Scoping review: Quality of Care for Chronic Conditions. Retrieved grey literature and summary of contents

	Title	Authors	Organization	Year	Place / Country	model(s) / framework(s)	Dimensions/domains/elements
1	A Guide to Real-World Evaluations of Primary Care Interventions	Peikes D, Taylor EF, Genevro J, et al.	Agency for Health Care Research & Quality	2014	USA	evaluation	Not applicable Additional information: provides practical advice for designing real-world evaluations of interventions such as the patient-centered medical home (PCMH) and other models to improve primary care delivery.
2	Care Coordination Measures Atlas	McDonald KM et al	Agency for Health Care Research & Quality	2014	USA	Care Coordination Measurement Framework	[1] Establish accountability or negotiate responsibility - Make clear the responsibility of participants in a patient's care for a particular aspect of that care. Specify who is primarily responsible for key care and coordination activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants. [2] Communicate – Share knowledge among participants in a patient's care. [3] Facilitate transitions - information about or accountability for some aspect of a patient's care is transferred between two or more health care entities or is maintained over time by one entity. Facilitation may be achieved through activities designed to ensure timely and complete transmission of information or accountability. [4] Assess needs and goals - Determine the patient's needs for care and for coordination, including physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services. [5] Create a proactive plan of care - Establish and maintain a plan of care, jointly created and managed by the patient/family and health care team, which outlines the patient's current and longstanding needs and goals for care and/or identifies coordination gaps. [6] Monitor, follow up, and respond to change – Jointly with the patient/family, assess progress toward care and coordination goals.

							Refine the care plan as needed. Provide necessary followup care to patients. [7] Support self-management goals - Tailor education and support to align with patients' capacity and preferences . Education and support include information, training, or coaching provided to patients or their informal caregivers to promote patient understanding of and ability to carry out self-care tasks, including support for navigating their care transitions, self-efficacy, and behavior change. [8] Link to community resources - Provide information on the availability of and, if necessary, coordinate services with additional resources available in the community that may help support patients' health and wellness or meet their care goals. (Community resources are any service or program outside the health care system that may support a patient's health and wellness.) [9] Align resources with patient and population needs - Within the health care setting, assess the needs of patients and populations and allocate health care resources according to those needs. [10] Teamwork focused on coordination.Integration among separate health care entities participating in a particular patient's care (whether health care professionals, care teams, or health care organizations) into a cohesive and functioning whole capable of addressing patient needs. [11] Health care home (medical home) - a model of the organization of primary care that delivers the core functions of primary health care and functions as the central point for coordinating care around the patient's needs and preferences. [12] Care management - to assist patients and their support systems in managing their medical/social/mental health conditions more efficiently and effectively, and includes case management and disease management. [13] Medication management - Reconciling discrepancies in medication use in order to avoid adverse drug events. [14] Health IT-enabled coordination - Using tools, such as electronic medical records, patient portals, or databases, to communicate information about patients and their care between health care entities

							(health care professionals, care teams, or health care organizations) or to maintain information over time.
3	Better Outcomes for people with Chronic and Complex Health Conditions	Report of Primary health advisory group	Australian Institute of Health and Welfare	2015	Australia	Health Care Home	7 basic principles: 1. Voluntary patient enrolment: ongoing partnership between patients and a clinical " home base" which optimizes co ordination, management and support for their chronic and complex conditions, to enrol, patient and providers will agree to establish and keep updated shared electronic health records (SEHR) summary of the patient-SEHR will empower patients to take active roles in their care, assist them to understand and communicate with hcproviders, reduce duplication of services and unnecessary tests and support better healthcare across the system. 2. Patients, families and their careers as partners in their care: Aimed to put patients in control of their care with knowledge, skills and confidence to manage their health supported by the healthcare team, families and carers where appropriate 3. Patients have enhanced access: to services through HCH which will include non face-to-face services where clinically appropriate and effective. Such services can be enabled by telephone, email or video conf and supported by home monitoring devices. 4. Patients nominate a preferred clinician: within HCH who is aware of the patient's priorities and wishes and responsible for care co ordination; Preferred clinician could be GP and in some case nurse practitioner working with a team of HCP within and outside HCH who will have expertise and accountability to lead the ongoing care of the patient. 5. Flexible service delivery and care teams are enabled through shared integrated care planning: spans primary health and acute care as required. The HCH co ordinatescare across elements of HC community enabled where appropriate by digital health , Electronic health records and health information exchange, supported by funding models. The model supports different clinical leadership and expertise within HC teams empowering specialists to improve

							development and refining of healthcare planning and service delivery, where appropriate 6. The HCH is committed to high quality care which is safe- care planning and clinical decision is guided by evidence based patient health care pathways and supported where possible b best possible decision support tools 7. Data collection and sharing: by patients and their HC teams to measure patient HO (Health outcomes) and improve performance. To ensure ongoing, high standards of service delivery HCH would be expected to participate in quality imp and performance measurement programmes including measures of patient experiences
4	Multimorbidity care model: Recommendations rom the consensus meeting of the joint Action on Chronic	Palmer et al	EU Joint Action on Chronic Diseases and Healthy Ageing Across the Life Cycle	2016	Europe		Delivery system design: regular comprehensive assessment, multidisciplinary team, individualised care plans, appointment of a case manager Decision support: Implementation of evidence based medicine, team training, Self Management support - training of care providers to tailor self management support for patients, providing options for patients to improve their health literacy, patient education, involving family members and family education, offering approaches to strengthen patients self manageemnt and self efficacy , involving patients in decision making, training patients to use medical devices, supportive aids and health monitoring tools correctly Clinical Information system : Electronic patient records and computerized clinical charts, exchange of patient information, uniform coding of patients' health problems and patient platforms allowing patients to exchange information with their care providers Community resources - Access to community resources, Involvement of social support and psychosocial support

5	QCR Tool based on CHRODIS: Recommendations to improve prevention and quality of care for people with chronic diseases		EU Joint Action on Chronic Diseases and Healthy Ageing Across the Life Cycle	undated	Europe	practice quality evaluation tool	quality criteria to assess practices and used in implementing practices or interventions on prevention, health promotion, care management, education, and training, and ultimately to improve prevention and quality of care for people with chronic diseases. 1. Practice design 2. empowerment of target population 3. evaluation 4. comprehensiveness of practice 5. training and education 6. ethical considerations 7. governance 8. interaction with regular and relevant systems 9. sustainability & scalability
6	CHRODIS QCR Toolguide		EU Joint Action on Chronic Diseases and Healthy Ageing Across the Life Cycle	undated	Europe	QCR tool	see above

7	Deliverable 7.1 WP7 Pilot action design: A blueprint fot action	Maggini and Zalatel	EU Joint Action on Chronic Diseases and Healthy Ageing Across the Life Cycle	2019	Europe	QCR tool	Practice Design : The practice aims and objectives are clearly specified, design builds on relevant data, theory context, evidence previous practice including pilot studies., structure organization and content of practices were clearly defined, clear description of target population, practice includes an adequate estimation of HR, material and budget requirements, dimensions of equity considered Target population empowerment: Actively promotes target population empowerment by using mechanisms such as self management support, shared decision making, education information or value clarification, active participation in the planning process and in professional training); considered all stakeholders needs in terms of enhancing or acquiring the right skills, knowledge and behaviour to promote target population empowerment; Evaluation: evaluation outcomes were linked to action to foster continuous learning and/or improvement and/or to reshape the practice, evaluation outcomes and monitoring were shared among stakeholders, evaluation outcomes were linked to the started goals and objectives, evaluation took into account social and economic aspects from both target population and formal and informal caregiver perspectives ; Comprehensiveness of the practice: considered relevant evidence on effectiveness cost effectiveness, quality, safety etc, the practice has considered the main contextual indicators and practice has considered the underlying tisks of target population; Education and training: Educational elements are included in the practice to promote the empowerment of target population (eg strengthen their health literacy, self management, stress management etc) ; relevant professionals and experts are trained to support target population empowerment

8	Disease Management Programs: Improving health while reducing costs		Georgetown University's Institute for Health Care Research and Policy	undated		Disease Management Program	Population identification processes: first step is to identify a population as well as how to enroll patients; demographic characteristics and health care use and expenditures are generally reviewed to identiy individuals who will benefit from a disease management program; programs are designed to target individuals with a specific disease ; Evidence based practice guidelines: Physicians and providers withint these programs are critical to educating patients on an ongoing basis about how to better manage their conditions, many programs provide physicians with practice guidelines based on clinical evidence to ensure consistency in treatment across targeted population Collaborative practice models: Disease management entails using a multidisciplinary team of providers - including physicians nurses, pharmacists, dietician, respiratory therapists and psychologists to educate and help individuals manage their conditions. Health care providers may also work with support service providers to fill any gaps in the care team; Patient Self Management Education - Disease management programs are based on the concept of individuals who are better educated about how to manage and control their conditions - which results in cost savings; Program enrollees amhy need educational support to stick to medical regimen, Counseling, home visits, 24 hour call centers and appointment reminder systems have been used to support individuals who are managing their chronic conditions; Process and Outcome Measurement: A method or the measurement of outcomes, including healthcare service use, expenditures and patient satisfaction must be determined prior to start of the program, These measures are compared to a baseline or a control group in order to measure the impact of the program . Routine reporting and feedback between patients, providers and health plans: Routine reporting and feedback between patients, physicians and other providers on the care team is often necessary to assure that patients are effectively managing their conditions and receiving the care they need. Additionally health plans need feedback from patients and providers in order to evaluate the programs

9	Understanding patient and provider experience with relationship, management and informational continuity	Jackson J, Lahtinen M, Cooke T	Health Quality Council of Alberta	2016	Canada	Continuity of Care	Continuity of care is classified into 3 subdimensions: 1. Relationship continuity, referring to patient-provider relationship 2. Management continuity, referring to seamless, well-coordinated care 3. Informational continuity, referring to patient health records being accessible to all care providers involved and to the patients themselves. Relationship continuity is important to structure care practices and processes to create a "continuity" hub
10	Crossing the quality chasm - a new health system for the 21st century	Clemmer et al	IOM Committe on quality of health care in America - Institute of medicine	2001	USA	IOM Quality aims	Aims of 21st century healthcare system Safe: avoiding injuries to patients from the care that is intended to help them Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit Patient-centered: providing care that is respectful and is responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions Timely: Reducing waits and sometimes harmful delays for both who receive and those who give care. Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socio economic status. Recommendations: 1. All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States. 2. All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable.

11	Crossing the Global Quality Chasm: Improving Health Care Worldwide (2018)	Berwick et al	IOM	2018	USA	IOM Quality aims	Safety: Avoiding harm to patients from the care which is intended to help them; Effectiveness: Providing sevices based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding overuse of inappropriate care and underuse of ineffective care) Person centeredness: Providing care that is respectful of and responsive to individual prefererences, needs and values and ensuring people's value guide all clinical decisions. Care transition and co ordination should not be centered on healthcare providers but on recipients Accessibility, Timeliness, Affordability: reducing unwanted waits and harmful delays for both those who receive and those who give care, reducing access barriers and financial risk for patients, families and communities and promoting affordable care for the system Efficiency: Avoding waste, including waste of equipment, supplies, ideas and energy and including waste resulting from poor management, fraud, corruption and abusive practices. Exisitng resources should be leveraged to the greatest degree possible to finance services ; Equity: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, race, geographic location and socioeconomic status
12	To err is human, building a safer health system	WC Richardson et al (eds)	IOM Committee of quality of healthcare in America, Institute of Medicine (IOM)	1999		IOM Quality aims	Action plan - developing and testing new technologies to reduce medical errors, conducting large scale demonstration projects to test safely interventions and error reporting strategies, supporting new and established multidisciplinary teams of researchers and healthcare facilities and organizations, located in geographically diverse locations, that will further determine the causes of medical errors and develop new knowledge that will aid the work of the demonstration projects, supporting projects aimed at achieving a better understanding of how the environment in which care is provided affects the ability of providers to improve safety. Funding researchers and organizations to develop, demonstrate and evaluate new approaches to improving provider education in order to reduce errors

13	Tackling chronic disease - a policy framework for the management of chronic diseases		Department of Health and Children	undated	Ireland		Development of intersectoral working to deal with the preventative aspects of chronic disease: a single interdepartmental structure through hich all health improvement actions will be channeled and build on the work on the senior officials group on social inclusion. Health service delivery should provide structured and integrated care for patients with long term chronic conditions: an implementation plan to indicate the resource requirements, the manner in which the services are to be integrated as well as how the objectives will be achieved. Disease management programs should be evidence based, recognise the nature of interdisciplinary work concerned and comprise the total course of the disease - Disease management programs should be quality assured via performance indicators and reflected in the service planning process. It will require the support of a professional training body and other providers who have a role to play in the management of the chronic disease. Definition, Diagnosis and stratification of the major chronic diseases: Diagnostic criteria including the stage of the disease should be developed for each of the major conditions. Clinical Decision systems such as guidelines for the management of the major chronic diseases should be developed: Disease management programs should incorporate clinical guidelines for the major conditions. These should be developed and updated on incremental basis starting with cardiovascular disease, stroke, diabetes and cancer. Models of shared care should be developed within disease management programmes: Disease management programmes should incorporate the existing clinical guidelines where available and incorporate these into shared care models for each condition. This will require the agreement of medical practitioners, nurses and other healthcare staff in seeing out the roles and responsibilities of all concerned. It should also acknowledge the partnership role of community groups who make an important contribution in enhancing the health of local communities. It should also include the training and educational requirements, the task requirements and the necessary areas of competence to fulfill these tasks. establishment of clinical

							networks in the primary and acute care settings -to provide integrated and appropriate care of patients with chronic diseases Primary healthcare strenthening- rollout of healthcare teams and development of multidisciplinary team working and integration with hospital services; roles and responsibilities of general practitioners nurses and professional staff within primary care teams should be agreed, work to be supported by clinical protocols and guidelines for the management of major chronic conditions Agreed Management plan: Services should be patient centered and individual disease management plans should be prepared for each patient and include the treatment goals, plan should also include the patients commitments to comply with the achievement of treatment goals. Active participation of patients: Developement of self care program for patient with chronic conditions. It should include disease specific patient education including the skills required for self monitoring and seld treatment and psychological support as appropriate. Health care professionals in Chronic care should participate in the development of these programs Clinical information system: Developement of patient registration systems for major chronic conditions should continue to be supported, development should begin at local level using primary and specialist data where available. Quality assurance : Quality assurance must be an integral part of disease management program- it should include incidence data, hospital utilization data, clinical outcomes and other quality data including patient satisfaction Evidence based methods and research on chronic disease programs: Healthservice research should be strengthened; this should include health determinants and prevention, health inequalities and clinical intervention to reduce chronic disease and its complications Monitoring and Evaluation: Each program should include targets and performance indicators so that progress in achieving the objectives of the program can be monitored

14	Organisation of care for chronic patients in Belgium: Development of a position paper		Belgian Healthcare Knowledge center	2012			Organise routine high quality care in outpatient settings: Design individualised care plan: The care plan designed in collaboration with patient's GP and primary care team will be integrated into this plan; care should be provided by multidisciplinary teams who share a common care plan and have access to electronic medical records containing follow-up, evaluation of patient's needs based on standardized tools), issues of privacy and selective access rights - training sessions in patient oriented multidisc teams must be included in basic curricula and continuing education for health professionals Provide care in outpatient settings: HIgh quality care is synonymous to qualified staff, investment in academic training and appealing work conditions are two main factors Promote and measure the quality of care: Implementation of a system to evaluate the quality of care provided by 1) deifing the goals of quality system and potential consequences of healthcare providers 2) feedback to professionals concerned to guarantee efficacy of this system 3) selection of relevant quality indicators and implementation of data collection system Coordinate the care: Patients with multiple and complex needs require coordinated actions to ensure concerted actions between care providers.One shot to permanent intervention of a case manager from the care team could help to optimize the impact of all interventions, in close co operation with the patient and other members of the team. Coordination structures at a higher level are important for case managers and care providers to offer them local networks on which they can rely to provide medical and social services in an integrated way. Seamless care between the first line of care and specialised settings: efficacy of action of hospital units and specialized physicians depends on sharing of information between primary care providers. Measures which can help to reduce complications related to transition periods are sharing of electronic medical record and targeted interventions by a discharge manner who collaborates with home care providers and guarantees of success of a seamless transition between hospital and home settings Detect early the chronic disease and its complications: Detecting the first symptoms of the disease and anticipating the

							complications are key tasks which depend on training and skills of primary care professionals. Support the patients and informal caregivers: the informal caregivers need accurate relevant and timely information to fulfil this role: information on the disease, various therapeutic options and available support; patient empowerment requires the training of care providers and other awareness of the importance of a partnership with the patients and caregivers Implement and follow the dynamic care model: the care model 13ocused on patients with chronic needs requires followups which evolves with changing healthcare system, values of society, patent needs, budgetary sources and scientific knowledge. Harmonization between coordinated structures: creation or re-organization of coordination structures and platforms between professionals at meso level will help to harmonise the services proposed to promote exchange between providers and to co ordinate existing social and medical structures Focus on accessibility and equity: efforts are required in some areas such as waiting lists for certain institutions, respite care, limited geographical or pathology related accessibility ; accessibility is also co related with availability of healthcare professionals, available workforce must be monitored to redirect policies connected with the attractiveness and planning of medical professions A payment system that encourages high quality care: rewarding quality of care is also an option to consider seriously . Certain aspects of quality are difficult to reconsile with a system mainly based on fee for service payment delegation sharingof tasksm multidisciplinary and co ordination call for other types of incentives

15	Manual for implementing quality care for chronic conditions	Escobar et al	WHO PAHO	undated	USA		Practice process and outcome measure monitoring : a mechanism for evaluating the quality of healthcare delivery through the assessment of process indicators while reviewing and measuring clinical outcomes in reference to use of established guidelines Training the healthcare team to manage chronic conditions: create healthcare team responsible for care of chronic conditions based on available resources and patient profiles , plan monthly continuous education activities to strengthen the team members' competencies such as patient centered care, partnering with patients, providers and community, quality improvement , information and community technology and public health perspective Assign roles and responsibilities of each of team members, design coordination mechanism amongst team members to assure quality of care Quality improvement: determine the specific targets of improvement strategies, parameters of change and determine how it will be measures and implement the particular strategies Delivery system design : risk stratification and population management - organize clinic visits according to risk and available resources Clinical information system: education reminders and patient support interventions for diabetes , review the attached patient record card to compare to standards of care Decision support: Contacting several health care providers via mass mailing which contains single clear message to improve evidence based practice Self Management support: Group visits can be conducted to bring patients who have the same chronic conditions together with a healthcare provider or team of providers, blood pressure self monitoring, educational intervention using 5 As of reducing smoking Community resources and policies : provide information and promote behavioral skills which help patients to carry out the tasks necessary to live as well possible with chronic illness, they may be led by either peers or professionals and may be disease specific or provide more general information and strategies for developing problem solving skills regardless of chronic condition

16	Benchbook on performance improvement of health services		Philippine National Health Insurance Corporation	2004	Philippines	Quality Standards	Access: organization informs community about services provided and of their availability , physical access to organization and its services is facilitated and appropriate to patients needs. Entry: patients receive prompt and timely attention by qualified professionals upon entry, organization documents and policies and procedures provides resources to ensure proper patient triaging Respect for autonomy:health professionals responsible for the care of patient obtains informed consent for treatment, planning for discharge begins upon entry into organization and ensures coordinated approach to discharge and continuing management Assessment: each patient'ss physical, psychological and social status is assessed, appropriate professionals perform co ordinated and sequenced patient assessment to reduce waste and unnecessary repetition, assessments are performed regularly and are determined by patients' evolving response to care, assessments are documented and used by ther health care team to ensure effective communication and continuity of care, diagnostic examinations appropriate to the provider organization's service capability and usual case mix are available and are performed by qualified personnel. Assessment of patients with special needs are determined by policies and procedures that are consistent with legal and ethical requirements Care planning: care plan addresses patient's relevant clinical, social, emotional and religious needs, care plan is consistent with scientific evidence professional standards, cultural values, medico legal and statutory requirements, organization ensures that information about the patient's proposed care is clear and readily accessible to designated multidisciplinary health care providers and relevant persons Implementation of care: care is delivered in a timely, safe, appropriate and coordinated manner according to care plans, rights and needs of patients are considered and respected by all the staff, care is coordinated to ensure continuity and to avoid duplication, appropriate personnel educate patients and or their families to help them understand patient's diagnosis, prognosis, treatment options health promotion and illness prevention strategies, drugs are administered and treatment procedures performed in a standardized and systematic manner in the provider organization

17	Multiple chronic conditions - a strategic framework		U.S department of Health and Human Services	2010			Define appropriate healthcare outcomes for individuals with multiple chronic conditions - define desired health outcomes appropriate for individuals with MCC, ensure that testing of care models includes evaluation of MCC relevant outcomes Develop payment reform and incentives - work with stakeholders to identify, develop and test incentives and payment approaches that promote effective care co ordination for individuals, disseminae information about and implement the use of incentives that promote cost effective care co rodination by providers who care for individuals with MCC Implement and effectively use health information technology - encourage the meaningful use of electronic health records, patient portals and clinical registries to improve care for individuals with MCC, test and implement the use of secure messaging and additional health information exchange platforms, encourage the use of health information technology as a public health tool for monitoring the population's health and key performance measures Facilitate self care management: continually improve and bring to scale evidence based sel care management activities and programs and develop systems to promote models that address common risk factors Facilitate home and community based services: critical role in enabling individuals with MCC to live and work successfully in their communities Provide tools for medication management: develop and disseminate shared decision making and other tools for individuals with MCC to provide accessible information Enhance health professionals training- identity or develop information relevant to the general care of individuals with MCC for use in health and social service professional training programs

18	Primary care puting people first		WHO	2008		Puting people first	people centered primary care- focus on health needs, enduring personal relationship, comprehensive, continuous and person centered care, responsibility for the health of all in the community along the life cycle, people are partners in managing their own health and that of their community Comprehensive and integrated responses: entry point health workers should solve all the health problems which are presented there; primary care team should be able to respond to bulk of health problems in the community Continuity of care: an important determinant of effectiveness, continuity of care depends on ensuring continuity of information as people get older A regular and trusted provider as entry point: comprehensiveness continuity and person centerednessa are critical to better health outcomes and are dependent on a stable long term personal relationship , building trust and ensuring relationship Organizing primary care networks: offer a comprehensive range of integrated diagnostic, curative, rehabilitative and palliative services, bringing care closer to people in settings in close proximity and direct relationship with the community relocating the entry point, giving primary care providers the responsibility for the health of a defined population, strengthening primary care providers role as co ordinators of the inputs of other levels of care by giving them administrative authority and purchasing power Bringing care closer to people: relocate entry point to the health system from specialized clinics, hospital, outpatient departments and emergency services Primary care team as a hub of co ordination: The coordination (or gatekeeping) role this entails effectively transforms the primary-care pyramid into a network, where the relations between the primary-care team and the other institutions and services are no longer based only on top-down hierarchy and bottom-up referral, but on cooperation and coordination

19	Integrated Care Models: an overview		WHO	2016		Integrated Care Models	Community - mobilize community resources to meet the needs of patients; Health system - create a culture, organization and mechanism that promote safe, high quality care, Delivery system design - Assure the delivery of effective , efficient, clnical care and self management support , Self management support - empower and prepare patients to manage their health and health care, Decision support : Promote clinical care that is consistent with scientific evidence and patient preferences Clinical information system: organize patient and population data to facilitate efficient and effective care
20	Delivering quality health services		WHO	2018		Elements of health care quality	Elements (dimensions) of healthcare quality: Effective : patient should receive evidence based care and a systematic process to arrive at an integrated management plan across various providers of care Safe: Minimizes harm including preventable injuries and medical errors to the patient People centered: respects and responds to patient preferences, needs and values; multidisciplinary care team listening to questions and concerns, asnsweing patiently and codevelop the care management plan with her active involvement Timely: delays in providing and receiving services should be minimum, situations requiring urgent intervention would be recognized and acted on as quickly as possible Equitable: quality of care does not vary according to personal characteristics such as gender, race ethnicity, geographical location and socioeconomic status Integrated : care across facilities and providers would be co ordinated, post discharge social worker evaluation and support for care plans and connect her with agencies Efficient: avoids waste of resources including equipment, medicines, energy and ideas. Each of medical providers would be able to track previous tests and procedures.

21	Assessing national capacity for the prevention and control of non communicable diseases		WHO	2019		Not applicable	Countries report on the following topics relating to NCDs: (i) public health infrastructure, partnerships and multisectoral collaboration; (ii) policies, strategies and action plans; (iii) health information systems and surveillance; and (iv) health-system capacity for detection, treatment and care. The results of the 2019 survey showed that, as regards NCD infrastructure and resourcing in the national government, 95% of countries had a unit, branch or department responsible for NCDs within their Ministry of Health, with nearly all having at least one full-time technical or professional staff member working within the unit, branch or department. Dedicated staff for each of the NCDs and the major NCD risk factors was reported by most countries for all NCD-related topics; staff dedicated to chronic respiratory diseases and oral diseases were the least prevalent worldwide. More than 80% of countries reported having funding available for the following NCD-related areas: health care and treatment (90%); primary prevention (88%); health promotion (88%); early detection and screening (87%); and surveillance, monitoring and evaluation (84%). Funding for capacity-building was slightly less prevalent (79%) while funding for palliative care (68%) and NCD-related research (65%) lagged further still. Taxation on alcohol and tobacco were widely implemented; however other fiscal incentives, such as taxation on sugar-sweetened beverages and foods high in fats, sugar or salt were not widely utilized.
22	Health System performance assessment		WHO	2022		Health systems performance	Dimensions mentioned are: Effectiveness: Extent to which a service achieves the desired results or outcomes, at the patient, population or organizational level. Safety: Extent to which health care processes avoid, prevent and ameliorate adverse outcomes or injuries that stem from the processes of health care itself. User experience: Extent to which the service user perspective and experience of health care is measured and valued as an outcome of service delivery. Access: Extent to which services are available and accessible in a timely manner that does not undermine financial protection. Equity: Extent to which the distribution of health care and its benefits among a population is fair; it implies that, in some circumstances,

							individuals will receive more care than others to reflect differences in their ability to benefit or in their particular needs. Efficiency: Relationship between a specific product (output) of the health system and the resources (inputs) used to create the product (Palmer & Torgerson, 1999), distinguishing technical and allocative efficiency
23	A vision for primary healthcare in the 21st century		WHO , UNICEF	2018		Primary Health Care	First contact: Primary care should be the first point of contact; for primary care to effectively provide first contact co ordinated care, a comprehensive array of services needs to be readily available. The critical characteristic of effective primary care is strengthened when access to other levels of care and services is always arranged though referral from primary care or when there are financial incentives for seeking care at the primary level Comprehensiveness: refers to scope, breadth and depth of primary care including the competence to address health issues throughout the life course; comprehensiveness decreases unnecessary referrals supporting efficient allocation of resources and responsibilities within the health system and facilitating continuity and integration of care Continuity: delivery of seamless coherent person focussed care over time across different care encounters and transitions of care; access and continuity should be promoted , achieving both will require more effective use of resources as demand for health services increases. Coordination - coordinate service delivery across the whole spectrum of health and social care services , including mental health services, long term and social care through integrated, functional and mutually supportive arrangements for transitions and information sharing along evidence based care pathways Person centredness: effective primary care is centred on the whole person in health and in sickness taking in consideration the full physical, mental and social circumstances rather than focussing on a specific organm stage of life or sub population
24	better NCD outcomes: challenges and opportunities for health systems		WHO	2014		NCD assessment guide	The country assessments aim to: (1) produce pragmatic and implementable policy recommendations for health system strengthening, to allow faster improvements in key NCD outcomes; (2) synthesize knowledge and experience in the countries of the Region on common health system

							challenges and promising approaches to overcome them; and (3) build capacity in policy analysis, policy development, and implementation through dialogue around HSS and NCDs. It provides key outcome indicators, potential core services and interventions for NCDs, and possible health system challenges and opportunities to improve NCD outcomes including political commitment, priority setting, interagency cooperation, population empowerment, establishing effective models for service delivery, improving coordination among healthcare providers and taking advantage of economies of scale.
25	Global action plan for the prevention and control of non communicable diseases		WHO	2013			Coverage: Expanding quality service coverage: strengthen and organize services, access and referral systems around close to user and people centred networks of primary health care that are fully integrated with secondary and tertiary care level of health care delivery system comprehensive palliative care and specialized ambulatory and inpatient care facilities ; enable all providers to address NCDs equitably while safeguarding consumer protection and harnessing the potential of a range of other services such as traditional and complementary medicine, prevention, rehabilitation, palliative care and social services, improve the efficiency of service delivery and set national targets for increasing the coverage of cost effective, high impact interventions, meet the needs of long term care of people ; establish quality assurance and continuous quality improvement systems for prevention and management of NCDs, take action to empower people with NCD to seek early detection and manage their own condition better
26	Innovative Care for Chronic Conditions		WHO	2002			Evidence based decision making: evidence should be the basis for all decisions in policy making, service planning and clinical management of chronic conditions. Evidence includes available information about the magnitude of chronic conditions, effective and efficient interventions to reduce the associated burden, current and anticipated resource needs, appropriate mix of skilled healthcare personnel. Evidence based information includes information on process of care and patient outcomes Population focus: Healthcare system for chronic conditions are most effective when prioritized on a defined population rather than a single unit of patient seeking care

							Prevention focus: As most chronic conditions are preventable health care interaction should include prevention support Quality focus: Quality control assures that resources are used properly that providers are accountable for providing effective and efficient care and patient outcomes are the best possible given any limitations Integration: Integration is the core of the ICCC framework and healthcare for chronic conditions. Integration, co ordination and continuity should occur across time and health care settings including primary healthcare, specialty care and inpatient care Flexibility and Adapatability: Healthcare systems need to be prepared to adapt to changing situations , new information and unforeseen events.

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