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

<table>
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<tr>
<th>Country</th>
<th>Targeted chronic condition</th>
<th>Recommendations chosen as implementation objectives</th>
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| 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