Process evaluation of five tailored programs to improve the implementation of evidence-based recommendations for chronic conditions in primary care

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Additional file 1 - Chronic conditions and recommendations targeted in the TICD-project

Country	Targeted chronic condition	Recommendations chosen as implementation objectives
Germany (GE)	Multimorbidity (polypharmacy)	1. **Structured medication counseling incl. brown bag review:** should be offered to multimorbid patients with polypharmacy and additional risk factors at least once per year 2. **Medication lists:** should meet minimum standards concerning layout and template and patients with permanent medication should always have them with them. 3. **Medication reviews** should be conducted by GPs using instruments to reduce potentially inappropriate medication
The Netherlands (NL)	Cardiovascular Diseases (CVD)	1. **SBP < 140 mmHg** in patients at high risk for CVD 2. **SBP < 140 mmHg** in patients with established CVD 3. **LDL < 2,5 mmol/l** in patients at high risk for CVD 4. **LDL < 2,5 mmol/l** in patients with established CVD 5. **Promote life-style-changes** in patients with (high risk for) CVD 6. **Create a risk-profile** for patients with chronic kidney disease
Poland (PL)	COPD	**1. A brief counseling to quit smoking**: should be offered to all patients with COPD at least once a year. **2. Assess prognosis of COPD using mMRC dyspnea scale**: All patients with COPD should have the degree of dyspnea assessed by the mMRC scale at least once a year and results recorded in their medical record. **3. Inform patients about COPD following a checklist**: Physicians should discuss the specific components of the care process with all patients with COPD. **4. Train patients in the correct use of inhaler devices**
United Kingdom (UK)	Obesity	1. **Use BMI or waist circumference**: to determine the degree of overweight or obesity 2. **Assessment**: of lifestyle, co-morbidities and willingness to change 3. **Management of obesity:** A multi-component intervention should be offered to encourage increased physical activity, improved eating behaviour, and healthy eating. Drugs may be used in certain groups. The intervention should involve long-term follow up by a trained professional and be tailored to the patient's preferences, initial fitness and lifestyle. 4. **Referral to specialists:** if the cause is uncertain, if conventional treatment has failed and surgery is being considered or if there are complex co-morbidities and specialist intervention are needed.
Norway (NW)	Depression in the elderly	1. **Social contact:** should be discussed with elderly patients with depression and actions to increase social contact recommended if needed 2. **Collaborative care plans:** should be developed by municipalities for patients with moderate and severe depression. 3. **Depression Care Manager:** PCP should offer regular contact with a Depression Care Manager 4. **Counseling:** PCP should offer advice regarding self-assisted programs on behavioural therapy, physical activity groups, sleeping habits, anxiety coping strategies and problem solving therapy 5. **Mild depression:** Avoid routine prescription of antidepressants 6. **Severe, recurrent or chronic depression or dysthymia:** Offer a combination of antidepressants and psychotherapy.

GP = general practitioner, SPB = systolic blood pressure, CVD = cardiovascular diseases, LDL = low density lipoproteine, COPD = chronic obstructive pulmonary disease, BMI = body mass index, PCP = primary care practices, mMRC = Modified British Medical Research Council