
*Joint Action on Chronic Diseases & Promoting Healthy
Ageing across the Life Cycle*

WORK PACKAGE 5

*Meeting on identifying, assessing quality and presenting
good practice interventions and policies*

Wednesday 20 April | Thursday 21 April

*National Institute for Public Health and the
Environment (RIVM)
Bilthoven, The Netherlands*



Co-funded by
the Health Programme
of the European Union

THIS PUBLICATION ARISES FROM THE JOINT ACTION CHRODIS, WHICH HAS RECEIVED FUNDING FROM THE EUROPEAN UNION, IN THE FRAMEWORK OF THE HEALTH PROGRAMME (2008-2013). SOLE RESPONSIBILITY LIES WITH THE AUTHOR AND THE CONSUMERS, HEALTH, AGRICULTURE AND FOOD EXECUTIVE AGENCY IS NOT RESPONSIBLE FOR ANY USE THAT MAY BE MADE OF THE INFORMATION CONTAINED THEREIN.

Inhalt

<i>April 19th and 20th 2016.....</i>	<i>3</i>
<i>Day 1 - 19 April - Chair: Marieke Hendriksen, Djoeke van Dale.....</i>	<i>3</i>
<i>Opening Session</i>	<i>3</i>
<i>SESSION 1: Feasibility/ applicability of PKE for health promotion practitioners.....</i>	<i>3</i>
<i>Day 2 – 20 April - SESSION 2 - Policy on the GP database in the Netherlands</i>	<i>5</i>
<i>SESSION 3 - Good practice databases (criteria, procedure, funding resources). What are the key elements of a good practice database?</i>	<i>7</i>
<i>SESSION 4 – The process of the beginning, the implementation and sustainability of a good practice database; successes and failures.....</i>	<i>11</i>
<i>SESSION 5 Success factors and challenges of successful implementation of the database (Djoeke and Marieke).....</i>	<i>13</i>
<i>Final discussion/closing session: reflection about the study visit. Take home messages.....</i>	<i>14</i>

Meeting Minutes Database Study

Visit – Utrecht, The NL

April 19th and 20th 2016

Attendance: 16 participants from 8 countries:

NL	Ireland
Brussels	Germany
Italy	Spain
Iceland	Portugal



SESSION 1: Feasibility/ applicability of PKE for health promotion practitioners

Presentation on PKE: Enrique Bernal-Delgado, Leader of WP4 and the development of the PKE

Suggestion for a new name for the PKE are welcome.

PKE modules and roles

Modules:

Engineers based in ICIII have put into practice ideas

Basic structure of the platform:

- (a) Digital library= functioning as a classic repository
- (b) Clearing house = all evaluated practices are stored in here
- (c) Help desk = acts as the backstage of any action

To access any content you need to register (for safety reason + collecting useful information on users) –

There are two different registration profiles: User and referee/reviewer

A search engine is interconnecting the content of PKE.

Progress so far: the clearinghouse and digital library in piloting phase. Other features will soon be tested in the piloting phase.

Roles:

Help desk manager: in charge of the maintenance of knowledge base, online toolkit and experts database and assisting users. In charge of putting practice's owners and experts in contact.

WP4 will ask Delphi participants to become experts or reviewers/referees.

Practice owner= submits practices and can become expert if the practice successfully stored.

Reviewer/referee (top individual behind final decision and final score given to the evaluated practices) –

A list of experts in different fields is needed – names from all meetings were gathered by WP4 (either associated partners or collaborating partners). The experts should not necessarily be people involved in the Delphi process.

At the moment there is no governing body behind PKE, but it could prove necessary in the future.

The PKE is for the moment a concept - no guarantees that it will be implemented in the future.

Platform is prepared to be scaled up in terms of the number of people interacting with it and not implement functionalities that might be needed in the future. A business plan has been also prepared.

Experts can be recruited for increased reputation by being JA-CHRODIS platform expert (that would be part of the success if the platform has an impact – countries are using it, etc.)

The Platform's Registration process

Account profile

Identification/user information area gathering useful information about the user profile: According to the information entered by the user, and if the user agrees on being a reviewer, a good practice for review can be sent.

Dashboard – depending on your profile you have access to different content. As regular user you have access only to “add content” and “activity”. As a reviewer/referee you have access to the assessment

functionality. Some headings and terms need to be reviewed and changed as they are too medical (suggestions coming from Irish participants).

All kind of content (policies, strategies, videos, leaflet, publications, etc.) can be uploaded on the Digital Library. The content will be checked before publication to verify it is relevant – no evaluation process.

To upload on the Clearinghouse there is a different process:

Submission process

Add content – 4 possible entries representing CHRODIS WPs + 1 representing patient empowerment (multimorbidity and organizational interventions grouped together). Reviewers can self-assess their submitted practices

Work flow process for reviewing process. Two peers reviews (blinded peers), then the referee receives both assessments. GPs have to fulfil all criteria. The referee takes final decision and approves the GP for upload to the Clearinghouse if the final score is above the threshold (percentile 10 – threshold to be updated each 2/3 years). GPs not scoring enough are stored and the referee sends a report to the submitter.

* Reviewer– As a reviewer you receive the assess form and the description of the GP. You have to agree or not to the self-assessment done by the submitter. There is a 0 - 5 points scale for evaluators: 5 if you fully agree with the self-report, 0 if you totally disagree.

Different points are given according to level of agreement.

Referee profile – sums and checks the scores given by the two peer reviewers

List of content: those with the higher scores are on the top of the list. Content is divided under 4 different tabs.

Contents: policies are included in the practices; there's a list of other contents, for example videos, etc

Issues to solve / concerns:

- People don't have particular benefits in participate, except from the reputation (further, they can become experts)
- Is there a government embody or commitment? At the moment no, but there's a business plan in case of any governments interested in PKE
- Terms: they are nearer the clinical fields vs health promotion (taxonomy from Mesh)

Day 2 – 20 April - SESSION 2 - Policy on the GP database in the Netherlands

***Presentation:** The beginning of the Dutch GP database: a policy perspective, Annemiek van Bolhuis (RIVM Director Public Health Services)*

Questions and Answers:

Synthesis from the Q&A round:

The responsibility for the initiative lied within the directorate of health.

It was important to establish means of communication between different levels (local to national) to recognize demands and needs “from the ground”.

An incentive system has been established to stimulate the uptake of interventions from the database.

The policy cycle is set up for a four year turn and based on the 4-annually published health status and forecast report. The congruency with the 4-year elections cycle can be of advantage but also pose challenges due to the changing political priorities.

Presentation: The added value of the Recognition System for the Netherlands, Wil de Zwart

Synthesis from the Q&A round:

A national white paper is published every four years with certain priorities. Currently these priorities are: smoking, drinking, diabetes, obesity.

It's a national responsibility: the ministry finances municipalities to reduce socio-economic inequalities. But the main message is: “health is a responsibility for all, not only for the ministry”.

Additionally, white papers are also published on the loco-regional level and they ideally align with the national priorities.

Local units apply national policy, but they have to follow the evidence-based interventions.

The municipalities are not linked into the “health care service”. ‘Service’ in the Dutch understanding means public service, whereas in Ireland it is seen as health care.

The role of the Ministry in the support of recognition system is to provide financial support in specific settings and domains, e.g. schools, sports, healthy ageing.

Furthermore the definition of conditions for research projects. For instance, projects financed by the MoH can receive a clause that they need to be uploaded in the recognition system.

3 main domains:

A - to improve public health and health service

B - Environment and safety

C - Infectious diseases

A – Public health policy cycle in the Netherlands

According to the recognition system, in 2005 we had 3000 interventions in public health, with:

- no insight in quality and effectiveness of interventions
- no coherence in local health policy (not very developed local actions and not clear adherence to national policy papers/statements)
- different organizations

So the Ministry started a formalized centre for healthy living with an assessment system and database to have an insight in quality and effectiveness of the interventions.

Current status: Database with 350 good practices; up-to-date database (1900 interventions)

There are a few effective interventions, and a lot of subjects/partners involved (among the stakeholders: ambassadors)

Helpful tips (to promote the database filling):

- create a sense of urgency (to start to do something...) through a strong report *
- risk to waste money because of ineffective interventions
- timing is important
- there are some groups working but they are not coordinated

Tips and advises

1. Create collaboration and commitment within your department or ministry
2. Involve parties, knowledge institutes, research institutes, experts
3. Keep it Smart...start with a restricted number of issues
4. Create financial support and...a guaranty for continuity!
5. Stimulate research on the effectiveness of interventions or on the implementation of effective interventions
6. Do not support interventions that have insufficient evidence
7. Develop a 'brand awareness': refer to the database and recognition system in letters, white papers etc.

SESSION 3 - Good practice databases (criteria, procedure, funding resources). What are the key elements of a good practice database?

Praxisdatenbank, Germany - Roger Meyer (Gesundheit Berlin-Brandenburg)

General info on the database:

- Run in a joint collaboration with Gesundheit Berlin-Brandenburg and BZgA

- It contains: 2798 health promotion projects, 119 HP good practices
- Health situation – health potential (there's a gap)
- Focus: projects aiming at socially disadvantaged people
- Selection process: self-entry forms, external assessment of practices
- Twelve GP criteria, which have been “operationalised”
- It's a tool for self-reflection
- “Centres for equity” (regional centres) are independent; they propose potential projects
- It's a possibility for the project leaders to exchange their projects
- It allows to describe step-by-step the process of evaluation in different systems.

Synthesis from the Q&A round:

The creation of the database approach followed a sense of urgency imposed by the persistence of social health inequities. The project originated in 2003 to target socially vulnerable people and projects should have a focus on it, although in reality it is sometimes difficult if that focus exists or not.

Twelve good practice criteria were developed . The criteria development is a constant process and criteria are developed out of existing projects. The operationalisation of criteria can follow different stages, e.g. the criteria “participation” defines different levels of involvement.

Human resources involved include one to two persons for technical work only, while the actual assessment process is very time consuming. A small monetary compensation is therefore paid to reviewers (two people review one practice).

The review is a question and answer process, based on the documentation of the practice. Over the course it's about one full day of work per reviewers, while the question and answer process to receive full documentation per practice can take around three to four weeks.

The actual “core work” is done through documentation staff from the database provider, not by the submitter. The procedure is not a self-assessment during the submission of the documentation.

An advisory board with 15 members is established for regular consultation.

The incentive for the projects to undergo the process of evaluation in the database is not monetary. The “Good Practice”-label comes with a positive reputation in the field.

Over the course of time, the sustainability and stability have increased, but it is getting harder and harder to find new projects for upload.

The existence of the database has gained high visibility in Germany, but no strong evidence exists on whether the uptake of practices in general has increased nor whether it's direct impact on social health inequities. The database stipulates inspiration through the knowledge transfer process that comes with it.

Pro.Sa database, Italy – Rita Longo (DoRS, Health Promotion Documentation Centre)

The project of database started in 2000 to document all regional experiences and projects. Good practice area started in 2004. In 2011 it was converted from a regional to a national instrument.

The aims of the system are:

- To obtain regional and local data of HPP interventions
- To share project materials and results
- To help development through methodological guides, of evidence based projects and interventions
- To evaluate and to highlight GPs
- To create synthesis tables and maps with loco-regional details

Structure: Health promotion projects can be uploaded, an extra possibility to submit good practices for evaluation exists. There's a *public area* with open access with guided search function + *reserved area*, to which only regions have access, to monitor and evaluate its own projects. Regions appoint workers who are experts in projects for submitting the projects to the database. The database collects qualitative and quantitative data. A project guide helps professionals to improve and write projects along good practice criteria (18 criteria).

Each project is evaluated by two independent readers (one expert in methodology and the other expert in the project's specific field (smoking, physical activity...)) The review process goes along a cascade and results in a scoring system. Procedure leads to a final score.

The purpose was to not only evaluate but also highlight good practices, train professionals, support decision making. However, only 12 out of >1000 practice submitters have "applied" for evaluation. In future, it would be desirable if the procedure can be included in national Prevention Plan and consequently in Regional prevention plan to provide the reader activity (that is an activity that can't be paid but must be institutionally provided)

Dutch Recognition System, the Netherlands - Djoeke van Dale (RIVM, NL)

Key elements:

- database
- assessment system
- presentation of good practices
- implementation activities

Recognition system is a collaboration of seven organisations:

1. NL youth institute
2. Centre for healthy living
3. National centre of youth and health care

4. Knowledge centre for sports
5. NL centre for social development
6. Mental health
7. Chronic care

Stepwise system:

1st stage: peer review: 3 professionals from national institutes

2nd stage: assessment by 3 experts (science, policy, and practice)

second assessment then in a meeting (10 meetings per year)

two different committees (youth and adults/ageing)

Resources: Submission advice and feedback about 10 hours per interventions
 Submission of an intervention in total about 50 hours

Many GP criteria are implicit in the intervention's description and to be assessed by joint meetings, therefore the submission can be a lengthy process.

A list of recommended interventions according to topics is available for different settings.

The implementation of feedback mechanisms on uptake and transfer of good practices is difficult. Few monitoring studies exist in the field, the main feedback comes from web statistics.

Some points of reflection::

- people that have used the db say that they are most aware of the process (they are more conscious of qualitative criteria when they design a project now)
- People need help to fill the form (training?), especially when projects aren't simple and focalized
- Some projects are well described but they forget specific elements (effective elements)
- If you do not have a database you do not know what works
- You can get inspiration and example from a db, it's not only the case that I take the effective elements
- If there are effective elements and specific interventions, the government could make them apply
- They must be not only databases but also an opportunity to learn, share, etc.
- Db must provide practical information vs theoretical speech
- It can make sense for the user if he becomes more aware
- How can we convince policy makers? Social marketing strategies
- Db are a powerful tool for reflection

Criteria: they do not have explicit criteria on equity.

Dissemination: digital magazine and infographic (they proved to be useful!)

SESSION 4 – The process of the beginning, the implementation and sustainability of a good practice database; successes and failures

After a short introduction participants are invited to ask their questions about the experiences with submitting and the implementation of an intervention.

Group Praxisdatenbank

The geographic and political range of the database is nationwide, the office is based in Berlin.

The impact on the health of socially disadvantaged people is not directly measured. It is assumed, that if all the good practice criteria meet the practice, then we can expect an impact, even though it is hard to quantify.

The general procedure is: submission, interview with submitter, feedback round(s) and review. The interview part can take up to six months with questions pinged back and forth.

Workload:

The documentation of one good practice description requires around one to two weeks of full time equivalent.

What would you do different with the lessons learned?

The operationalisation process was important to develop and shape our own understanding on how the criteria translate into reality.



Group Dutch Recognition System

The initial sense of urgency was good to have to start over with the centre and the database; everyone was talking about starting doing it but not actually doing it. Essential precondition is the financial support either from the ministry or another organization.

The practitioners “on the ground” have been consulted and asked for a database to facilitate the knowledge exchange.

The mapping of existing approaches is one important function of the system. The quality assessment is important to acquire support from the practitioners. It's important to find the balance between inclusiveness for interventions and strictness of quality criteria. There is a 3-5 years expiration date for assessed interventions.

The system follows a stepwise procedure:

1. Who do we target with the database?
2. Who is our target population?
3. Criteria development

It is difficult to “chop” the interventions into criteria/pieces because you don't know in the end if it's still effective.

Challenges: While collecting the good practice examples it is often difficult to convince effective practices to submit their information because it's extra work.

Pro.SA – Italy

Reviewers come from different regions, their work is conducted during regular working hours.

Reviewers are psychologists, sociologists, doctors and veterinaries, in total. It is mandatory to be an expert in health promotion planning, and be acquainted with the GP assessment form. Local unit health coordinators are being trained to use the form.

Recommendations to start a database based on the Italian experience:

- Define main objective.
- Conduct mapping of existing approaches in the region/field. In Italy many fragmented databases existed on a local level, but a more comprehensive approach was needed.
- Spark reflection process about good practice criteria
- Disseminate the knowledge emerging from good practices to improve other existing projects. This has resulted in an Italian guidance document
-

The number of practices in the Dutch system is inspiring. The number of submissions for evaluation should be increased in Italy. A reflection might be necessary whether the criteria are too strict. However, the assessment depends strongly on the quality of the submitted information. Maybe a project is really promising but the submission is not well written. More time is needed to advise and guide submitters.

Challenges:

The motivation to submit a project derives from the positive reputation through a „Good Practice Award“.

At this point, good practice examples come geographically only from three regions mainly due to the pilot character. However, it is still a challenge to spark interest among other regions and to promote the added value of the database approach. In some cases, local health units in regions are interested in submitting projects, but the regional authorities are not.

SESSION 5 Success factors and challenges of successful implementation of the database (Djoeke and Marieke)

Key lessons learned from practical perspectives

User's perspective:

- Database submission facilitates reflection process (“Forces you to sit down and reflect on what are you doing?”)
- The reflection process benefits future project design
- Personall, having effectiveness as a focus can give a different perspective. The use of the database can help to grow professionally.
- Time burden is a key barrier for submitters from the ground
- The development of an operationalisation manual for the good practice criteria has helped to support the self-learning/-reflecting process
- The database helps to increase visibility and support documentation. Facilitates to obtain information on “what works” fast. It's important that the intervention is “owned” by someone who feels responsible for a knowledge transfer process
- Knowledge transfer process is needed. Sometimes people pick up certain elements of interventions, but miss out key parts and call it “adaption” without it actually being effective anymore
- It's important that the providers conduct the submission themselves as a learning process, but it's favourable to do it with other colleagues.
- The db is useful to get information
- The structure is well described, it is helpful for users, like a sort of consultant

Personal lessons learned by user(s):

- “We can tell better about effects (what works)”
- „It’s near to reality“
- „What should you do different?“
- “What should I do different?”

Challenges:

- How to score/quantify the effectiveness of an intervention?
- Lack of integrated approaches.
- Self-reflection is often hindered by time constraints

Final discussion/closing session: reflection about the study visit. Take home messages

Iceland: We're in a preparation phase, received valuable information. Start as mapping and later on build the quality assessment part, according to resources. The Italian approach it's clever to leave it to the submitters whether information is public or not. We consider database as a complimentary element to existing activities.

Ireland: Details of review process, depth of levels, How to tackle discrepancies between submitters and reviewers. Dutch model shows how much assessment is too much assessment. Starting point has to be: Document what is actually out there. Most important step of database is at submission step because of high impact on review process – this is also a strong implication for the PKE. It’s interesting, that some databases provide training for the uploading process.

Spain: Emphasise learning experience

Portugal: Have a high need for a database. A personal meeting like this helps to shape a better picture and makes sense to understand the fuller picture. How can we convince the policy makers that the implementation of such a database makes sense.