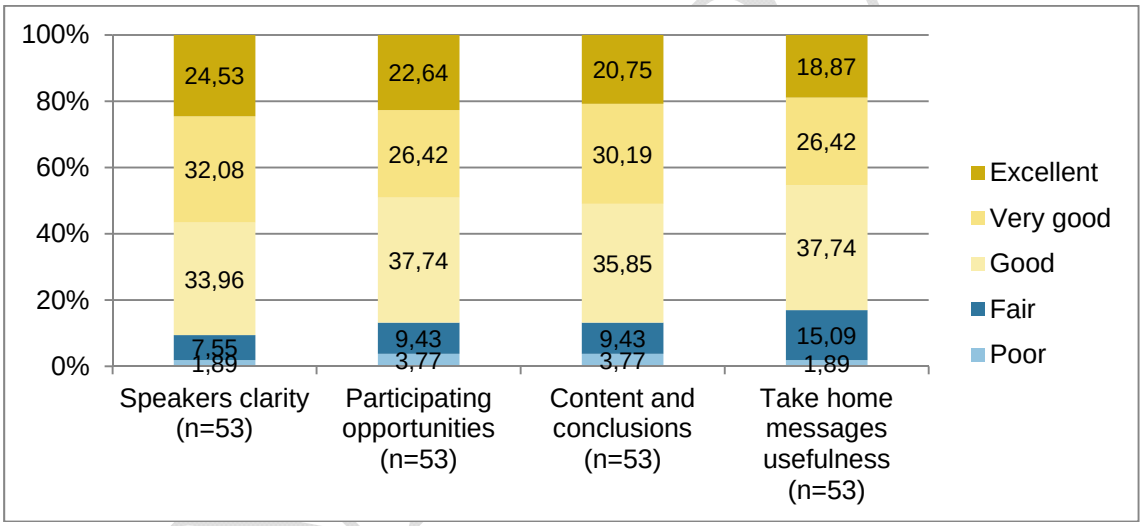


Figure 7 reflects the survey participants' opinion with regard to the usefulness of the main deliverables of WP5, WP6 and WP7 of JA-CHRODIS:

- "Recommendations report on applicability and transferability of practices into different settings and countries" (WP5),
- "Report on care pathways approaches for multimorbid chronic patients" (WP6), and
- "Recommendations to improve early detention, preventive interventions and the quality of care for people with diabetes" (WP7).

The perception of applicability, that is future use or intention to share, were similar across the reports (around 30% of participants stated to surely use them), although the WP7 deliverable was more unknown and less frequently expected to be used than the other deliverables. Lack of knowledge/non-familiarity with the deliverables were reported by 15% (WP6), 17% (WP5) and 25% (WP7) of respondents.

The number of participants answering qualitative answers with feedback on the deliverables was scarce (n=20, 20, 11). Most comments were positive and pointed at:

- WP5: the results are useful to define a NCD strategy, the key elements to consider transferability are also seen positively, and in general, the approach can be seen as both a reference and a source for inspiration.
- WP6: the results are also useful to define a NCD strategy, can be useful and good for associates working with the issue and can be seen as a good framework to work with stakeholders, especially after previous incoherent proposals.
- WP7: the results are useful, contribute to reflection and have potential for both practice and care.

A selection of survey participants' comments on the deliverables is displayed below:

- WP5: *"It will help us build our NCD Strategy", "It is practical", "…key point to change the overall present paradigm".*
- WP6: *"Very needed in the national context in order to fill some gaps", "We plan to implement MM care model in our institution …", "Excellent clear document".*
- WP7: *"Important to work together to reduce the chronic diseases", "The value in policy making".*

Figure 7: Future use or intention to share the main WP5 (health promotion and disease prevention), WP6 (multimorbidity) and WP7 (Diabetes) JA-CHRODIS deliverables

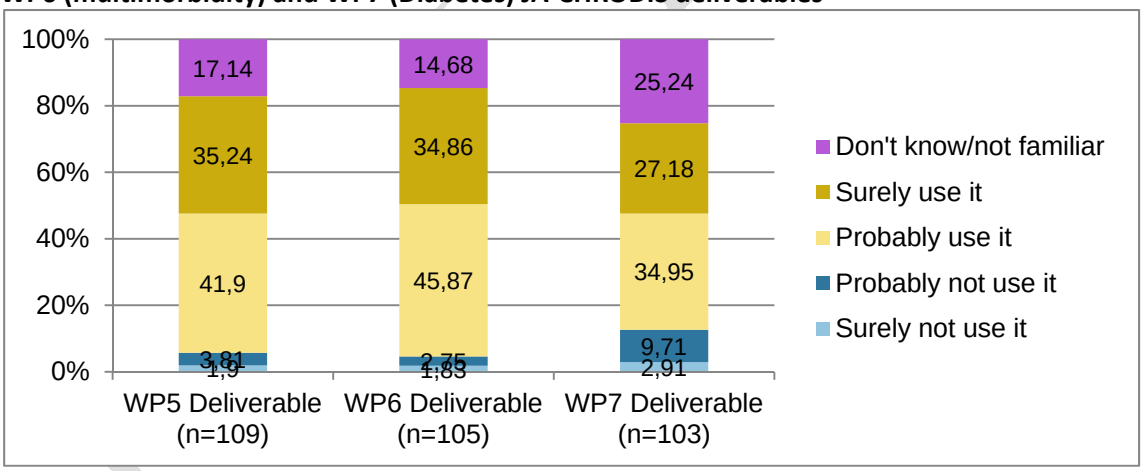
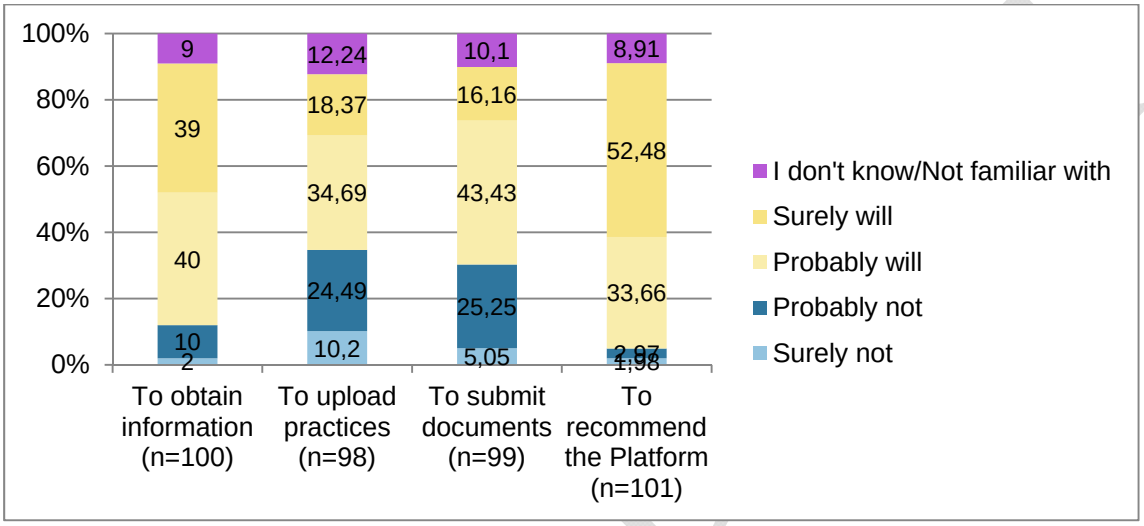


Figure 8 reflects the opinion of 100 survey participants with regard to the usefulness of the CHRODIS Platform (WP4's main deliverable). Knowledge of CHRODIS Platform were higher than that of the other core work packages. Only 16-18% of participants stated that they surely will submit documents/upload practices, 39% declared that they surely will use it to obtain information and 52% surely will recommend it.

11 participants gave qualitative feedback on this deliverable having a similar number of answers with:

- Positive feedback: the Platform willed be used in the future and is perceived as most useful
- Negative feedback: there are some reflections about the workload that implies to introduce practices (e.g. translation, uploading) and the number of practices included at March 2017 is evaluated as scarce

Figure 8: Future use and recommendation of the CHRODIS Platform (WP4)



BLOCK 3: Rating Final Conference sessions on joining forces and moving forward for better health policies across Europe

The following four figures describe the opinion of the survey participants regarding the sessions attended on February 28th. The pattern of responses was similar across each of the first three sessions (with higher positive rates of response pointing at the clarity of the speakers and higher negative rates concerning the chances to participate). Session 4 received slightly poorer evaluations than the others, but still positive.

The number of participants giving qualitative feedback on the sessions was scarce (n=5, 4, 6, 5). The main qualitative messages for each session were:

- Session 1: Although it was qualitatively valued as great by attendees, the majority of qualitative messages were negative, especially with regard to the lack of opportunity to engage in a debate and to a lesser extend about the perception that some speakers seemed not familiar with JA CHRODIS results. Some examples of the contributions are: *"Great challenging session", "It was a pity that most panellist needed to leave prior to the start of the discussion".*

- Session 2: The number of positive and negative comments was similar. Some survey participants were satisfied with specific speakers (e.g. Italian and French representatives). Others found some contributions were out to the point and subsequently less useful than expected. For example: *"While some speakers had a clear message that linked to JA-CHRODIS, others stayed within the circles of problems and approaches of their countries".*

- Session 3: The session received mainly comments as great and outstanding with special mention to the Portuguese speaker. On the other hand, two comments pointed at an excess of presentations and lack of time to debate. As examples of these ideas: *"Particularly Ricardo Leite's speech was very inspiring"*, "*Excellent speakers but more time to debate could have made this session more useful*".

- Session 4: The number of positive and negative comments was similar. Positive comments highlighted the interest of the session and negative ones referred to excessive presentations and narrow scope. Some examples of the contributions are: *"Very interesting session, in particular to see that actually something is done with the results…"*, *"Overall I found the content and conclusions too local"*.

Figure 9: Survey participants' opinion of 28th February JA-CHRODIS Final Conference session 1

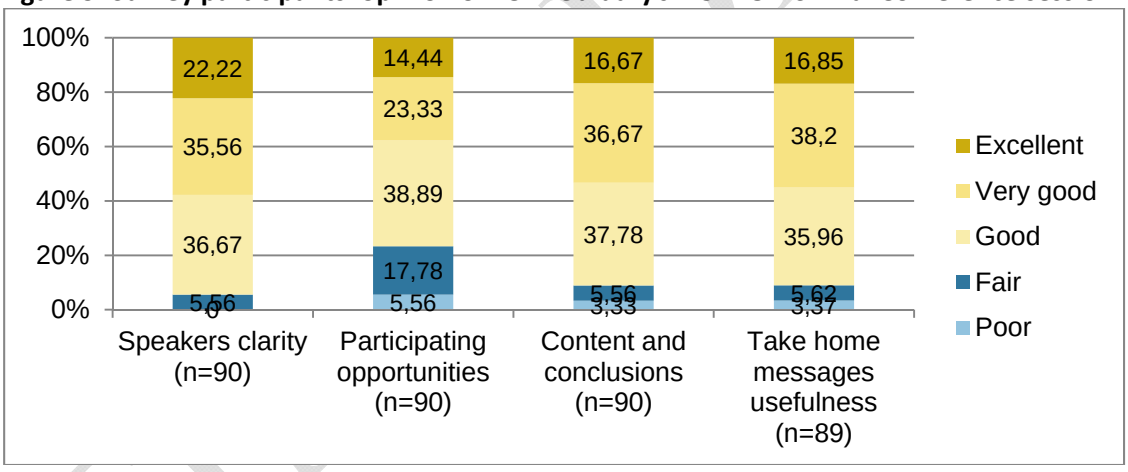


Figure 10: Survey participants' opinion of 28th February JA-CHRODIS Final Conference session 2

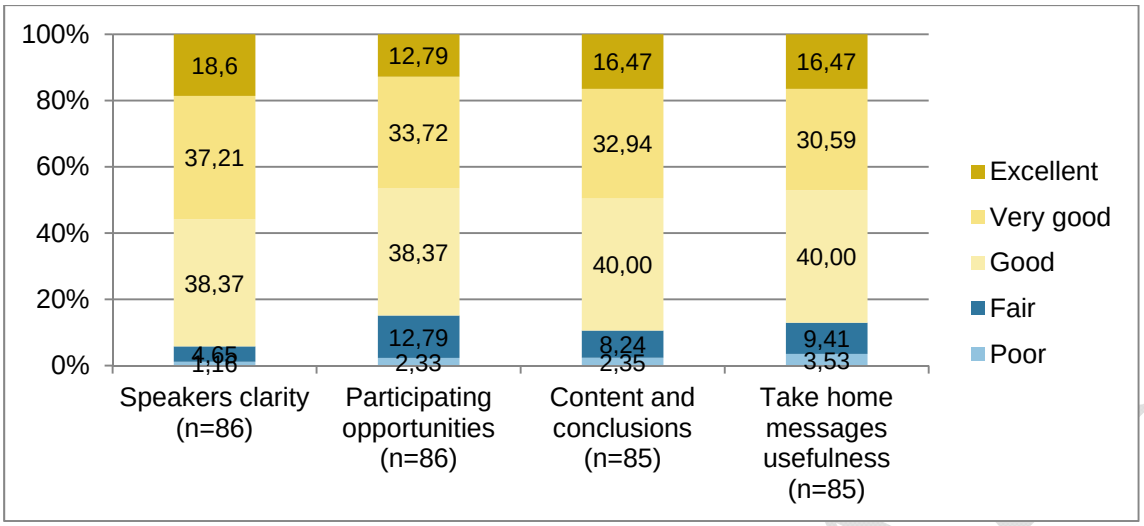


Figure 11: Survey participants' opinion of 28th February JA-CHRODIS Final Conference session 3

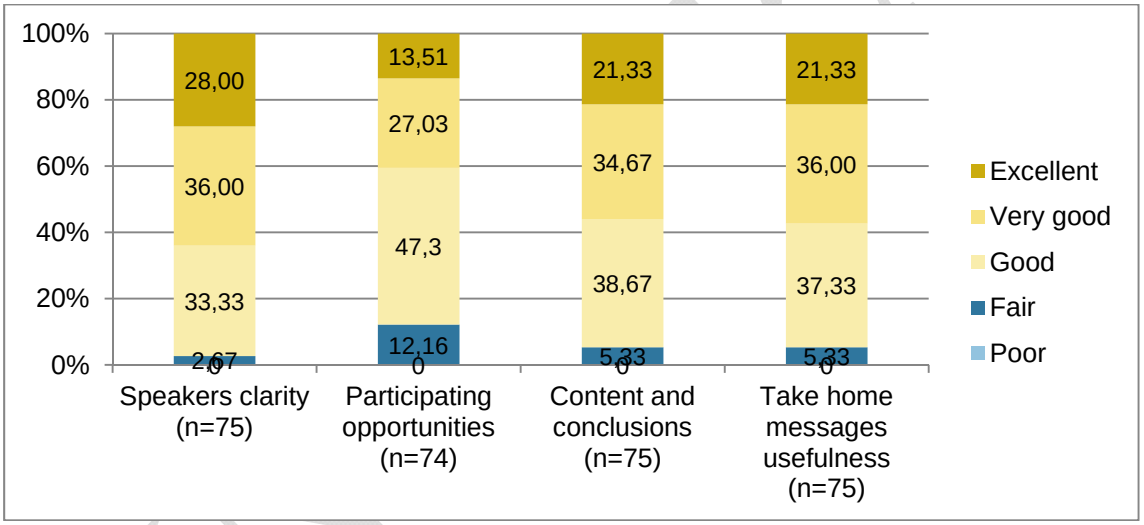
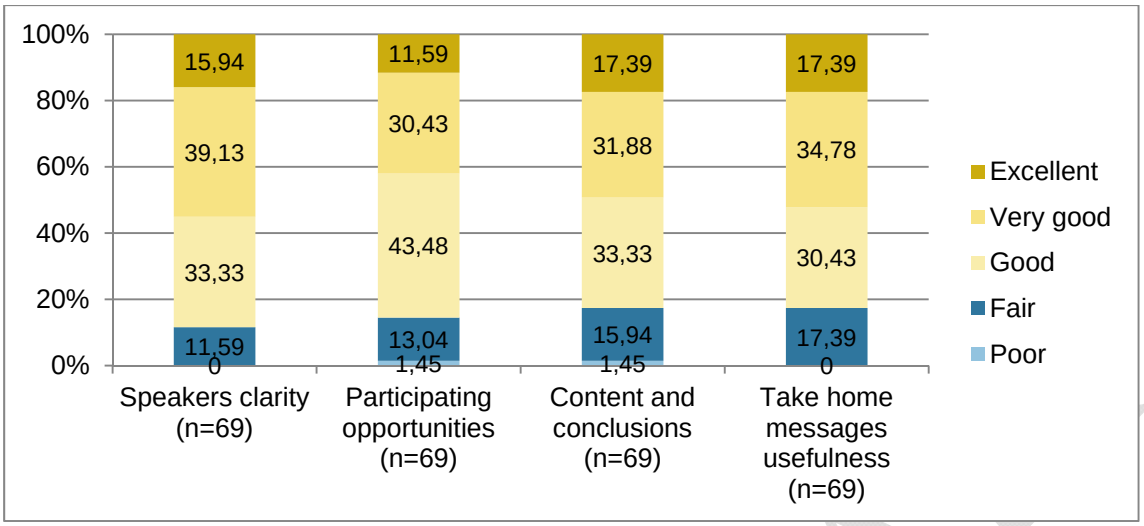
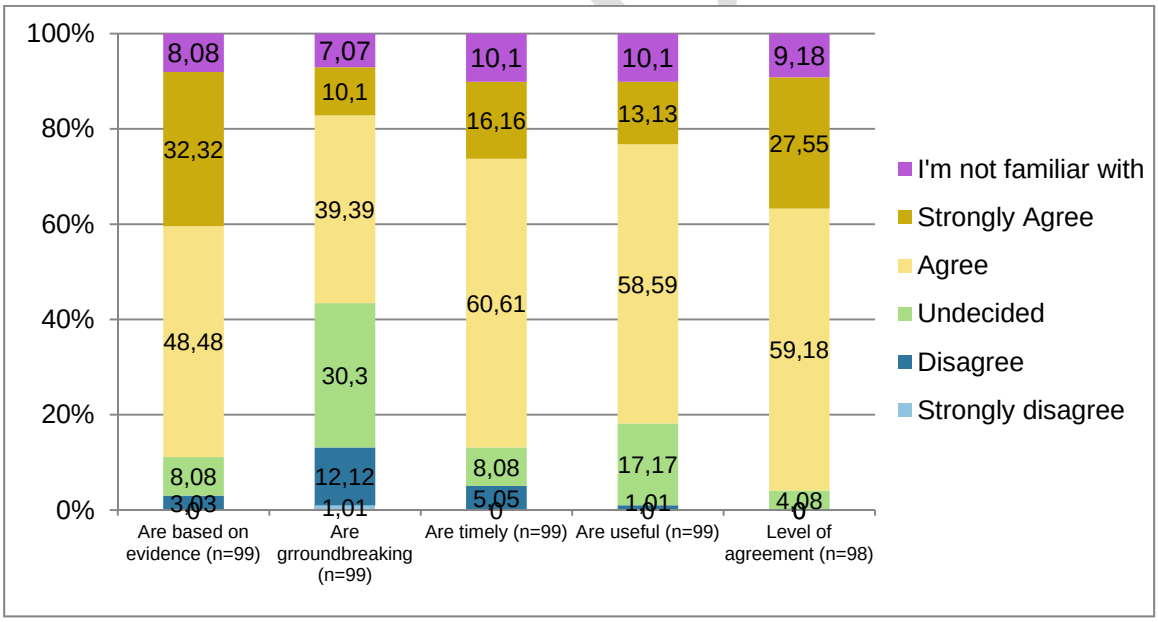


Figure 12: Survey participants' opinion of 28th February JA-CHRODIS Final Conference session 4



Concerning the "12 steps to address the chronic disease challenge" aimed to implement practices to reduce the burden of chronic diseases, more than 80% of 99 attendees stated to agree with them and with the fact they were based on evidence. Moreover, more than 70% agreed that they are timely and useful for their local context. On the other hand, only 49% considered them to be ground-breaking.

Figure 13: Survey participants' opinion of the JA-CHRODIS 12 steps

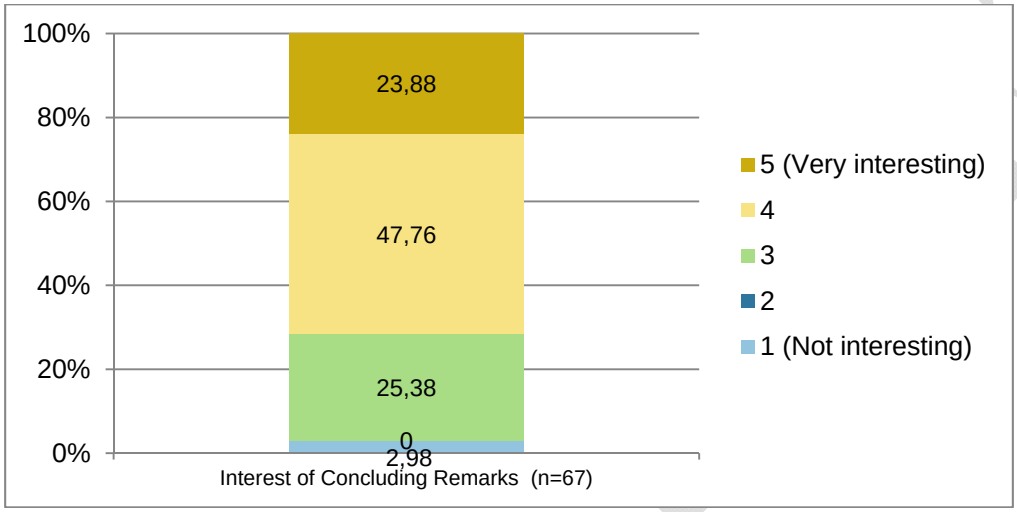


Additionally, 8 participants gave qualitative feedback on the "12 steps to address the chronic disease challenge" with a balance of favourable and critical comments. On one hand, some participants pointed out their practicality and usefulness, stating that they will disseminate them (e.g. *"Clear and pragmatic"*, *"I am planning to undertake a plan of dissemination at national level"*), and on the other hand they were describe as very generic or not innovative

(e.g. *"…very generic and not very new, already know"*, *"…do not seem to be interconnected and rather a number of general points to be taken into account"*).

At the end of the 28th, there was a brief session called "Concluding Remarks", which was attended by 67 respondents (68.4% of survey participants). Approximately three quarters (71.6%) of attendees rated this session as 4 or 5 on a scale of 1 (not interesting) to 5 (very interesting) and the average score was 3.9.

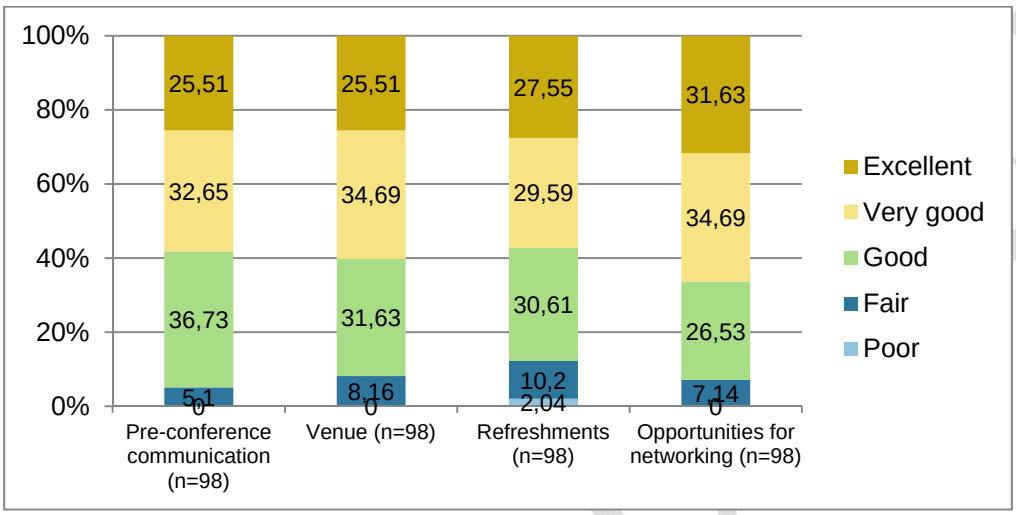
Figure 14: Level of interest with the concluding remarks of the JA-CHRODIS Final conference



BLOCK 4: Rating JA-CHRODIS Final Conference overall satisfaction

The following figure shows the opinion of 98 survey responders with regard to organisational aspects of the conference. Between 86 and 93% rated these aspects as “good”, “very good” or “excellent”. Refreshment was the aspect more frequently rated as fair or poor.

Figure 15: Organisational aspects of the JA-CHRODIS Final conference opinions



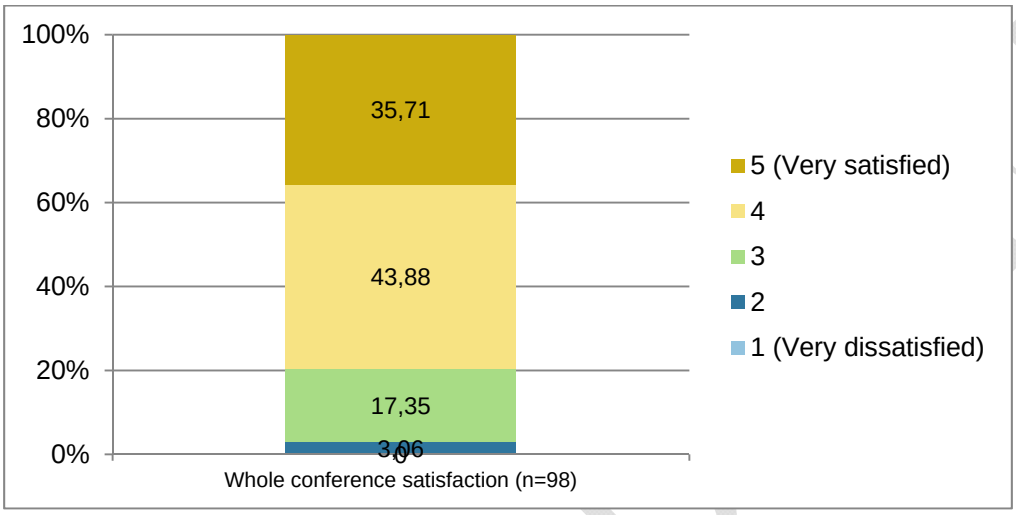
Regarding the main message or learning to take home from the conference, there were 32 qualitative contributions. The main ideas referred to health promotion and disease prevention as the focus activities to invest in (n=5). Other ideas noted were that JA-CHRODIS (and its outputs) is a good starting point to work from (n=3), that different health sectors should be more unified and collaborate better (n=2) and that there is a need for communicating and sharing good practice, e.g. using the CHRODIS Platform (n=2). Other interesting messages reported by only one participant pointed at: (a) the potential impact of the messages in terms of regulation and healthcare delivery, (b) the fact that key stakeholders are involved in JA-CHRODIS and the next JA will have an impact on healthcare policy, (c) the fact that we are still talking a lot about patients instead of with patients, and (d) the lack of time spent on discussing how the results can be integrated into country contexts.

69% (n=62) of the survey participants stated that they will surely share the take-home messages from the conference with their colleagues/network back home, 30% probably will, and only one (1%) does not know. No respondent said that they will surely not share it.

The following figure shows the level of satisfaction of 98 survey respondents regarding the time and energy invested in relation to the quality and interest of the whole conference. 36% (n=35) stated to be very satisfied and around 60% reported good rates of satisfaction (3 and 4 scores). Quantitatively, the average level of satisfaction was 4.1 (S.D.= 0.8) out of 5.

In addition, 16 responders made qualitative comments on the whole conference. The main ideas referred to usefulness and work appreciation. There were also some constructive critiques mainly referred to reduce the number of presentations, have more time for debate and isolated comments regarding the registry process or the comfort of the chairs.

Figure 16: Level of satisfaction with the JA-CHRODIS Final Conference



Summary of results according to Final Conference attendee profile

The results for the Final Conference Survey were analysed according to the profile of the attendees responding the survey. Three profiles were distinguished: Governing Board (GB) (n=8), Partners (P) (n=56, including WP leaders, Associated and Collaborating Partners), and others (O) (n=46, Advisory Board and other profiles).

The main results can be summarised as follows:

Involvement in JA-CHRODIS

Partners participating in the survey have been more often involved in JA-CHRODIS work packages (91.1%) than GB survey participants (25.0%) and others' profile (13.0%), as well as their institutions (P=98.2%, GB=25.0%, and O=13.0%).

Attending past events was more usual for GB and Partner participants (around 85%) than for the others' profile (41.3%).

Attendance to Final Conference sessions

Partners and others' profile responding the survey attended more often the sessions corresponding to WP5 about health promotion and disease prevention (P=58.2% and O=56.5%) and WP6 on multimorbidity (P=55.4% and O=47.8%) than GB participants (37.5%, both).

On the other hand, GB survey participants attended more often the session corresponding to WP4 about the CHRODIS Platform and the concluding remarks (75.0% and 87.5%, respectively) than the rest (around 50% and 65%).

Opinion of the sessions

The opinion of the sessions is positive for all survey participants regardless of their profile of membership, but some differences can be pointed out. Regarding the sessions held on Monday, 27th February, corresponding to WP5, WP6 and WP7 only the profiles of partners and others can be compared, because of the low attendance from GB participants. Partners reported a better opinion about speakers, content and conclusions, and the usefulness of take-home messages of the three sessions, scoring these aspects more frequently as "Excellent" than the others' profile.

With regard to the session corresponding to WP4, Partners rated all the aspects (i.e. speakers, opportunities for participation, content and conclusions, and usefulness of take-home messages) more frequently as "Excellent" or "Very good" compared to GB and others' profile.

Session 1 held on Tuesday 28th February was generally better evaluated by the GB survey participants in comparison to the rest, especially regarding content and conclusions and usefulness of take-home messages (rated both as "Very good" by 71.4%).

GB and Partner survey participants valued more positively the speakers, opportunities for participation and usefulness of take-home messages of Session 2 in comparison to the others' profile. But Partners rated content and conclusions more frequently as "Excellent" (22.2%) than the rest. Concerning the "12 steps to address the chronic disease challenge" presented in session 2, GB survey participants agreed more frequently, than the rest, that they are based on evidence ("Strongly agree"=50%) but their opinion about their usefulness for their local context was poorer.

For session 3, there is no a clear pattern but GB and Partner survey participants perceived more positively the opportunities for participation than the others' profile. Additionally, content and conclusions of the session were better valued by GB ("Excellent"=33.3%).

Partners reported a better opinion of the speakers, content and conclusions, and usefulness of take-home messages of Session 4 than GB and others' profile. It should be highlighted that GB survey participants never considered the characteristics of this session as "Excellent".

Finally, the Concluding remarks session was valued as "Excellent" more often by Partners and others' profile (P=27.8% and O=20.8%) than by GB survey participants (GB=14.3%).

Perception of applicability of WP deliverables

GB survey participants stated more often that they surely will use or share the main deliverables of WP6, WP5 (50.0% both), and WP7 (62.5%) than the rest of participants (around 33% for WP6 and WP5 deliverables, and 25% for WP7).

Regarding the CHRODIS Platform, GB survey participants also reported more often to be sure that they will surely use the Platform to obtain information (62.5%) and recommend it (75.0%) than the rest (around 40% and 50%, respectively). The probability of uploading a practice was similar among the three profiles, and submitting a document was more probable for GB and Partners than for other participants.

Final Conference overall satisfaction

GB survey participants had a slightly better perception of the pre-conference communication ("Excellent"= 37.5%) than the others' profile (21.6%). On the other hand, Partners reported more frequently to be very satisfied (39.6%) with the balance between time and energy invested and quality and interest of the whole conference than GB participants (25.0%).

Conclusions of the evaluation

- 110 attendees participated in the survey (46.2% of participation). The number of survey participants identifying themselves as partners (WP leaders, AP or CP was 56 (50.9%)

- There were similar high response rates evaluating aspects of the different sessions as good, very good, or excellent (87% or more at all aspects assessed) in contrast with the rest; fair or poor assessments.
- The perception of applicability (future use or intention to share), were similar across the main JA reports, although the WP7 deliverable (vs WP5 and WP6) was less frequently expected to be surely used (27% vs 35%)
- Only 16-18% of participants stated that they surely will submit documents/upload practices at the CHRODIS Platform, 39% declared that they surely will use it to obtain information and 52% surely will recommend it
- Concerning the "12 steps to address the chronic disease challenge" aimed to implement practices to reduce the burden of chronic diseases, more than 80% of 99 attendees stated to agree with them and with the fact they were based on evidence. Moreover, more than 70% agreed that they are timely and useful for their local context. On the other hand, only 49% considered them to be ground-breaking.
- With regards to the "Concluding Remarks", 71.6% of 67 attendees rated this session as 4 or 5 on a scale of 1 (not interesting) to 5 (very interesting) and the average score was 3.9.

Annex I: Final Agenda

Programme

Day 1 – Monday 27 February

13:30 – 14:00 **Registration and welcome coffee**

14:00 – 14:30 **Welcome by Carlos Segovia,** Coordinator, JA-CHRODIS

14:30 – 15:45 **Parallel sessions** *(These sessions will run simultaneously):*

1. How can decision-makers, professionals, patients and researchers make the best use of the CHRODIS Platform and share valuable knowledge & experiences (WP4)?
Enrique Bernal-Delgado (IACS)
Rogério Tavares Ribeiro (APDP)
Marieke Hendriksen (RIVM)
Tamara Poljicanin (CIPH)
Cristina Blas Miranda, (IACS)
Wil M. de Zwart (Dutch Ministry of Health, *Welfare and Sport*)

2. How can Europe approach the care of persons with multimorbidity? (WP6)?
Graziano Onder (AIFA)
Federica Mammarella (AIFA)
Rokas Navickas (VULSK)
Elena Jureviciene (VULSK)
Mieke Rijken (NIVEL)
Maria João Forjaz (ISCIII)
Valentina Strammiello (EPF)

15:45 – 16:15 **Coffee break**

16:15 – 17:30 **Parallel sessions** *(These sessions will run simultaneously):*

1. What needs to be taken into account for the exchange and transfer of good practices in health promotion and disease prevention (WP5)?
Moderator: Kenneth Eaton, The Platform for Better Oral Health in Europe
Anne Pierson (EuroHealthNet)
Djoeke van Dale (RIVM)
Teresa Bennett (HSE)
Francisco Ruiz (Andalusian Regional Ministry of Health)
Luciana Costa (INSA)
Alexander Haarmann (BZgA)

	2. What are the lessons for the prevention and care of chronic diseases, taking diabetes as an example (WP7)? **Marina Maggini** (ISS) **Jelka Zaletel** (NIJZ) **Jaana Lindström** (THL) **Valentina Strammiello** (EPF) **Anne-Marie Felton** (FEND) **David Somekh** (EHFF)
19:15 – 22:00	**Networking event (by invitation only)**

Day 2 – Tuesday 28 February

09:00 – 09:30	**Registration and welcome coffee**
09:30 – 11:00	**Session 1 - Addressing the chronic disease challenge in Europe** **Moderator: Clive Needle,** Senior policy advisor, EuroHealthNet
09:30 – 09:45	**Welcome note** - How JA-CHRODIS contributed to reducing the burden of chronic diseases across Europe and launch of "12 steps towards implementing practices to reduce the burden of chronic diseases" **Carlos Segovia,** Coordinator, JA-CHRODIS
09:45 – 10:00	**Keynote presentation** - How does the Joint Action CHRODIS contribute to the EU work to prevent and address chronic diseases? **Vytenis Andriukaitis,** Commissioner, European Commission
10:00 – 10:15	**Keynote presentation** - What is the potential link between JA-CHRODIS and WHO Europe's Action Plan on NCDs? **Zsuzsanna Jakab,** Regional Director, WHO Europe
10:15 - 10:30	**Keynote presentation** **In which ways can JA-CHRODIS help address the sustainability of our health systems?** **Ian Forde,** Senior policy analyst in the Health Division, OECD
10:30 - 11:00	**Panel Discussion**
11:00 - 11:30	**Coffee break**
11:30 – 12:30	**Session 2 - How can policy makers use the JA-CHRODIS results to (plan to) address the chronic disease challenge and ageing society?** **Moderator: Clive Needle,** Policy and Advocacy Director, EuroHealthNet **Ranieri Guerra**, Director General Prevention, Chief Medical Officer, Italian Ministry of Health **Mirosław J. Wysocki**, Director General, National Institute of Public Health, Poland (NIH) **Alain Brunot**, Medical Inspector for Public Health, French Ministry of Health **Jolyce Bourgeois**, Belgian Ministry of Health **Gintarė Šakalytė**, Vice Minister of Health, Lithuania **Gabrijela Korže**, Attaché for Public Health and Pharmaceuticals, Permanent Representation of the Republic of Slovenia to the EU

12:30 - 13:30	**Lunch**
13:30 - 15:00	**Session 3 - Making the link: How can we better integrate health promotion in comprehensive healthcare?** **Moderator: Anne Hendry,** Clinical Lead for Integrated Care, Scottish Government
13:30 - 13:45	**Keynote presentation** - An external view on ways to move forward the JA-CHRODIS recommendations on comprehensive care in relation with sustainable health systems **Ellen Nolte,** Head of London hubs, European Observatory on Health Systems and Policies
13:45 - 14:00	**Keynote presentation** - Integrating health promotion in healthcare from different perspectives **Ricardo Baptista Leite,** Member, Portuguese Parliament
14:00 – 15:00	**Panel Discussion** **Ellen Nolte,** Head of London hubs, European Observatory on Health Systems and Policies **Ricardo Baptista Leite,** Member, Portuguese Parliament **Annabel Seebohm,** Secretary General, CPME **Nicoline Tamsma,** President of EuroHealthNet, Co-ordinating Advisor International Affairs at the National Institute for Public Health and the Environment (RIVM) **Nicola Bedlington,** Secretary General, European Patients' Forum
15:00 – 15:30	**Coffee break**
15:30 – 16:45	**Session 4 - How does JA-CHRODIS leave its mark, including examples in practice?** **Moderator: Anne Hendry,** Clinical Lead for Integrated Care, Scottish Government **Mieke Rijken,** NIVEL, The Netherlands: *Dutch implementation of the JA-CHRODIS multimorbidity care model* **Helen McAvoy,** Director of Policy, Institute of Public Health in Ireland: *Opportunities and challenges to implement health promotion practices from Ireland's perspective* **Vesna Knjeginjic,** Assistant Minister, Serbian Ministry of Health: *Setting up a pilot national chronic disease plan using the tools prepared in JA-CHRODIS* **Antonio Sarría-Santamera**, Coordinator of CHRODIS PLUS, **Rokas Navickas**, Scientific Coordinator of CHRODIS PLUS: *Presentation of the next Joint Action*
16:45 – 17:00	**Concluding remarks** **Moderator: Anne Hendry**, Clinical Lead for Integrated Care, Scottish Government ☐ **Xavier Prats Monné,** Director General for Health and Food Safety, (DG Sante) European Commission **Paloma Casado Durández,** Ministry of Health Spain

Annex II: 12 steps

Building on JA-CHRODIS, what can we do to plan and implement practices to reduce the burden of chronic diseases?

It is evident that European health systems must become more efficient in the future. The ageing society, coupled with the increasing incidence of chronic diseases, play major roles in governments' decisions about healthcare and public health investments. Chronic diseases, like diabetes and cardiovascular diseases, affect 8 people out of 10 over the age 65 in Europe. Approximately €700 billion are spent every year across the EU on the treatment of chronic diseases.

The three-year EU Joint Action on Addressing Chronic Disease and Healthy Ageing across the Life Cycle (JA-CHRODIS), co-funded by the European Commission and Member States (plus Iceland and Norway), and including 73 Partners, aimed to contribute to reduce the burden of chronic diseases by facilitating the exchange and scaling-up of good practices, which address chronic diseases and healthy ageing.

JA-CHRODIS adopted the following definition of "good practice": "A good practice is not only a practice that is good, but a practice that has been proven to work well and produce good results, and is therefore recommended as a model. It is a successful experience, which has been tested and validated, in the broad sense, which has been repeated and deserves to be shared so that a greater number of people can adopt it"1.

Four main areas were identified and need to be continuously developed:

- Health promotion and primary prevention of chronic disease;
- Organisational interventions focused on dealing with people with multiple chronic conditions;
- Interventions for the empowerment of patients with chronic conditions;
- National diabetes plans.

[1] Agriculture Organization of the United Nations (FAO). 2013 (9). Good practices at FAO: Experience capitalization for continuous learning. http://www.fao.org/docrep/017/ap784e/ap784e.pdf (accessed on 3 January 2017)

12 STEPS TOWARDS IMPLEMENTING PRACTICES TO REDUCE THE BURDEN OF CHRONIC DISEASES

1. Design your practice

Design the practice you want to implement or improve, based on existing evidence or good practices, and develop a specific plan to achieve this goal. Include monitoring and evaluation as integral part of the plan.

2. Empower the target population

Identify your target population and involve them in designing and evaluating the practice as appropriate.

3. Ensure adequate investment and resourcing

Make sure that the practice has the funding necessary to incorporate the elements that are essential to be effective. Try to achieve the highest coverage possible while keeping the practice effective.

4. Be comprehensive but not too complicated

Try to address all relevant determinants (including social determinants) and use different strategies adapted to different settings and local situations as appropriate to the scope of the practice. JA-CHRODIS' multimorbidity care model is the recommended way of addressing groups of patients with the highest healthcare needs.

5. Interact regularly with relevant systems

Ensure a strong, well-resourced monitoring and liaison component for intersectoral coordination. Implement effective partnerships: Health in all Policies approach in health promotion, multidisciplinary and intersectoral teams in healthcare, public-private partnerships. More can be achieved together with social care, agriculture, transport, education, employment and finance sectors, for example.

6. Educate and train

Educate those professionals and actors involved in the practice's implementation on its overall and long-term goal, including for instance care givers. Train them to perform their activities with the highest quality and to coordinate with each other.

7. Respect ethical considerations

Implement interventions proportional to needs. The objectives and strategy should be transparent to the target population and stakeholders. Preferences and autonomy of target population should be respected and promoted.

8. Apply good governance

Define and describe organisational structures clearly. Ensure they are transparent (i.e. responsibility assignments, flows of communication, work and accountabilities). Create ownership amongst all stakeholders.

9. Ensure sustainability and scalability

Have a long-term concept for your intervention and make it as cost-effective as possible. Take into account that health promotion and disease prevention are proven to be cost-effective measures.

10. Make sure equity is addressed

Take specific actions to tackle the social determinants of health and consider the equity dimension, as well as populations at greatest risk of inequalities (e.g. gender, socioeconomic status, ethnicity, rural-urban area, vulnerable groups)

11. Evaluate

Monitor and evaluate your intervention/good practice constantly. Make sure there is a defined and appropriate evaluation framework assessing structure, process, outcomes and results.

12. Make use of the CHRODIS Platform

Upload your practice to the CHRODIS Platform and have external reviewers evaluate it. Receive feedback to improve your practice. Disseminate your practice to a wide audience through the CHRODIS Platform. Learn from others registered on the CHRODIS Platform and contact and cooperate with them on issues of common interest.

Annex III: Biographies of speakers

Speaker Biographies

Carlos Segovia, Coordinator, JA-CHRODIS

Carlos Segovia is the coordinator of the Joint Action-CHRODIS. He is Head of the unit of Accreditation of Health Research Institutes at the national Institute of Health Carlos III (ISCIII), Spain. He is also Chair of the Joint Programming Initiative on Antimicrobial Resistance. He was Deputy Director for International Research Programmes from 2009 to 2013, being involved in several European and international health research initiatives. Carlos Segovia is primary care physician and master of public health from Harvard University. Before joining ISCIII, Carlos has been coordinator of a primary care centre for two years, deputy director for primary care quality and research of a province for ten years, and expert for social and health care coordination at a Regional Department of Health for two years.

Enrique Bernal-Delgado, Senior Scientist, Instituto Argonés de Ciencias de la Salud (IACS)

Enrique Bernal-Delgado is senior health services and policy researcher at the Institute for Health Sciences in Aragon, and principal investigator of the Atlas of Variations in Medical Practice in the Spanish National Health System (www.atlasvpm.org) and the European Collaborative for Healthcare Optimization –ECHO (www.echo-health.eu). Both projects have raised his interest on the use of Real World Data to inform policy making. As a consequence, he is currently co-leading a European initiative, BRIDGEHEALTH (www.bridge-health.eu), Particularly interested in Chronic Care, he is actively participating in REDISECC – Spanish Network for Health Services Research in Chronic Care (www.redissec.com) and JA-CHRODIS JA – Joint Action on Chronic Diseases (www.chrodis.eu).
Currently, he is editor-in-chief of the Spanish Atlas of Variations and associate editor of BMC Health Services Research.
He graduated as a Medical Doctor in 1988, serving as primary care practitioner for five years; afterwards, he specialized in Public Health and Preventive Medicine. He holds a PhD in Sociology from the University of Zaragoza, Spain and a Master Degree in Health Economics from the Universities of Barcelona and Pompeu Fabra, Spain. In 2003, he was visiting scholar at the CECS, currently The Dartmouth Institute.

Rogério Tavares Ribeiro, Researcher, Diabetes Portugal (APDP)

Rogério Tavares Ribeiro has a degree in Biology, from the Faculty of Sciences of Lisbon, and a PhD in Biomedicine, from NOVA Medical School, Portugal. Currently, he is an invited assistant professor at the University of Aveiro, and a senior researcher at the Centre for the Study of Chronic Diseases (CEDOC) – NOVA Medical School, and at the Education and Research Department of APDP (the Portuguese Diabetes Association). Since 1999, he pursues research in the field of Diabetes, first in animal models, and currently in clinical studies and implementation research regarding diverse aspects of Diabetes prevention and management. Rogério participates in several national and European research projects in these areas, from basic research to patient empowerment.

Marieke Hendriksen, Scientist, National Institute for Public Health and the Environment (RIVM)

Marieke Hendriksen works as a nutritionist at the National Institute for Public Health and the Environment. She specialized in public health nutrition and epidemiology and her main work focuses on the monitoring and evaluation of policy measures and interventions, with a particular focus on salt reduction strategies in the Netherlands. She is involved in several European projects, such as the DEDIPAC project (part of the joint programming initiative 'A healthy diet for a healthy living') and Joint Action CHRODIS. In addition, she is one of the coordinators of the WHO Collaborating Centre for Nutrition of the RIVM. Marieke successfully defended her PhD thesis entitled 'Public Health Impact of Salt Reduction' in October 2015.

Tamara Poljicanin, Head of Biostatistics Department, Croatian Institute of Public Health (CIPH)

Tamara Poljicanin is a medical doctor, specialist in epidemiology experienced in diabetes epidemiology, epidemiological research and statistical analysis, and author of more than 100 publications in the field of diabetes and non-communicable diseases. She has managed the development and implementation of the CroDiab National Diabetes Registry and the National Diabetes Programme since 2000; held the post of Director-General of the Croatian Institute of Public Health 2012-2015, and of Head of the CIPH Biostatistics Department since 2015. She lectures at the Medical Faculty in Zagreb, and is actively involved in the national and international education and research projects, including EUBIROD and Patient Registries Initiative PARENT JA. Dr. Poljicanin is a member of the JA-CHRODIS Governing Board.

Cristina Blas Miranda, Help Desk Manager, Institute of Health Sciences in Aragon (IACS)

Cristina Blas Miranda is Help Desk Manager in the CHRODIS Platform for knowledge exchange of good practices in chronic diseases and healthy ageing, within JA-CHRODIS (WP4), managed by the Aragon Health Research Institute. Cristina is a journalist and has over 18 years of experience in media and communication, specialized in International Affairs and Digital Marketing. Before joining JA-CHRODIS, Cristina worked as Communication Officer for the European Economic Area Financial Mechanism in Spain, in charge of developing the communication strategy and digital profile of the EEA Grants. Cristina holds a BA in Information Sciences by the University Complutense of Madrid (Spain), an MA in Economic and Stock Market News and an MA in Advertising and Corporate Communication, and several postgraduate courses in Digital Marketing.

Wil M. de Zwart, Senior Policy Officer, Dutch Ministry of Health, Welfare and Sport

Educated as a psychologist, Wil worked for many years as a social scientist in the field of substance abuse and addiction, among others at the Netherlands Institute for Mental Health and Addiction. Since 2001 she has been working as a senior policy officer at the Ministry of Health, Welfare and Sport, Department of Nutrition, Health Protection and Prevention. Her portfolio includes mainly the coordination of monitoring activities in relation to life style policy, the national best practice portal of interventions, illegal drug policy and (international) research. In these domains she is the representative of the ministry in several national and international platforms.

Dr. Graziano Onder, Assistant Professor, Università Cattolica del Sacro Cuore

Graziano Onder, M.D., Ph.D. is a Geriatrician working as an Assistant Professor at the Department of Geriatrics of the Università Cattolica del Sacro Cuore, Rome, Italy. Dr. Onder has previously worked as Research Associate at the J. Paul Sticht Center on Aging, WakeForestUniversity, Winston Salem, NC, USA (2001-2002). He is Fellow of the European Academy for Medicine of Ageing. The main focuses of his research are pharmacoepidemiology in the elderly, multimorbidity, chronic diseases, and organizational characteristics of health care systems. He received grants from public and private institutions including the Italian Ministry of Health and the European Commission through the Seventh Framework Programme (FP7). He is author of more than 250 publications in peer-reviewed journals.

Federica Mammarella, MD, PHD Consultant, Italian Medicines Agency, (AIFA)

Dr. Federica Mammarella, M.D.,Ph.D., is a specialist in geriatric medicine. She's working on multimorbidity in the context of JA-CHRODIS. She has developed valuable duties and experience in both clinical and research field with particular on frail elderly patients. She is an active member of the European Academy for Medicine of Ageing. The main fields of scientific interest include pharmaco-epidemiology in the elderly with particular focus on adverse drug reactions and inappropriate prescribing, frailty, multimorbidity, integrated care for elderly. She is specifically trained in Health Technology Assessment. She has a consolidated experience in coordinating clinical research projects having participated to numerous international, pharmacological and non-pharmacological, observational and intervention studies such as the following EU funded international projects: Frailclinic Project on preventing and detecting frailty in elderly population and PACE project (Palliative Care for Older People in care and nursing homes in Europe).

Dr. Rokas Navickas, Co-leader, Principal Researcher, Vilnius University Hospital Santariskiu klinikos (VULSK)

Rokas Navickas holds a Ph.D in Medical Sciences and is currently undergoing M.Sc. in Health Economics. He completed his core medical training in the UK, later completed his specialty training in cardiology and is currently a practising cardiologist at the VULSK. He is co-leading principal researcher at the JA-CHRODIS Multimorbidity work package and scientific coordinator of the planned CHRODIS plus, which is due to be launched later this year. His published scientific papers include risk predicting models, epigenetic biomarkers, health economics and management related questions.

Elena Jureviciene, Director of Management, Vilnius University Hospital Santariskiu klinikos (VULSK)

Elena Jurevičienė, MD, works as pulmonologist and director of management in Vilnius University Hospital Santariškių klinikos. She studied medicine in Medical Faculty of Vilnius University, since 1998 works as practicing pulmonologist. In 2004 she acquired a Master's degree in management and business administration in Vilnius University. Since 2012 she works as director of management in VilniusUniversity Hospital Santariškių klinikos. Since 2014 she is an Executive Board member in EU Joint Action on Chronic Diseases and Promoting Healthy Aging across the Life Cycle, WP of Multimorbidity. Since 2015 she is a country coordinator in EU Joint Actions on E-Health and Rare Diseases. She is a member of European Respiratory Society. She participated in European Health Forum 2014 and 2015, EC conference on Multimorbidity in 2015. In 2015 she started PhD in Vilnius University. She is co-author of several publications on multimorbidity.

Mieke Rijken, Research Coordinator, Netherlands Institute for Health Services Research (NIVEL)

MIEKE RIJKEN, PhD, is working as a Senior Researcher at NIVEL, the Netherlands institute for health services research. Mieke has been involved in many research projects over the last 20 years, with a focus on person-centered care for people with chronic illness and their needs for health and social care. She has coordinated the EU funded 'Innovating care for people with multiple chronic conditions in Europe' project (ICARE4EU), which aimed to contribute to the innovation of care for European citizens with multiple chronic conditions. She has been an active participant in JA-CHRODIS, and contributed to the work package on multimorbidity care in particular. Mieke is also involved in the International Expert Working group on care for complex patients (coordinated by the Commonwealth Fund), which has formulated recommendations to policy makers and care providers in OECD countries on ways of providing the most appropriate care for patients with complex needs.

M. João Forjaz, Researcher, Spanish Health Institute Carlos III (ISCIII)

Dr. M. João Forjaz is a research scientist at the Spanish Health Institute Carlos III since 2008. She graduated in Psychology at the University of Lisbon, Portugal, and obtained her PhD in clinical psychology from the University of North Texas, as a Fulbright scholar. She did her Clinical Psychology internship at Rush Medical Center, Chicago, in 2000.
She was the leader of several research grants on quality of life of older adults and she belongs to a multidisciplinary Spanish Research Group of Quality of Life and Aging. She is an associate member of the JA-CHRODIS (WP6, multimorbidity) funded by the European Union, and the Spanish Research Network on Health services and Comorbidity (REDISSEC). Her research interests are also centered in patient-reported outcomes (scale development and validation) as well as Parkinson's and Alzheimer's disease, disability, and comorbidity. Dr. Forjaz is the author of over 80 articles in peer-review journal as well as several book chapters.

Valentina Strammiello, Programme Officer, European Patients' Forum (EPF)

Valentina Strammiello is an Italian national and has been working as a Programme Officer since January 2013. She holds a Master Degree in International Relations from the University of Bologna. In 2007, Valentina was awarded a MA in European Studies with majors on Regionalism, Social Cohesion and Minority Rights from the University of Graz. In her experience at EPF as Programme Officer, Valentina has managed a wide range of projects and activities. Her main areas of expertise include HTA, sustainability of healthcare systems (FP7- InterQuality We Care), Joint Actions with a focus on Chronic Diseases, their prevention and management and health promotion, and tender studies on empowerment and self-management.In 2005-2006 Ms Strammiello was enrolled in a traineeship at the Apulia Region Representation Office in Brussels and then worked on gender equality at the European Commission, DG Employment.

Prof. Kenneth Eaton, Past Chair and Representative to JA-CHRODIS, The Platform for Better Oral Health in Europe)

Professor Kenneth Eaton PhD, MSc, BDS, FFGDP(UK), MGDS RCS (Eng), LDS RCS (Eng), FFPH, FHEA, FICD, DHC. is listed by the UK General Dental Council as a specialist in Periodontics and in Dental Public Health. He has held visiting chairs at a number of European universities and is currently a Visiting Professor at the University of Leeds and an Honorary Professor at the University of Kent. He has advised several national Ministries of Health, the Council of European Chief Dental Officers and WHO. He has been Chair or President of a number of European organisations including the Platform for Better Oral Health in Europe and the European Association of Dental Public Health. He has given conference presentations in more than 35 countries and has published over 300 academic papers and other scientific publications.

Anne Pierson, Health Promotion Europe Manager, EuroHealthNet

Anne Pierson is managing the Health Promotion Europe work at EuroHealthNet. Activities include facilitating capacity building for EuroHealthNet members (through information and communications, study visits, etc.) and (co)-leading project work strands (JA-CHRODIS, Pilot Project on reducing health inequalities for LGBTI people, etc.). Anne has considerable experience in communications, projects and events management and worked for various European and international organisations before joining EuroHealthNet in 2015. She coordinated EU-funded projects related to anti-discrimination and social inclusion, international campaigns to prevent diabetes or its complications, and activities to fight against fraud and corruption in the healthcare sector. Anne's background is in languages and management.

Dr. Djoeke van Dale, Senior Advisor, Institute for Public Health and Environment (RIVM)

Djoeke van Dale is based at the National Institute of Public Health and Environment (RIVM) in the Netherlands where she manages the Quality of Interventions Programme at the Centre for Healthy Living. She has a background in health sciences and obtained her PhD studying the interaction between diet, physical activity and obesity. Ms Van Dale developed the Dutch national quality assessment ('Recognition') system for health promotion interventions.
In JA CHRODIS she contributed to Work Package 5 on Health Promotion (country review, identification of best practices, and transferability report) and to Work Package 4 (Platform) as expert for the Delphi panel in developing criteria to evaluate best practices.

Dr. Teresa Bennett, Senior Health Promotion Officer and Project Manager, Health Service Executive (HSE)

Teresa has over 15 years experience working in the areas of health promotion and improvement and project management in the HSE with a further 3 years experience as a Senior Research Scientist at University College Cork, Ireland. Teresa has received a Ph.D in Nutritional Sciences from University College Cork and more recently a postgraduate diploma in Healthcare Leadership & Management from the Royal College of Surgeons in Ireland.
Current interests include evaluation and assessment of effectiveness of health promotion interventions and public health nutrition and has co-led the development of a National Policy on Vitamin D supplementation for infants in Ireland. She has contributed to and participated in WP5 JA CHRODIS on behalf of the HSE since September 2014.

Francisco Ruiz, Scientific Adviser, Andalusian Regional Ministry of Health

Francisco Ruiz earned his Ph.D. in Social Psychology at Okayama University (Japan) For the last 12 years he has worked as a scientific adviser at the Health Promotion Department of the Regional Ministry of Health in Andalusia -Spain´s most populated region. In 2005 he co-authored the Andalusian Comprehensive Tobacco Action Plan, a leading action plan in the Spanish scenario, and coordinated for more than 5 years some of the strands of action it encompassed. He has actively been participating in JA CHRODIS since its launch, and he is a strong advocate for projects promoting health and innovation in healthcare.

Prof. Luciana Costa, Researcher, Portuguese National Institute of Health Dr Ricardo Jorge (INSA)

At present, Luciana Costa is a Researcher in the Department of Health Promotion and Prevention of Noncommunicable diseases at the Portuguese National Institute of Health.
Since 2000, she has a PhD in Biomedical Sciences (specialization is Immunology) by the Abel Salazar Institute for Biomedical Sciences from University of Oporto. She has a Master in Biophysics (Faculty of Sciences, University of Lisbon) in the Area of Medical Physics Specialization. She graduated in Pharmaceutical Sciences from the Faculty of Pharmacy University of Lisbon in 1991.
Her main research interest has been focused in the study of immunologic determinants of non-communicable diseases.
Currently she participates in the JA-CHRODIS (Work Packages 4 and 5) on the selection of criteria to identify Good Practices in the area of Health Promotion and Prevention of Chronic Diseases and its dissemination by the development of the CHRODIS platform.

Dr. Alexander Haarmann, Scientific Officer, German Federal Centre for Health Education (BZgA)

Alexander Haarmann (PhD) has a background in sociology and political sciences and has analysed health from different perspectives: Different research projects incorporated topics such as health inequalities, health and migration, healthcare systems and countries' attempt to reform them, healthcare provision research, and patient involvement in a comparative perspective. In collaboration with colleagues from EuroHealthNet he is currently leading the work package on Health Promotion and Prevention of Chronic Diseases in the JA-CHRODIS at the German Federal Centre for Health Education and working with members from all across Europe.

Dr. Marina Maggini, WorkPackage 7 Leader, Istituto Superiore di Sanità (ISS)

Marina Maggini, Senior epidemiologist at Italian National Institute of Health. She leaded the National diabetes disease management project (IGEA), and the National project on chronic diseases in collaboration with the Italian Ministry of Health. From 2014, she leads the work package "Diabetes: a case study on strengthening health care for people with chronic diseases" within the European Joint Action on Chronic Diseases (JA-CHRODIS).

Dr. Jelka Zaletel, Work Package 7 coleader, National Institute of Public Health, Slovenia (NIJZ)

Jelka Zaletel, MD, PhD, diabetologist, senior expert at National Institute of Public Health Slovenia. She is vice-president of National Diabetes Plan steering group and president of national association of diabetologists. From 2014, she is co-leading the work package "Diabetes: a case study on strengthening health care for people with chronic diseases" within the European Joint Action on Chronic Diseases (JA-CHRODIS) and leading the task on National Diabetes Plans.

Dr. Jaana Lindström, Research Manager, National Institute for Health and Welfare, Finland (THL)

Jaana Lindström, PhD, Adjunct Professor works as a Research Manager in the National Institute for Health and Welfare in Finland. She has over 20 years of experience in research related to prediction and prevention of type 2 diabetes, with special emphasis on lifestyle factors. She is the developer of the Finnish Diabetes Risk Score FINDRISC. She has participated in several national and international projects, e.g. the Finnish Diabetes Prevention Study (DPS) and the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER), Stop Diabetes – Knowledge-based solutions (StopDia), Development and Implementation of a European Guideline and Training Standards for Diabetes Prevention (IMAGE), Early Prevention of Diabetes Complications in Europe (ePREDICE), and Families across Europe following a healthy lifestyle for diabetes prevention (Feel4Diabetes). She is also a Task Leader in JA-CHRODIS WP7.

Anne-Marie Felton, Co-Chair, European Coalition for Diabetes (ECD); President, Foundation of European Nurses in Diabetes (FEND)

Anne-Marie Felton was a diabetes specialist nurse for over 20 years. She is currently working within the voluntary sector pro bono, nationally and internationally. She is President and co-founder of FEND. In 1999 she was appointed as a Vice President of Diabetes UK. In addition, Anne-Marie is an Honorary consultant at Queen Mary's Hospital, Roehampton, London, UK; immediate past Vice President IDF and Chair of the IDF Global Advocacy Task Force; a member of the IDF Steering Group for the 'Unite for Diabetes' campaign that resulted in the passage of the United Nations Resolution on diabetes in December 2006; a member of the Alliance for European Diabetes Research (EURADIA); is co-chair of European Coalition for Diabetes 2012 (ECD). In September 2015 she was appointed an Honorary member of the EASD (European Association for the Study of Diabetes). This is the first time EASD has bestowed this honour on a nurse.

Dr. David Somekh, Network Director, European Health Futures Forum (EHFF)

David Somekh M.A., M.B., B.Ch., PhD, FRCPsych. is a forensic psychiatrist, psychoanalyst and experienced clinician in management, retired from the UK NHS. He served as an NGO representative on the Advisory Committee of ISQuA (International Society for Quality Assurance), and on the Advisory Committee of the UK NICE. He was a member of the Executive of the European Society for Quality in Healthcare since it was founded in 1998, was President 2005-7 and Vice-President 2007-9. He was a member of the EC expert group on Patient Safety and Health Quality from 2008-2016. David and three colleagues set up EHFF, the European Health Futures Forum, as a not-for–profit network organisation in 2013 and he is currently Network Director. EHFF has served on the steering groups of both the EMPATHiE and PISCE tenders on patient empowerment. EHFF has been active in the integrated care area of the EIP-AHA, the JA-CHRODIS and was recently involved in a H2020 consortium on ICT enabled empowerment, EMPATICCS.

Clive Needle, Senior policy advisor, EuroHealthNet

Clive Needle is policy advisor for EuroHealthNet, and an independent advisor for numerous national and international organisations.

Vytenis Andriukaitis, Commissioner for Health & Food Safety, European Commission

Vytenis Povilas Andriukaitis was appointed the European Commissioner for Health and Food Safety in November 2014.
Vytenis Andriukaitis was born on 9 August 1951 in Kyusyur in Siberia, where his family was deported in 1941 from Lithuania. He returned to Lithuania in 1957 together with his mother and two brothers. His father was permitted to return one year later.
Andriukaitis went on to graduate from medical school in 1975 and has been a practicing surgeon, gaining specialisation in cardiovascular surgery in 1989, for more than 20 years. He also holds a degree in History from Vilnius University acquired in 1984.
From 1969 onwards the Commissioner was active in the anti-Soviet movement, while his political career began already in 1976. In 1990 Andriukaitis was elected to the Supreme Council of the Republic of Lithuania which preceded Seimas (Lithuanian Parliament), and was a signatory of the Independence Act of Lithuania on 11 March 1990. Vytenis Andriukaitis was also one of the co-authors of the Constitution of the Republic of Lithuania adopted in 1992, and one of the founders of the Lithuanian Social Democratic Party.
Andriukaitis was a Member of the Lithuanian Parliament for six terms. During that time he served as a Deputy Chairman of the Committee on European Affairs, a member of the Foreign Affairs Committee and a Vice-President of Social Democratic Party. The Commissioner was also the head of the Lithuanian delegation to the Convention on the Future of Europe. From 2012 to 2014 Vytenis Andriukaitis was a Minister for Health in the Lithuanian Government.

Zsuzsanna Jakab, Regional Director, WHO Europe

Dr Zsuzsanna Jakab is the WHO Regional Director for Europe since February 2010. Prior, Dr Jakab served as the founding Director of the European Union's European Centre for Disease Prevention and Control (ECDC) in Stockholm. Between 2002 and 2005, she was State Secretary at the Hungarian Ministry of Health, Social and Family Affairs, where she managed the country's preparations for European Union accession in the area of public health. Between 1991 and 2002, she worked at the WHO Europe in a range of senior management roles. Dr Jakab holds a PhD degree in Health Sciences from the University of Debrecen; a Master's degree from the Faculty of Humanities, Eötvös Lóránd University, Budapest; a postgraduate degree from the University of Political Sciences, Budapest; a diploma in public health from the Nordic School of Public Health, Gothenburg, and a postgraduate diploma from the National Institute of Public Administration and Management, Hungary. She began her career in Hungary's Ministry of Health and Social Welfare in 1975.

Ian Forde, Senior policy analyst in the Health Division, OECD

Ian Forde MD (1998), PhD (2012), British, is a Senior Policy Analyst in the Health Division at the OECD. He has previously worked as a policy advisor in the Ministry of Health, Bogotá, and in the Prime Minister's Strategy Unit, London. He also maintains work as a General Practitioner in London. He has a degree in Social and Political Science from Cambridge University, in Medicine from Oxford University and a PhD from University College London, examining the health impacts of welfare reform in Colombia. He was a member of the secretariat of the WHO Global Commission on Social Determinants of Health and has published in the Lancet, the BMJ, the American Journal of Public Health and several other peer-reviewed journals.
At the OECD, he is co-ordinator of a series of reviews of health care quality across OECD countries, has led reviews of health system performance in Colombia, Mexico, Peru and Latvia, and leads the Health Division's work on primary care and in the Latin America region.

Ranieri Guerra, Director General Prevention, Chief Medical Officer, Italian Ministry of Health

Ranieri Guerra is a physician, currently Director General of Preventive Health at the Ministry of Health and Chief Medical Officer of Italy. He is a member of the WHO/EURO SCRC, where he leads the working group on migrants' health, and he is an elected EB member of WHO Geneva to start in 2017. He specialised in public health in Italy and the UK and has practiced in several areas of the world, besides Italy, belonging to the small club of visitors to more than 150 countries. His professional interests and experiences range from emergency and rescue operations (especially in war torn areas) to the design and implementation of health reforms in less developed and in transitional countries, from the climate change's impact on health, to global health and SDGs, with a focus on vaccination and antimicrobial resistance. Before his appointment, he was the Scientific Attaché for life sciences at the Embassy of Italy to the US. He served also in the Technical Review Panel of the Global Fund for AIDS, TB and Malaria and has conducted several missions with the EU development aid in many ACP countries. He has dedicated substantial time to creating a national school of public health in Italy, chairing a WHO Collaborating center on human resources for health for more than a decade and training several hundreds of participants with innovative curricula, educational techniques and technologies, introducing postgraduate problem based learning in the country, pioneering distance education for doctors, pharmacists, nurses and other health professionals within the National Health System and overseas. He is adjunct professor of medicine at the G. Washington University in Washington DC and visiting professor at Chengdu University in China. In China, he is also a member of the Lancet Commission on PHC. His scientific production concerns mainly dissemination and focuses on community health issues and controversial aspects of the interaction between the health service providers and the end users.

Prof. Mirosław J. Wysocki, Director General, National Institute of Public Health (NIH), National Consultant in the area of Public Health

Mirosław J. Wysocki is professor of medicine, with a degree from the Warsaw Medical University. In 1971 – 72 he was WHO Senior Research Fellow in the Department of Epidemiology and Social Medicine of St. Thomas's Hospital Medical School, London, UK. Since 2010 he is Director of the National Institute of Public Health – NIH in Warsaw.
Mirosław holds specialisation degrees in epidemiology, internal medicine and public health. He has been Regional Advisor for Health Situation & Trend Assessment at the WHO/SEARO and WHO/HQ in Geneva from 1988 to 2000, and Chair of the Senior Level Public Health Group of the European Commission during the Polish EU Presidency in 2011.
He represented Poland at WHO World Health Assemblies, Executive Boards and Regional Committees and was a member of the WHO/EURO Standing Committee from 2010-2013, and of the Independent Expert Group of DG Research and Innovations of the European Commission (2012-2013) on the priority of public health research in HORIZON 2020. He is National Public Health Consultant and has authored and co-authored more than 170 publications and chapters on epidemiology of NCDs and public health.

Alain Brunot, Medical Inspector for Public Health, French Ministry of Health

MD (Dijon university, 1989)
Master of Public health (Harvard School of Public Health, Boston, USA, 2000)

Dr Brunot is medical officer at the Ministry of social affairs and health, department of population health and prevention of chronic diseases, direction générale de la santé (General directorate of health). He is working on non- communicable disease prevention, with focus on CV disease and diabetes, patient education. He has worked within the health administration since 2003, at local level (office for département de Paris) in HIV prevention, detainee health care, then as head of the department of prevention and health promotion for the Département de Paris, within the regional health authority.

Previously, Dr Brunot had a long-term experience in Vietnam, coordinating bilateral medical cooperation programs : training programs for junior health care professionals, technical assistance programs for hospitals, and support for public health projects. After graduating the MPH, he worked in health economic research units in Paris and Lille, with focus in pharmaco-epidemiology.

Jolyce Bourgeois, Belgian Ministry of Health

Jolyce Bourgeois, born in 1987 is a pharmacist with a PhD in medical sciences. The focus of the research was the utilization of sleep medication in nursing home residents and investigating whether discontinuation is possible in this elderly, often frail population. At the moment, she is still involved in projects tackling psychotropic use in the nursing home population. Currently, she is policy advisor for the organization of acute, chronic care at the federal service for Health in Belgium, and more specifically she is a member of the coordination team for the national plan for integrated care for persons with a chronic disease. Hence, international development concerning integrated and chronic care is a special interest.

Gintarė Šakalytė, Vice Minister of Health, Lithuania

(n/a)

Gabrijela Korže, Attaché for Public Health and Pharmaceuticals, Permanent Representation of the Republic of Slovenia to the EU

Gabrijela Korže, LL.M., has completed graduate studies in law and postgraduate studies in Labour, Social and Economic Law. She has rich working experiences in the field of Human Resources Management, Public Health, Pharmaceuticals, Medical Devices, Social Issues, Foodstuffs, coupled with the experiences in the multicultural environment. She was an Adviser for Human Resources, Budgetary and Administration Issues to the Director at the Customs Administration of the Republic of Slovenia (2000-2006). Later on she was Head of the Human Resources Management Sector at the Ministry of Health of the Republic of Slovenia (2006-2007). In international field she started with the position of a Health Attaché at the Slovenian Mission at the UN in Geneva during the Slovenian Presidency to the Council of EU (2007-2008). Currently she works as a Health Attaché at the Permanent Representation of Slovenia to the EU in Brussels. She covers several topics such as Public Health, Pharmaceuticals and Medical Devices where her main tasks are coordination and presentation the positions of Slovenia in the EU Council.

Prof. Anne Hendry, Clinical Lead for Integrated Care, Scottish Government

Anne, a geriatrician, stroke physician and clinical lead for Integrated Care, has extensive experience of improving integrated health and social care for adults with long term conditions in Scotland. As a Senior Associate with the International Foundation for Integrated Care, Anne promotes the adoption and spread of innovation and good practice on population based, people centred and integrated care. She supports a number of regional, national and international knowledge exchange, leadership development and policy and practice initiatives including the new European Joint Action on Frailty.
Anne is honorary professor at the University of the West of Scotland, holds honorary appointments with the University of Glasgow and the University of Edinburgh's Global Health Academy, and is a Board member of the ALLIANCE Health and Social Care Academy that uses the lens of lived experience to focus on the relational and human aspects of change.

Ellen Nolte, Head of London hubs, European Observatory on Health Systems and Policies

Dr Ellen Nolte, MPH, PhD, heads the two London offices of the European Observatory on Health Systems and Policies at the London School of Economics and Political Science and the London School of Hygiene & Tropical Medicine, where she is also Honorary Professor. Her expertise is in health systems research, integrated and chronic care, international healthcare comparisons and performance assessment. She combines this expertise with experience in the systematic analysis of population health indicators across European countries, including the application of demographic and epidemiological approaches to understanding factors contributing to population health outcomes. She has published widely in both the international peer-reviewed literature and the wider literature, including 4 books and numerous scientific papers on chronic disease and integrated care. Ellen was previously Director of the Health and Healthcare Policy programme at RAND Europe, Cambridge, UK.

Ricardo Baptista Leite, Member, Portuguese Parliament

Ricardo Baptista Leite, is a Medical Doctor and Member of the Portuguese Parliament in the Health and Foreign Affairs Committees, as well as City Councillor of Cascais. He is also Head of Public Health at the Catholic University of Portugal, Coordinator of the Sustainable Healthcare Unit at NOVA Information Management School and guest lecturer at NOVA Medical School. He is a PHD candidate in Public Health at Maastricht University and completed his post-graduate studies in, amongst other institutions, Johns Hopkins University (MD, USA), Harvard Medical School (MA, USA), Harvard Kennedy School of Government/IESE (Madrid, Spain) and the Albert Einstein College of Medicine (NY, USA).

Annabel Seebohm, Secretary General, CPME

Annabel Seebohm is the Secretary General of the Standing Committee of European Doctors (CPME). Prior to joining CPME in May 2016, Annabel worked as head of the Brussels office and legal advisor of the German Medical Association (GMA). From 2007 to 2016 she was also legal advisor of the World Medical Association (WMA). Annabel studied law at the University of Bonn, undertook her judicial service training in Hamburg and holds a Masters degree from the University of Auckland, New Zealand. She is admitted to the Berlin Bar.

Nicoline Tamsma, President of EuroHealthNet, Co-ordinating Advisor International Affairs at the National Institute for Public Health and the Environment (RIVM)

Nicoline Tamsma is President of EuroHealthNet and Co-ordinating Advisor International Affairs at the National Institute for Public Health and the Environment (RIVM), the Netherlands. At RIVM, her main responsibility is to advise the institute's Board of Directors on international policy and strategy with a specific remit for public health, health services research and health promotion. Previous posts included a focus on European policy and health systems research at the Nuffield Institute for Health in Leeds (UK), the co-ordination of cross-national efforts on integrated local HIV/AIDS policies for WHO Europe, and international affairs at the Netherlands Institute for Care and Welfare.

Nicola Bedlington, Secretary General, European Patients' Forum

Nicola Bedlington is British and was born in Kirkcaldy, Scotland.
Nicola studied business and human resource management in the UK and France. She lived for almost 10 years in Brussels, Geneva for 12 years, moving to Vienna in 2011.
Nicola was the founding Director of the European Disability Forum, an umbrella organisation uniting over 70 European disability NGOs and National Councils of Disabled People to advocate for the human rights and inclusion of disabled citizens in Europe (1996 to 1999). Prior to this she worked as an external expert for the European Commission, heading the NGO unit within the HELIOS Programme (1991-1996). From 2004 to 2006, she worked for the Swiss Government, leading the Environment and Schools Initiatives Secretariat (ENSI). Whilst in Switzerland, she has also worked as an independent consultant/evaluator, specialising in European social and development policy and health advocacy.
Nicola joined the European Patients' Forum as its first Executive Director in June 2006. In this capacity, she is the Co-ordinator of the European Patient Academy on Therapeutic Innovation (EUPATI).

Dr. Helen McAvoy, Director of Policy, Institute of Public Health in Ireland

Dr. Helen McAvoy graduated from Trinity College Dublin with a primary medical degree in 1997 and worked for several years in clinical practice. She completed her MD in 2000 as part of the NUIG Masters in Health Promotion. She had a lead role in the government's first health promotion strategy for older people. She is now working as Director of Policy with the Institute of Public Health in Ireland aiming to support policy and programmes relevant to the government's health inequality agenda in Ireland and Northern Ireland. In this role, she contributes to policy development, implementation and review on a broad range of public health priorities including tobacco, obesity, alcohol as well as evaluation of health promoting interventions.

Dr. Vesna Knjeginjic, Assistant Minister, Serbian Ministry of Health

Vesna Knjeginjic, MD, was born in Novi Sad. She graduated from the Faculty of Medicine, University of Novi Sad and holds a Master in public health from the Faculty of Medicine, University of Belgrade, which she ended with great success.
After finishing medical studies she worked as a general practitioner in primary healthcare centre. Working in institutions of social protection enabled her to gain a wealth of experience in health care protection.
Since 2015 she has been appointed as assistant minister in the Ministry of Health, Republic of Serbia, in charge of the Sector for public health and programming health care. Her main tasks include monitoring the implementation of projects and programs, as well as the effects and results of programs and projects in the field of health care; monitoring and assessment of the social needs of the population and the establishment of cooperation between organizations and service users.

Antonio Sarría-Santamera, Professor of Health Services Management, Spanish National School of Public Health

Antonio Sarria-Santamera, MD PhD is Professor of Health Services Management at the National School of Public Health and of Public Health Medicine at the Faculty of Medicine, University of Alcalá. He has been a Senior Researcher at the Institute of Health Carlos III since 1996. From 2006-2015 he was the Director of the Spanish Agency for Health Technology Assessment and member of the Spanish Committee of Benefits, Insurance and Financing of the National Health System.
His main areas of research are the development of methods to evaluate the effectiveness of health interventions, with a special interest in chronic conditions, and investigating the relationship between the development of scientific evidence and clinical and health policy decision-making as well as the conditions that facilitate the uptake of knowledge for the improvement of quality of care. Antonio is a member of the Steering Committee of the Spanish Network of Health Services Research and Chronic Disease.
As well as being Principal Investigator of numerous national research projects, he has been actively involved in EUnetHTA since 2006, as well as in several other EU-funded projects like TANDEM, EUSANH, DISMEVAL, FOCUS, EUPRIMECARE and recently BRIDGE-HEALTH.

Xavier Prats Monné, Director General for Health and Food Safety, (DG Sante) European Commission

Xavier Prats Monné is the Director-General for Health and Food Safety at the European Commission. He is responsible for EU policies and programmes in health and food safety, including the promotion of public health, the assessment of national healthcare systems' performance, pharmaceutical legislation, animal health and welfare, as well as the strengthening of Europe's capacity to deal with crisis situations in human health and the food sector.
Prior to this position, he was the Director-General for Education and Culture at the European Commission and Director for Employment policy, Europe 2020 strategy and international relations in the field of employment. He previously served as Director for the European Social Fund, as Deputy Chief of Staff of the European Commission Vice President for external relations, and as Advisor of the Commissioner for Regional policy. He holds degrees in Social Anthropology from the Central University of Madrid, in Development Economics from the International Centre for Advanced Mediterranean Agronomic Studies in France, and in European Affairs from the College of Europe in Belgium.

Paloma Casado Durández, Ministry of Health Spain
Deputy Director General for Quality and Cohesion
Spanish Ministry of Health, Social Services and Equality

Annex: IV JA-CHRODIS Final Conference Survey Questionnaire

JA-CHRODIS Closing Evaluation Survey

Please take 8-10 minutes to complete this survey. Your feedback will help us assess the extent to which JA-CHRODIS has met both aims and expectations by means of the project work and final outputs and findings, which have been presented in the frame of the Final Conference held 27-28th February in Brussels.

All answers obtained are strictly anonymous; only aggregated data will be analyzed and reported.

Block 1: Basic info

Are you a member of	WP leader organisation	Associated Partner	Collaborativ Partner	Advisory board	Governing board	Others
	☐	☐	☐	☐	☐	☐

Q1.1 If others, please specify _____

Note: only one reply possible, the logic being that if one is a WP leader, they do not mark AP nor CP, and if one is an AP, they do not mark CP.

Has <u>your institution</u> been actively involved in any CHRODIS work package (WP)?

Yes ☐ No ☐

Have <u>you yourself</u> been actively involved in any CHRODIS work package (WP)?

Yes ☐ No ☐

Have you attended past JA-CHRODIS events?

Yes ☐ No ☐

Has your institution participated in past JA-CHRODIS events?

Yes ☐ No ☐

Block 2: Rating and usability of JA-CHRODIS work and outputs

A) How can Europe approach the care of persons with Multimorbidity (WP6)?

Did you attend the session 'How can a comprehensive care model for multimorbid patients be implemented', held on Monday 27th at 14.30?

Yes ☐ No ☐ *(Skip to deliverable question*)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

(*) Bearing in mind the "Report on care pathways approaches for multi-morbid chronic patients" to what extent will you us this deliverable or share it with colleagues or your local stakeholders (policymakers, healthcare professionals, patients, researchers...)

I will surely not use it/share it	I will probably not use it/share it	I will probably use it/share it	I will surely use it/share it	I don´t know /I´m not familiar with it
☐	☐	☐	☐	☐

Please could you briefly explain why you will/will not use or share this deliverable?

B) Exchange and transfer of good practices in health promotion and disease prevention (WP5)

Did you attend the session 'What needs to be taken into account for the exchange and transfer of good practices in health promotion and disease prevention', held on Monday 27th at 16.15?

Yes ☐ No ☐ *(Skip to deliverable question*)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

(*) Bearing in mind the "Recommendations report on applicability and transferability of practices into different settings and countries", to what extent will you use this deliverable or share it with colleagues or your local stakeholders (policymakers, healthcare professionals, patients, researchers...)?

I will surely not use it/share it	I will probably not use it/share it	I will probably use it/share it	I will surely use it/share it	I don´t know /I´m not familiar with it
☐	☐	☐	☐	☐

Please could you briefly explain why you will/will not use or share this deliverable?

_____

C) Diabetes as an example of prevention and care of chronic diseases (WP7)

Did you attend the session 'What are the lessons for the prevention and care of chronic diseases, taking diabetes as an example', held on Monday 27th at 16.15?

Yes ☐ No ☐ *(Skip to deliverable question*)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

(*) Bearing in mind the " Recommendations to improve early detection, preventive interventions, and the quality of care for people with diabetes", to what extent will you use this deliverable or share it with colleagues or your local stakeholders (policymakers, healthcare professionals, patients, researchers...)?

I will surely not use it/share it	I will probably not use it/share it	I will probably use it/share it	I will surely use it/share it	I don´t know /I´m not familiar with it
☐	☐	☐	☐	☐

Please could you briefly explain why you will/will not use or share this deliverable?

_____

D) The CHRODIS Platform for sharing knowledge and experiences (WP4)

Did you attend the session 'How can decision-makers, professionals, patients and researchers make the best use of the CHRODIS Platform and share valuable knowledge and experiences', held on Monday 27th at 14.30?

Yes ☐ No ☐ *(Skip to deliverable question*)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

(*) Bearing in mind the JA-CHRODIS Platform for sharing knowledge and experiences, over the next year,to what extent will you:

	Surely not	Probably not	Probably will	Surely will	I don't know
Use the platform to obtain information?					
Upload a practice to the platform for evaluation?					
Submit a document for the platform's Digital Library?					
Recommend the platform to colleagues or your local stakeholders (policy-makers, healthcare professionals, patients, researchers...)?					

If most of your previous answers above have been 'surely not' or 'probably not', please could you give a brief explanation as to why you do not expect to use the platform or recommend it? We also welcome suggestions on what might need improving as to better meet your needs:_____

Block 3: Joining forces and moving forward for better health policies across Europe

Did you attend Session 1- Addressing the chronic disease challenge in Europe (9.30-11h), Tuesday 28th February)?

Yes ☐ No ☐ *(Skip to session 2 questions)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

Did you attend Session 2- How can policy makers use the JA-CHRODIS results to (plan to) address the chronic disease challenge and ageing society (11.30-12.30h, Tuesday 28th February)?

Yes ☐ No ☐ *(Skip to "12 steps" questions)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

Concerning the '12 steps to address the chronic disease challenge' presented in this session, please rate your level of agreement with the following statements:

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
The '12 steps' are based on evidence					
The '12 steps' are groundbreaking					
The '12 steps' are timely					
The '12 steps' are useful for my local context (policy, practice, research)?					
I agree with the '12 steps'					

Please feel free to provide us with any other comment about this session or the '12 steps'

Did you attend session 3: Making the link: How can better integrate health promotion in comprehensive healthcare society (13.30-15h, Tuesday 28th February)?

Yes ☐ No ☐ *(Skip to session 4 questions)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

Did you attend session 4: How does JA-CHRODIS leave its mark, including examples in practice (15.30-16.45h, Tuesday 28th February)?

Yes ☐ No ☐ *(Skip to concluding remark questions)*

Bearing in mind this session, please rate:

	Poor	Fair (regular)	Good	Very good	Excellent
The speakers (clear, compelling)					
Opportunities for participating and sharing					
Content and conclusions (appropriate, interesting, based on evidence presented)					
Usefulness of take home message(s) (relevance for your local context, policy, practice...)					

Please feel free to provide us with any other comment about this session:

_____

Q19. Please rank from 1 to 5 (1: not interesting / 5: very interesting) the concluding remarks of the conference:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ I did not attend ☐

Block 4: JA-CHRODIS Final Conference overall satisfaction

Please rate the following organizational aspects of the conference:

	Poor	Fair (regular)	Good	Very good	Excellent
Pre-conference communication					
Venue					
Refreshments					
Opportunities for networking					

Please briefly explain which is the main message or learning you take home from the conference _____

Will you share this message with your colleagues / network back at home?

1= Surely not	2= Probably not	3=I probably will	4= I surely will	I do not know
☐	☐	☐	☐	☐

Please rank from 1 to 5 (1: very dissatisfied / 5: very satisfied) if your investment in time and energy was repaid by the quality and interest of the whole conference.

1= Very dissatisfied	2= Somewhat dissatisfied	3= Neither satisfied nor dissatisfied	4= Somewhat satisfied	5= Very satisfied
☐	☐	☐	☐	☐

Please feel free to provide us with any other comment:_____

THANKS FOR YOUR COLLABORATION