



DANISH HEALTH
AUTHORITY

Preventive services for people with chronic diseases

Quality standards

Health for all ♥+●

Preventive services for people with chronic diseases
Quality standards

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Table of contents

Table of contents	3
1. Introduction	5
1.1. Background.....	5
1.2. Purpose.....	6
1.3. Definitions.....	7
2. Target group	8
2.1. Target group.....	8
2.2. Referral.....	8
3. Organisation	10
3.1. Clarifying conversation.....	11
3.2. Health education and skills in preventive services.....	12
3.3. Health equality.....	13
3.4. Differentiation and retention.....	14
3.5. End of course.....	15
4. Disease management	16
4.1. Target group.....	16
4.2. Content elements.....	16
4.3. Format, scope and duration.....	17
4.4. Other disease-specific considerations.....	18
4.5. Skills.....	18
5. Nicotine weaning	19
5.1. Target group.....	19
5.2. Content elements.....	19
5.3. Format, scope and duration.....	20
5.4. Particular disease-specific considerations.....	21
5.5. Skills.....	21
6. Physical activity	22
6.1. Target group.....	22
6.2. Content elements.....	22
6.3. Format, intensity, frequency and duration.....	23
6.4. Particular disease-specific considerations.....	24
6.5. Skills.....	25
7. Nutrition action	26
7.1. Target group.....	26
7.2. Content elements.....	27
7.3. Format, scope and duration.....	28
7.4. Particular disease-specific considerations.....	28
7.5. Skills.....	29
8. Preventive conversation about alcohol	30
8.1. Target group.....	30
8.2. Content elements.....	31

8.3. Format, scope and duration.....	32
8.4. Particular disease-specific considerations.....	32
8.5. Skills.....	33
9. Monitoring and quality development	34
9.1. Monitoring and quality development in municipal preventive services	34
9.2. Research.....	36
References.....	37
Appendix 1: Terms of reference.....	44
Appendix 2: Members of the working group.....	46

1. Introduction

1.1. Background

The Danish Health Authority's quality standards for municipal preventive services for people with chronic diseases contain quality requirements and recommendations directed at municipal healthcare services.

Quality standards for municipal preventive services for people with chronic diseases have been drawn up as part of the follow-up to the political 'Agreement on health reform' of May 2022. This states that the national quality plan, with its quality requirements and quality recommendations, should support the transformation of the healthcare system, e.g. including through geographically uniform availability and quality. The quality plan should also contribute to better health for the individual and thus delay or reduce the use of health services in later life.¹

The quality standards contain requirements regarding clarifying conversations, disease management, nicotine weaning, physical activity, nutrition action and preventive conversations about alcohol, as well as monitoring and evaluation of the overall preventive services offered. These are influential services, and municipalities already have knowledge and experience of providing them to residents with chronic diseases and those at risk of developing chronic diseases.

Quality standards for preventive services for people with chronic diseases have been produced on the basis of the Danish Health Authority's publication 'Recommendations for preventive services for people with chronic diseases' (2016) and therefore replace that publication. The quality standards aim to build on existing recommendations regarding chronic diseases, but they also take an innovative approach in order to meet current challenges and trends in the healthcare system.

The quality standards should be viewed in conjunction with the Danish Health Authority's recommendations on health promotion and prevention, care programmes and cross-sectoral recommendations, which have been published for a number of chronic diseases. The publications mentioned are a supplement to this quality standard.

The quality standards are not disease-specific, but rather address general preventive services. However, certain disease-specific matters may need to be taken into account in the individual services offered. These will be mentioned in the individual sections with reference to relevant guidelines etc.

In developing the quality standards, the Danish Health Authority has been advised by an external working group with members from a wide range of areas, which has made verbal and written contributions to the process. The terms of reference and membership of the working group are set out in Appendices 1 and 2.

Based on the Danish Health Authority's 'Recommendations for preventive services for people with chronic diseases' (2016), Local Government Denmark (KL) and the Danish National Institute of Public Health at the University of Southern Denmark monitored the services offered by the municipalities in 2017. They found that the vast majority of municipalities stated that the options they offer to people with chronic disease included the recommended services.² Municipalities are also continuously developing new preventive services and actions that they believe will benefit the municipality's residents in a prevention context.

¹ [Text of the 2022 agreement on health reform.](#)

² [Monitoring preventive services_2017. \(KLdk\)](#)

For example, a number of municipalities have established services to support residents with symptoms of stress, anxiety and depression.

Going forward, we may expect a need to build capacity in municipal preventive services. It is the individual municipality's responsibility to continually assess the need for the preventive services offered and to adjust them to the needs of the target group within the scope of the quality standard and available capacity.

The Danish Health Authority sets national quality standards, including quality requirements and recommendations, for health services that are managed by the municipalities based on authorisation granted by the Minister for the Interior and Health.³

The local authority is responsible for creating a framework for a healthy lifestyle and establishing preventive health services for its residents. In addition, the municipalities also have an obligation to establish preventive and health-promoting services directed at patients within the municipality.⁴

The Regional Council must offer preventive services directed at patients within the hospital service and practice sector, and must also advise with respect to the services provided by the municipalities.⁵

1.2. Purpose

The purpose of preventive services for people with chronic diseases is to provide people with insight, tools and a belief in their own abilities, which over time can lead to a better management of life with chronic illness(es), e.g. improved state of health, self-care and health behaviour.

The purpose of the quality standards is to ensure that people with chronic diseases are offered uniform and high-quality services. The quality standards are directed primarily at the municipalities, but can also be applied by general practitioners and hospitals when planning cross-sectoral patient pathways.

The quality standards are intended to enable differentiated actions based on the functioning, motivation and health literacy of residents so that the municipalities can focus and prioritise their actions in the best way possible. Digital solutions can be an integral part of preventive services, with the aim of providing differentiated and flexible options and greater geographical equality in terms of health.

Finally, the quality standards are intended to support the cooperation of municipalities with general practitioners and hospitals, which must refer patients to municipal prevention services. The quality standards support general practitioners and hospitals in referring to uniform services, and the quality standards are expected to be incorporated into regional care programmes.

³ See sections 118 b and 119 of the Danish Health Act.

⁴ See section 119 of the Danish Health Act.

⁵ See section 119(4) of the Danish Health Act.

1.3. Definitions

Chronic disease

A chronic disease is an illness that has a long-term course or is constantly recurring. There is considerable variation in the need for prevention and rehabilitation among people with chronic diseases.

Prevention

In the Danish Health Authority's publication 'Terminology – Prevention, health promotion and public health' (2005), prevention is defined as health-related activity that seeks to prevent the occurrence, development and/or worsening of diseases or psychosocial problems or incidents, thereby promoting public health.

'Preventive services for people with chronic diseases' refer to the municipal services that form part of these quality standards in the sense of prevention with the aim of rehabilitation, based on the concept of functioning (see below).

Rehabilitation

A number of different definitions of rehabilitation are used internationally. The Danish Health Authority aligns itself with the definition of the WHO and the Danish 'White paper on rehabilitation' (2022).

The WHO uses the following definition: "Rehabilitation is defined as 'a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment'."⁶

The 'White paper on rehabilitation' uses the definition: "Rehabilitation is aimed at people who experience or are at risk of experiencing limitations on their physical, mental, cognitive and/or social functioning and thus their everyday lives. The purpose of rehabilitation is to allow for a meaningful life with the best possible level of activity and participation, management and quality of life. Rehabilitation is a collaborative process between an individual, relatives, professionals and other relevant parties. Rehabilitation efforts are targeted, cohesive and knowledge-based, taking the individual's perspectives and entire life situation as a starting point."

Functioning

Functioning is a term for the ability that forms a person's basis for carrying out their everyday activities and participating in society. ICF (International Classification of Functioning) is the WHO's internationally adopted reference framework for functioning, disability and health. This biopsychosocial approach describes how all the elements interact and affect each other. Functioning comprises three components: body functions and anatomy, activities and participation. The components influence each other, and overall functioning is affected by environmental, personal and health factors.

⁶ [Rehabilitation \(who.int\)](https://www.who.int)

2. Target group

2.1. Target group

The target group for these quality standards is people with chronic diseases, e.g. diabetes, cardiovascular diseases, COPD, cancer and musculoskeletal disorders such as back and lower back pain. People with chronic diseases form a diverse group with varied needs, so the need for preventive services depends on the individual's functioning.

It is a requirement that the municipalities offer clarifying conversations, disease management, nicotine weaning, physical activity, nutrition action and preventive conversations about alcohol to residents with chronic diseases who may benefit from preventive services on the basis of a professional health assessment of their functioning and health situation.

It is a requirement that nicotine weaning and preventive conversations about alcohol are also offered to residents who are motivated to change their consumption – regardless of whether they also have a chronic disease.

It would be beneficial for the municipalities to use the physical activity and nutrition action services for other residents who, based on a professional health assessment of their functioning and health situation, are at risk of developing a chronic disease and may therefore benefit from a preventive service. If someone is considered to be at risk of a chronic disease, this person may benefit from one or more of the services described in the quality standards, potentially preventing or delaying the onset of the illness. The sooner this person gets started with e.g. physical exercise, better nutrition and stops smoking, the greater the chance of delaying the illness. The services may also increase a person's ability to live a good life with a high quality of life if they do develop a chronic disease. Services for people with chronic diseases and those who are at risk of developing a chronic illness may be organised in tandem in order to create sustainable professional units.

2.2. Referral

On the basis of a health assessment, hospitals, medical specialists and general practitioners must refer individuals in the target group for a clarifying conversation in the municipality (see section 3.1). The referral must specify the background against which the referral is being made. Electronic referral must be used in accordance with the applicable national standard.^{7,8}

In many cases, there is no need for a medical assessment in order to determine whether the individual will benefit from a preventive service. The individual should therefore also be able to make contact or be referred for a clarifying conversation by other municipal administrative areas, such as a job centre in contact with the target group.

⁷ MedCom referral standard XREF15 and discharge note XDIS15 are directed at communication to and from municipal preventive services. The standards are used by general practitioners, municipalities and regional hospitals.

⁸ An actual agreement on referral is not part of the general practitioners' collective agreement.

The municipalities must also support local general practitioners' awareness of the municipal services directed at residents with chronic diseases via sundhed.dk (SOFT portal).

The municipality must contact the individual for a clarifying conversation as soon as possible after the individual has been referred or has made contact.

The referring party (general practitioner, specialist or hospital) must receive a message from the municipality stating the services offered to/implemented for the referred individual. In the case of individuals who have made contact themselves and made use of services, a notification must also be sent to the general practitioner. The message requires the consent of the individual.

3. Organisation

The preventive services should be seen as stand-alone services, but can also constitute sub-elements in a wider rehabilitation effort. It is important to coordinate across municipal administrations, e.g. between the employment sector and the health sector, in cases where parallel rehabilitation services are in place for the same resident. There will be residents who, in parallel with municipal services, are in contact with their general practitioner, specialist or hospital. Mutual awareness is therefore required in order to coordinate the individual's needs.

The preventive services are not generally disease-specific and can be used in a broad target group of people with chronic diseases and those at risk of developing a chronic disease. This makes it possible for the municipalities to put together group courses even when only a small number of residents with the same disease are in need of the service. Some intervention areas include disease-specific elements, and these must therefore be tailored to people's individual diseases. When there is a sufficient volume of residents with the same disease, it is possible to establish disease-specific group courses. If there is a small group of residents who need the same service with disease-specific elements, collaboration on these services can take place across different municipalities. In addition, as part of solving potential capacity challenges, the municipalities can also purchase courses from external suppliers either individually or across multiple municipalities.

Some people will require multiple parallel services, see figure 1. This means that the various services offered to a resident must be considered and organised jointly in order to accommodate people with complex problems such as multimorbidity.

Figure 1 shows an overview of municipally provided preventive services and related primary partners.

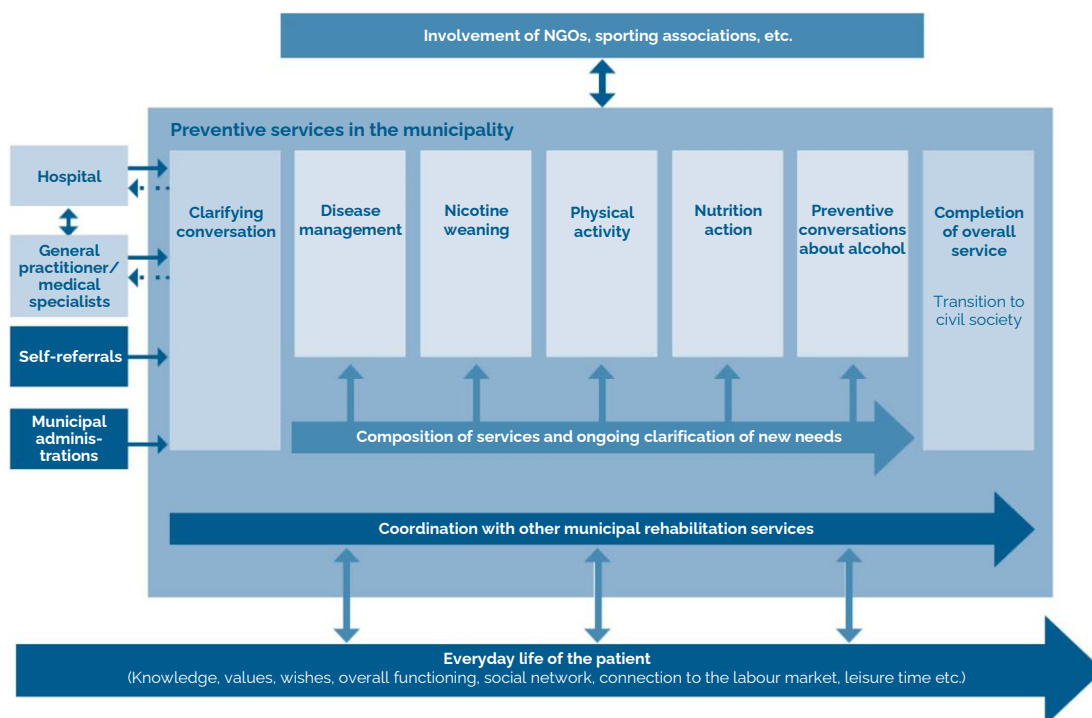


Figure 1: Illustration of municipal services and significant connections

3.1. Clarifying conversation

It is a requirement that the municipality offer a clarifying conversation to residents with chronic diseases who are referred by general practitioners, medical specialists, hospitals or other municipal administrative areas in contact with the target group.

It is recommended that the municipality offer a clarifying conversation to residents with chronic diseases who initiates contact to ask for a preventive service.

If a resident requires a preventive conversation regarding alcohol or nicotine weaning, they should not initially be referred for a clarifying conversation but should be referred instead directly to the preventive conversation about alcohol, actual alcohol treatment or nicotine weaning.

The clarifying conversation is the starting point for planning the pathway for the individual. The purpose of the clarifying conversation is to reach a shared understanding of what is important to the person, the objectives of participating in the courses, their motivation and to support them through dialogue in order to prioritise in a relevant and needs-oriented way.

The professional health assessment of functioning, health literacy and health situation in the clarifying conversation is crucial in determining which services will be offered to the individual and how they will be organised (see section 3.4).

The clarifying conversation is organised on the basis of the Danish Health Authority's '*Recommendations for needs assessment in the clarifying conversation*' (2019).

The conversation must be balanced so that it is systematic in achieving a thorough clarification, but must also be based on the individual person's wishes and challenges. The form and content of the conversation must satisfy the health literacy, social relationships and life circumstances of the individual, as well as their physical and mental limitations.

Regardless of the specific method or conversation tool selected, the clarifying conversation must thoroughly cover four overlapping areas:

1. *Functioning*
Clarification of the barriers that are particularly relevant to the person and what resources or challenges they may have.
2. *Everyday life*
Describing and forming a mutual understanding of the person's health literacy, everyday life, working situation, social network, habits, values and priorities that are relevant to their wishes, illness and prevention. At this stage, the conversation should already cover how the person will maintain the changes to their everyday life after the end of the course.
3. *Risk factors*
Identification of risk factors such as smoking, alcohol, physical inactivity, unhealthy diet and poor mental health, particularly those risk factors that directly aggravate a specific disease and/or lessen the effect of rehabilitation. Information about the interaction between risk factors is included in the dialogue on the services to be prioritised. For example, there are many interactions between alcohol and tobacco, and it is therefore appropriate to discuss changes in both areas if they are both being consumed at the same time.

4. *Disease situation*

Covering the specific nature, comorbidity and psychological consequences of the individual disease, its expected progression and the potential future course of treatment including a dialogue about the person's own knowledge and understanding of the disease, handling of the disease and course of treatment, and about supportive relationships in connection with the disease.

The conversation concludes with the healthcare professional and the individual working together to set objectives for the individual, a concrete and realistic plan and how those objectives can be achieved, e.g. by participating in relevant municipal services with attendance, digital courses private or communal activities or the person signing up to their own exercise regime. The clarifying conversation must consider how the person can continue making change, e.g. by joining a club, and who in their network it would be relevant to involve.

The structure of the clarifying conversation may take inspiration from the following:

- Recommendations for needs assessment in the clarifying conversations, Danish Health Authority.
- Experience gathering: Tools and methods for needs assessment, Steno Diabetes Center Copenhagen.
- CHAT, a tool for dialogue on health literacy, Institute of Public Health, Aarhus University.
- Conditions in FSIII ('shared terminology') under the health promotion and prevention function area.
- PRI (patient reported information); a tool for covering needs and for citizen engagement and preparation in connection with clarifying and subsequent conversations.

3.2. Health education and skills in preventive services

Health education is central to preventive services, and is regarded in this quality standard as a cross-disciplinary element that must be included in both the clarifying conversation and the individual services for disease management, nicotine weaning, physical activity, nutrition action and the preventive conversation about alcohol.

A basic condition in the work of providing preventive services for people with chronic diseases is an understanding that this is a collaborative process between the individual person, their relatives, healthcare professionals, civil society and other relevant parties. The individual is an expert in their own life, and the preventive services must always be based on their motivation, wishes and goals for their day-to-day life.

Different people may have very different levels of insight into the disease situation and may be at different points in the realisation process of living with a chronic disease. It is important that healthcare professionals work with individuals in order to provide an insight into the importance of the individual's own actions, opportunities for change and options for help and support.

Initiating change processes in the individual person requires the healthcare professional to have knowledge about and expertise in the following **core health education concepts**:

- Participation and involvement
- Motivation
- Agency and health literacy
- Information and insight
- A broad and positive concept of health
- Health from a setting perspective.⁹

It is the responsibility of the healthcare professional to focus on the individual person, bring (new) information to the conversation or group discussions and, through dialogue and exchanges of experience, to support the person's wishes, possible actions, motivation, priorities and motives.

Changing behaviours is often a long process, during which the forces driving the person's behaviour are constantly in flux and can change in nature. For this reason, it is important to continually investigate and understand the person's priorities and wishes, and to understand that people have very different circumstances and that it is therefore important to be able to take a differentiated approach to each individual person.

It is a requirement that those carrying out the clarifying conversation be healthcare professionals with appropriate skills¹⁰ and with a knowledge of and familiarity with the following:

- What it means to have a chronic disease in terms of the biological course of the disease, the individual person's understanding of the disease and the management of treatment.
- The significance of risk factors for disease and prognosis.
- Information about behavioural change and why change can be challenging, as well as information about how to support and maintain change.
- Pedagogical skills in health and adult education, so that the conversations and pathway can be organised based on the person's needs and motivation.
- Determination of the person's health literacy in relation to the extent of further preventive services.

In order to underpin the quality of the services, healthcare professionals conducting the clarifying conversation and courses for the individual preventive services should have the opportunity for regular dialogue with colleagues who also have the skills, knowledge and experience to carry out the tasks. Healthcare professionals should also be able to enter into dialogue with specialists, e.g. specialised physiotherapists or clinical dietitians at the hospital, if necessary.

3.3. Health equality

There are differences between who participates in preventive and rehabilitation services, and residents with lower health literacy take part less and drop out more frequently. The municipality should therefore work together with hospitals and general practitioners to provide support for all residents to participate, regardless of their level of health literacy. This particularly applies to residents with lower health literacy.

⁹ A setting perspective means that support for a person must be provided on the basis of an understanding and consideration of the everyday life lived by the person, the surroundings that the person is part of and their relationships.

¹⁰ In principle, skills equivalent to a professional healthcare qualification at the medium-length higher education level. Healthcare professionals who do not have a professional healthcare qualification at the medium-length higher education level, e.g. social and healthcare assistants, may fulfil the skills requirements via their basic training, supplemented by other relevant upskilling if appropriate.

A population-based approach can help ensure that those with chronic disease who have the greatest need have better access to preventive services and have a better retention rate within the courses. This means that the municipality should monitor which groups of residents take part in the courses and which do not. There may be a number of reasons for not participating, and those reasons must be identified so that work can be done to improve adherence. Such reasons may include access, communication, mistakes in the transfer between sectors or some residents not regarding the course as relevant.

It is recommended that work be done on organisational health literacy in order to address local challenges caused by lack of participation among some target groups.¹¹

3.4. Differentiation and retention

It is a requirement that the organisation of preventive services be differentiated on the basis of the individual's health literacy, preferences, motivation, resources, needs and available data. This differentiation is intended to help provide all residents with the same preconditions for deriving a positive effect from the services, regardless of differences in the way they are organised.

The preventive services may be offered through e.g. physical attendance, digital sessions, private or group activities or guidelines for a personal exercise regime, depending on the individual's needs and health literacy.

The municipality should use available data, e.g. via 'Health data across sectors' (see section 9.1), to identify target groups with different needs and thereby support a more systematic differentiation of the service based on the individual person's needs and health literacy.

The services should be organised with a focus on retaining those with the greatest needs, i.e. residents who have chronic diseases that impact on their functioning and who lack social networks and have lower health literacy, making it harder for them to live a life with a chronic disease. For instance, municipalities could provide services that are physically located close to those with the greatest need.

If residents do not attend appointments, the municipality can investigate the reasons for this. Residents who drop out of a course can be contacted for a dialogue about their reasons for dropping out and to give them information about their options for getting help again.

¹¹ Organisational health literacy is the way in which health services, organisations and systems make information and resources available to people with different levels of health literacy. See the publication 'Health literacy in the Danish healthcare system' (Danish Health Authority, 2023) for more information about the work of addressing inequality of participation in health services.

3.5. End of course

It is a requirement that the individual course be evaluated. The status must be sent to the person's general practitioner with consent from the individual. The person must be informed that their general practitioner may be contacted if the need arises in the future.

It is a requirement that active support be provided in order to continue and maintain the effect of the course after it has ended. At the start of the course, the focus might be on e.g. how the person can continue their activity elsewhere after the course has ended, and advice might be provided on participation in sports clubs, evening classes, voluntary social associations, patient associations, with private providers, social economic enterprises, etc.

It is recommended that the municipalities maintain close and ongoing cooperation with relevant local organisations and associations in civil society to provide them with support, including knowledge and skills to make their activities attractive for residents who are discharged from municipal preventive services.

4. Disease management

The purpose of disease management is to reinforce self-care among residents and thus improve their state of health and quality of life, enabling them to live a life with one or more chronic diseases in the best way possible.

Disease management refers to a structured health education service to support residents in their understanding of life with chronic disease and in taking an active part in managing their disease. This is a continuous process and an integral part of the overall preventive service, which takes place through an active interaction between residents and healthcare professionals.

Management strategies are the strategies and approaches that a person uses to manage new, difficult or possibly unpleasant situations, as well as changes in physical, psychological or cognitive function and the emotions that result.

4.1. Target group

It is a requirement that the municipalities offer disease management to residents with chronic diseases who may benefit from this on the basis of a professional health assessment of their functioning and health situation.

4.2. Content elements

When organising the courses, attention should be paid to adapting them as far as possible to the needs, knowledge, experience, challenges and resources of the individual person. As far as possible, it should be taken into account that some groups of residents may need special consideration or training related to e.g. age, gender and ethnicity, as well as the number and combination of chronic diseases or mental challenges, in addition to the ability to participate at different times of day.

The focus must be placed on involving the person in managing their chronic disease with a view to increasing the person's self-care, and on working with the person's motivation, self-belief, own resources and ability to manage the disease. This includes giving the person the insight and skills they need to set their own goals and choose what results they want to achieve.

In addition, attention should also be paid to residents with more than one chronic disease and how the courses are organised – including in terms of disease management.

It is a requirement that the following elements be included in the training:

- **Understanding of the disease:** A review and discussion of the disease(s), along with risk factors and the associated disease progression.
- **Disease worsening:** Signs of worsening or fluctuations in the intensity of the disease and the prevention and early treatment of these. A dialogue about how the person is keeping an eye on their condition, both on their own initiative and potentially together with others, with the help of symptoms/observations or relevant measurements, plus relevant responses to changes in their condition.

- **The significance of other preventive services:** The significance of sleep, alcohol, nicotine dependence, physical activity and exercise, and a healthy diet and stable weight, including prevention of unplanned weight loss or weight gain.
- **Mental health:** Management of symptoms such as depression, irritation, fatigue, agitation, panic and isolation. Information about normal mental reactions. Information about symptoms of conditions requiring treatment, such as anxiety and depression. Information about how to get help to treat mental conditions, if needed. Training in relaxation techniques, e.g. breathing and cognitive techniques such as tools for handling intrusive thoughts. Review of the possible psychosocial support options and help options that may come under consideration, including facilitating contact with relevant networking events, including those offered by patient associations etc.
- **Social circumstances:** Dialogue on the importance of starting/staying in education and work and of maintaining/getting started with leisure activities. Working with other public officials on relevant needs related to family, education and employment. Teaching the importance of social relationships and networks and how better to gain support and understanding through openness and dialogue with close friends and family.
- **Managing the disease in everyday life:** Dialogue about the effect of the disease on functioning and state of health and how most appropriately to manage daily physical and social activities and challenges. Management of pain, if any. Reviewing techniques for coping in everyday life despite disability, including methods for conserving energy and guidance on available assistive devices. Discussion of the individual's own experience and vision for the future. This includes life with a partner, family life and sexual health and well-being.
- **Relatives:** The significance of being a relative with difficult emotions and thoughts. The individual's closest relative may, on the individual's own terms, be included in the training to support and manage their everyday life as a relative. Sharing of experiences with other relatives. Information about where a relative can get help if they develop anxiety, stress and depression.

4.3. Format, scope and duration

It is recommended that the training be provided in smaller groups so that participants can benefit from discussing and sharing experiences of common problems and suggested solutions. If possible, the training can be disease-specific or supplemented with individual training if needed. Support for disease management can also be provided digitally, e.g. through distance learning if this is considered appropriate.

It is recommended that classes consist of at least four one-hour lessons, and that individual training consist of at least 2–4 lessons lasting approximately 30 minutes each, with repetition of key messages and incremental acquisition of knowledge and skills.

It is recommended that relatives be included in the training on the individual person's own terms, firstly because a person's illness can often affect the whole family/network and their relationships with each other, and secondly to strengthen their ability to support the person in the day-to-day management of the disease through insight and knowledge of the disease. At the same time, attention should be paid to any negative relationships and possible psychological consequences for relatives.

4.4. Other disease-specific considerations

The training must provide the person with information about the nature of the specific disease and the options in terms of prevention, treatment, rehabilitation and palliative care.

4.5. Skills

It is a requirement that those providing the training be healthcare professionals with appropriate skills¹² and have the necessary qualifications in health and adult education to be able to teach according to the needs and background of the participants. The healthcare professional must have a basic knowledge of the diseases in question and knowledge of any particular disease-specific considerations.

It is recommended, as a supplement to the disease-specific training, that the training include educators who themselves have experience with chronic disease, are familiar with living with illnesses on a day-to-day basis and have taken instructor training equivalent to the 'Lær at Tackle' (Learn to Tackle) training programmes.

¹² In principle, skills equivalent to a professional healthcare qualification at the medium-length higher education level. Healthcare professionals who do not have a professional healthcare qualification at the medium-length higher education level, e.g. social and healthcare assistants, may fulfil the skills requirements via their basic training, supplemented by other relevant upskilling if appropriate.

5. Nicotine weaning

Nicotine is a highly addictive substance that affects the brain and nervous system. Nicotine dependence means that the brain is accustomed to receiving a constant supply of nicotine. Attempting to wean oneself off nicotine can lead to withdrawal symptoms such as restlessness, irritability, depression, lack of concentration, etc.

Tobacco smoking is the single factor with the greatest effect on mortality. Smoking increases the risk of a wide range of diseases, especially lung cancer, chronic obstructive pulmonary disease (COPD), cancer and cardiovascular diseases, while also aggravating the prognosis for a wide range of diseases.

Tobacco smoking is the risk factor with the greatest potential for prevention – both before and after the individual has had a tobacco-related illness.

5.1. Target group

It is a requirement that the municipalities offer nicotine weaning to residents who use tobacco and nicotine products, including cigarettes, pipes, cheroots, waterpipes, heated tobacco, e-cigarettes and smoke-free nicotine products (snus, chewing tobacco, nicotine pouches, etc.) on a daily or occasional basis and who wish to give up.

5.2. Content elements

It is a requirement that the nicotine-weaning service contain advice that includes the following elements:

- Information on the importance of setting a cessation date.
- Information about dependence, the significance and progress of withdrawal and the nicotine-weaning process.
- Guidance on how to use nicotine-withdrawal medicine, including advice on ramping down the medicine.
- Systematic and correct use of validated testing, and carbon monoxide measurement if applicable, to assess the degree of nicotine dependence.
- Information about maintaining motivation and staying off nicotine after quitting.
- Help with managing risk situations, relapses, stress, mood swings, etc.
- The importance of appropriately regulating sleep, fluid balance, breathing, physical activity, etc.
- General nutritional challenges of nicotine weaning, including the importance of blood sugar balance and preventing weight gain.
- Information about the significance of smoking and nicotine for health.

Because nicotine dependence follows the same withdrawal pattern regardless of which nicotine products are used, these content elements apply to weaning off all types of tobacco and nicotine products.

It is a requirement that guidance on the use of nicotine-withdrawal medicine be included in the advice. Approved nicotine-withdrawal medicine is effective on its own, but the effect is greatest in combination with advice. The nicotine-withdrawal medicines approved in Denmark include two types of products: over-the-counter nicotine-withdrawal medicines and prescription nicotine-withdrawal medicines. The individual must always receive comprehensive advice on over-the-counter nicotine-withdrawal products, including a recommended dose based on the individual's level of dependence, how long they should be

used for and a phasing-out plan. Product advice is initially provided at the pharmacy, but may also be provided via a municipal advisor, for instance. The use of prescription nicotine-withdrawal medicine requires advice from a general practitioner.

5.3. Format, scope and duration

Nicotine weaning can be done in groups, individually or in a combination of group and individual pathways. Smaller groups can be beneficial when it comes to people with particular requirements (e.g. pregnant women) or particularly vulnerable target groups (e.g. people with mental health disorders). In addition to courses involving physical attendance, municipalities can also offer virtual and/or telephone courses. If a municipality does not have the capacity to set up nicotine-weaning services itself, these may be purchased from external suppliers.

Both short-term advice and longer, more intensive cessation support programmes can help with nicotine cessation. However, the effect increases with intensive cessation support programmes corresponding to courses in line with the Danish Cancer Society manuals.

The specific scope and format of nicotine weaning is determined in an initial interview with the individual person, during which the advisor should initially recommend an intensive nicotine-weaning programme that includes the content elements described.

Nicotine weaning should begin as soon as possible after the initial interview. If a person needs to wait more than 14 days from the initial interview until an actual cessation course begins, regular follow-ups should take place during the intervening period to support the person in maintaining their motivation to quit nicotine until the cessation course is initiated. The type of follow-up that best suits the individual person will be determined at the initial interview but it could, for instance, be telephone conversations or brief online meetings.

It is recommended that both group pathways and individual pathways be organised as intensive courses, e.g. following the Danish Cancer Society manuals 'Røgfrit liv – rygestop i grupper' (Smoke-free life – quitting smoking in groups) and 'Røgfrit liv – individuelt rygestop' (Smoke-free life – quitting smoking individually).

If the person is prevented from taking part in an intensive course, or if the person needs a more flexible course (e.g. the 'Kom & Kvit' (Come & Quit) format), the recommendation is to follow an advice pathway in which the person is offered as many of the described content elements as possible, including guidance on nicotine-withdrawal medicine.

Studies have shown that reducing nicotine consumption increases the chance of initiating a cessation attempt later on. Therefore, reducing nicotine consumption can be recommended as part of a process ultimately leading to nicotine cessation if the person is not yet ready to give up completely. A person can reduce their consumption while also using over-the-counter nicotine-withdrawal medicine. For people who are reducing their consumption but do not want to undergo nicotine weaning or who have relapsed after a cessation attempt, the recommendation is to follow up with information and opportunities to get help (again) to initiate nicotine weaning.

It is recommended that, in order to monitor the service, municipalities use the forms provided by STOPbasen to record data on the resident's progress with quitting, including data on the type of cessation course, the use of nicotine-withdrawal medicine and whether the resident was successful in their nicotine cessation.

STOPbasen contributes to the evaluation, quality assurance and visibility of municipalities' nicotine-weaning services. STOPbasen is currently used by 95 municipalities, and the data also contributes to research.

5.4. Particular disease-specific considerations

When stopping smoking, the metabolism of certain medicines may be affected; for instance, certain psychopharmaceuticals can be metabolised significantly more rapidly in the body if a person smokes, so quitting smoking can therefore cause the concentration of psychopharmaceuticals in the body to rise to levels that produce strong side effects. For people who wish to quit smoking and are using psychopharmaceutical medications, it is therefore very important to involve the doctor treating them in order to get the doctor's assessment as to whether the dose of psychopharmaceutical medication needs to be reduced in parallel with nicotine cessation.¹³

5.5. Skills

It is a requirement that the advisors be familiar with the current recommendations of the Danish Health Authority for the treatment of nicotine dependence and have the skills to provide qualified advice on the content elements of nicotine weaning.

It is recommended that advisors on individual pathways have skills equivalent to those obtained through participation in the 'Basic course: Individual advice on quitting smoking', and that advisors on group pathways have skills equivalent to those obtained through participation in the 'Basic course: Advice on quitting smoking in groups'. Both basic courses have been developed and are offered by the Danish Cancer Society.

It is recommended that advisors on nicotine-weaning services for individuals in vulnerable positions (e.g. those with severe mental illness, those with abuse issues and those who are vulnerable as a result of homelessness) have a healthcare or educational background and that, in addition to their teaching skills for standard individual or group pathways, they also have skills equivalent to those obtained through participation in 'Quitting smoking for people in socially vulnerable positions', which is offered by the Danish Cancer Society.

The advisor should be able to support the person with disease-related issues and should therefore have ongoing access to disease-specific information from staff with relevant medical training. The general practitioner should be involved in the event of a request for prescription nicotine-withdrawal medicine.

¹³ [Smoking and smoking cessation among people with mental health disorders, Danish Health Authority 2022](#)

6. Physical activity

Physical activity is any kind of motion that increases energy conversion. Physical activity has beneficial effects on people's general health and reduces their risk of developing a wide range of diseases. Alone or in combination with e.g. medicine and nutrition action, physical activity can produce a specific effect and reduce symptoms in a range of chronic diseases.

6.1. Target group

It is a requirement that the municipalities offer a physical activity service (guidance on physical activity or supervised physical exercise) to residents with chronic diseases who may benefit from this on the basis of a professional health assessment of their functioning and health situation.

Supervised physical exercise is offered to residents who will benefit from it on the basis of a health assessment. This could be when it is appropriate due to the severity of the disease or the number of concurrent diseases, or in light of the resident's resources, needs or wishes. Finally, for some diseases, there is documented evidence that exercise produces the best effect if it is supervised.

Other residents in the target group are offered guidance on physical activity.

6.2. Content elements

The purpose of the service is to increase the person's level of functioning or physical capacity (fitness, muscle strength and/or balance), depending on their medical history, symptoms, risk profile and preferences. The purpose is also to teach the person how to exercise and how to remain motivated after the course has ended so that it has an effect over time.

The course is organised so that the person is supported in making physical activity a part of their everyday life, even after the course has been completed and for the rest of their life.

Guidance on physical activity

Guidance on physical activity focuses on the beneficial effects of physical activity and on how the person can be physically active in their everyday life, including what opportunities are provided locally by commercial providers or clubs, and how physical activity can be incorporated into the person's everyday life. The guidance must focus on what can motivate the person to be physically active, what options exist for being physically active and how the person can overcome any barriers.

A plan for how the person can be physically active in their everyday life must be drawn up, with goals and subsidiary goals agreed with the individual person. For people with disabilities or low levels of physical activity, it is particularly important to draw up a concrete plan with quantifiable physical activity targets that are evaluated on an ongoing basis. The person must be offered a follow-up interview where the plan is evaluated and adjusted if necessary with a view to staying the course.

Supervised physical exercise

In this context, supervised physical exercise should be understood to mean individual professional guidance and support related to physical exercise, which can be given in groups or individually. The exercise course is intended to provide the person with information about and an understanding of physical activity and exercise to prevent consequences from and aggravation of a chronic disease. In addition to increasing the person's physical functioning, the exercise course should provide them with an experience of their own physical capacity and the confidence to be physically active. The person should therefore receive help through the exercise course in finding a form of physical exercise that gives them motivation to continue exercising. This should be done by jointly drawing up an exercise plan with goals and subsidiary goals at the start and end of the exercise course.

The supervised training courses must be organised individually, taking into consideration the person's resources, preferences, health literacy and disease situation, and on the basis of the most recent available information and exercise recommendations for the relevant patient group. The focus of the course will vary between increasing fitness and/or muscle strength and balance if appropriate, depending on the person's starting point.

The training can consist of a combination of the following elements:

- Aerobic exercise (fitness training), e.g. cycling, running/jogging, walking/interval walking, aqua aerobics or rowing.
- Strength training, e.g. using machines, the person's own body weight, weights or resistance bands.
- Motor skills training, e.g. functional exercises or training of components of a skill.

In many cases, combining aerobic exercise and strength training can increase the effect of the exercise.

It is a requirement that testing be included as part of a supervised exercise course at the beginning and end of the course. The purpose of this testing is to determine the starting point for the exercise (type, intensity, duration) and to determine whether the exercise has had the desired effect. The purpose is also to set targets and to motivate the person by highlighting their progress. The type of test to be used is assessed on the basis of the person's disease, risk profile, personal circumstances and preferences, as well as any professional guidelines.

If nutrition action is being taken at the same time, it is important to take this into account when planning exercise, as training without focusing on nutrition at the same time can aggravate symptoms. This is particularly important for people with unplanned weight loss because exercising without focusing on nutrition at the same time can lead to further weight loss.

6.3. Format, intensity, frequency and duration**Guidance on physical activity**

Guidance on physical activity can be provided through a group-based course, or individually if necessary. Guidance on physical activity can also be provided digitally, e.g. through distance learning if deemed appropriate, while digital or telephone contact can be used as a supporting tool if this is required with respect to motivation and retention.

Supervised physical exercise

In principle, the exercise is done in groups with the possibility of individual supervision. Exercising in groups is beneficial because it provides the opportunity for participants to exchange experiences and can strengthen the person's motivation and help to create networks between participants. The composition of the groups is primarily based on the functioning of their members rather than on their disease. People with different levels of need for supervised individual exercise can be members of the same group. If

there is sufficient volume to create groups for people with the same illness, this can be done. The recommended number of participants in a group per instructor is six to eight.

The exercise course can be conducted in a variety of settings, e.g. in nature, or even digitally if this is considered appropriate, e.g. via a screen with direct supervision so people can exercise in their own homes or via a programme that the person must follow. It is important to be aware that the intensity, frequency and duration must be maintained and for tests to be carried out in the same environment and using the same equipment, at the start and end of a course.

It is a requirement that the supervised exercise be planned and structured with an appropriate intensity, frequency and duration in order to achieve the intended effect for the person in question. The exercise must be done at moderate to high intensity where possible based on an individual and patient safety assessment.

It is recommended that the exercise session last 30–90 minutes and take place two to three times a week. The duration of the course should be 6–12 weeks, with subsequent independent exercise, group exercise or supervised exercise as appropriate.

It is a requirement that, towards the end of a training course, a follow-up should be carried out including an interview and the same test as at the start of the course (see previous page). It must be determined in consultation with the person whether it is necessary to make adjustments to the exercise and what is required in order for them to continue exercising after the course has ended, including the locally available opportunities for continued training alone or together with others in a club or self-organised group. Finally, the person can be given guidance on how to continue the exercise at home via online programmes if this motivates them to exercise.

Experience shows that a follow-up service is beneficial in terms of supporting the person in maintaining the physical activity. The follow-up can take place around three months to one year after the end of the course. Digital or telephone contact can be used as a supporting tool if necessary for the purposes of motivation and retention.

6.4. Particular disease-specific considerations

There may be particular disease-specific considerations, which healthcare professionals must keep in mind. The course must therefore always be based on the current physical activity and exercise guidelines for a particular disease. There may be factors related to the disease that mean that care needs to be taken when doing physical exercise. In case of doubt, the person's general practitioner or treating hospital department should be contacted.

Examples of physical exercise guidelines for specific diseases:

- The Danish Health Authority's handbook on physical exercise as treatment and reports on physical activity for adults and elderly people.
- The Danish Health Authority's exercise guide for people with dementia.
- The Danish Health Authority's recommendations for cross-sectoral care, e.g. for people with heart disease, COPD, type 2 diabetes and chronic lower back pain.
- Clinical guidelines from professional associations.
- Regional programmes for chronic diseases and recommendations for physical exercise.

6.5. Skills

It is a requirement that the physical activity service (guidance on physical activity and supervised physical exercise) be performed by healthcare professionals with appropriate skills¹⁴ and with the skills to:

- Provide guidance on physical activity
- Organise, supervise and evaluate the exercise, including testing
- Advise on specific physical exercises tailored to the individual
- Advise the person on disease-specific questions relating to exercise, e.g. lack of confidence in exercise, based on a basic knowledge of chronic disease.

¹⁴ In principle, skills equivalent to a professional healthcare qualification at the medium-length higher education level. Healthcare professionals who do not have a professional healthcare qualification at the medium-length higher education level, e.g. social and healthcare assistants, may fulfil the skills requirements via their basic training, supplemented by other relevant upskilling if appropriate.

7. Nutrition action

Unsuitable food and meal habits can worsen chronic diseases and increase the risk of related illnesses. Both unplanned weight loss and severe overweight can have serious consequences for people with chronic diseases. Unplanned weight loss¹⁵ increases the risk of loss of functioning, disease complications and hospitalisation. Severe overweight¹⁶ increases the risk both of exacerbation of the chronic disease and of a wide range of diseases and conditions, complications resulting from them and hospitalisation. Both unplanned weight loss and severe overweight increase the risk of premature death.

Healthier food and meal habits can have a beneficial effect on a number of chronic diseases, e.g. by reducing symptoms, potentially in combination with medicine and physical activity.

7.1. Target group

It is a requirement that the municipalities offer a nutrition action service (dietary guidance or diet therapy)¹⁷ to residents with chronic diseases who may benefit from this on the basis of a professional health assessment of their functioning and health situation.

The service is differentiated based on the person's resources and needs. Dietary guidance is the first choice.

Diet therapy should be offered based on an initial assessment of the person's nutrition-related risk and their resources and needs (see section 7.2).

The Danish Health Authority recommends the diet therapy option for people in the following target groups:¹⁸

- people with a chronic disease, where the nutrition action is considered to be a significant part of the preventive service, i.e. primarily in cases of type 2 diabetes or cardiovascular disease
- people with a chronic disease and severe overweight
- people with a chronic disease and unplanned weight loss or malnutrition.

Special attention should be paid to people who have recently been diagnosed with a chronic disease for whom the nutrition action is considered to be a significant part of prevention services, as well as people with multimorbidity for whom diet therapy may be more complex.

¹⁵ Weight loss of at least 1.0 kg.

¹⁶ BMI ≥ 30 ; BMI is calculated by dividing weight (in kg) by the square of height (in m).

¹⁷ The Danish Health Authority uses the term 'nutrition action' as an umbrella term for services in the area of nutrition, including 'diet therapy' and 'dietary guidance'. Diet therapy is typically directed at individuals and patients with nutrition-related risks, including chronic diseases, while dietary guidance is typically directed at individuals who do not have nutrition-related risks.

¹⁸ See the Danish Health Authority's 'Recommendations for cross-sectoral pathways for people with type 2 diabetes' (2017), 'Recommendations for cross-sectoral pathways for people with heart disease' (2018), 'Recommendations for cross-sectoral pathways for people with COPD' (2017), 'Pathway programme for rehabilitation and palliative care relating to cancer' (2018), 'Malnutrition: Detection, treatment and follow-up of individuals and patients with nutritional risks' (2022), 'Basic information for recommendations for preventive services for people with chronic diseases' (2016).

7.2. Content elements

It is a requirement that the nutrition action should begin with an assessment of the nutrition-related risk. This must include an assessment of weight and BMI, including development over time, and must cover the person's knowledge, skills and motivation. The assessment will help to ensure that the person receives the right service (dietary guidance or diet therapy) and support in changing their food and meal habits.

The purpose of the nutrition action (dietary guidance or diet therapy) is:

- to strengthen the person's level of knowledge and understanding of the importance of their diet in preventing the exacerbation of the chronic disease and associated complications on the one hand, and the emergence of new lifestyle diseases on the other
- to identify and strengthen the person's motivation and agency in changing their food and meal habits
- to encourage the person to reflect on their own food and meal habits in relation to healthcare recommendations and their own values, goals and abilities
- to help the person to prioritise and set targets for their own actions in relation to changes in food and meal habits
- to support the person in maintaining the changes they have achieved in their food and meal habits.

Dietary guidance

It is a requirement that the dietary guidance be based on Denmark's 'Official Dietary Guidelines' and, if applicable, the additional dietary recommendations for people aged 65 and over.¹⁹ These will be supplemented with the applicable nutritional recommendations for the relevant patient groups.

It is recommended that the dietary guidance comprise an assessment of current food and meal habits, as well as advice on healthy food and meal habits, including choice of foods and composition of meals.

Diet therapy

Diet therapy follows the applicable nutritional recommendations for the chronic diseases in question and is based on the applicable guidelines and framework plans for nutritional and diet therapy.^{20, 21, 22, 23}

It is a requirement that diet therapy include:

- Diagnosis (including dietary history, assessment of needs and nutritional diagnosis)
- Nutritional therapy (including drawing up a nutrition plan and individual dietary guidance)
- Follow-up (including monitoring, evaluation and completion).

The nutrition plan is based on the person's needs and resources and establishes an appropriately composed diet, which should be supplemented with medical nutritional beverages and tube feeding if appropriate. The individual elements of the therapy must be documented and established with interdisciplinary cooperation as necessary.

¹⁹ [Over 65 years old – Danish Veterinary and Food Administration \(foedevarestyrelsen.dk\)](https://www.foedevarestyrelsen.dk)

²⁰ ESPEN Guidelines & Consensus Papers, <https://www.espen.org/guidelines-home/espen-guidelines>

²¹ National Clinical Guidelines (NKR), <https://www.sst.dk/da/viden/Sundhedsvaesen/NKR-og-NKA>

²² NICE Dietary Guidelines, <https://www.nice.org.uk/search?q=dietary+guidelines>

²³ Framework plans for nutritional and diet therapy, Danish Professional Society of Clinical Dietitians, <https://kost.dk/fakd/rammeplaner>

When a patient is also receiving a physical activity service, this must be taken into account in the nutrition action service. For people with unplanned weight loss, a physical activity service should be combined with a nutrition action service because exercising without focusing on nutrition at the same time can lead to additional weight loss.

'Cooking in practice'²⁴ in groups can support both dietary guidance and diet therapy.

7.3. Format, scope and duration

Dietary guidance

Dietary guidance can be provided through a group-based course, or individually if necessary. Support for dietary guidance can also be provided digitally, e.g. through distance learning if deemed appropriate, while digital or telephone contact can be used as a supporting tool if this is required with respect to motivation and retention.

Diet therapy

It is a requirement that diet therapy consist of a service that is individually tailored to the person's needs. It may include individual and group-based elements, e.g. linked to the preparation of a nutritional plan and individual dietary guidance.

It is recommended that the diet therapy pathway consist of regular follow-up interviews with the person at least every two to three months, as well as telephone contact between these interviews if appropriate. The person's need for continued diet therapy will be assessed after no more than 12 months.

It is recommended that the first interview be held in person in order to assess body composition and identify any other physical and mental signs. If it is difficult for the individual to attend in person, the service can be carried out digitally. The initial assessment must be relatively long in duration and the follow-up interviews may be relatively short, depending on the person's needs and condition. Follow-up interviews can be conducted digitally if deemed appropriate, while digital or telephone contact can be used as a supporting tool if this is required with respect to motivation and retention.

7.4. Particular disease-specific considerations

People with unplanned weight loss and malnutrition are at high risk of disease and (re)hospitalisation for many different reasons. There are no general nutritional recommendations for the service, so personalised diet therapy is essential. These individuals will also often need their diet therapy to be provided individually.

In cases of multimorbidity, special considerations are also required in the nutrition action service. The service is based on an individual assessment of the person's needs and should involve healthcare professionals who can ensure that it is a multidisciplinary service that takes account of the special considerations and concerns.

²⁴ See FSIII initiatives (section 119 of the Danish Health Act).

The nutrition action service (dietary guidance and diet therapy) is based on descriptions of nutritional considerations for specific diseases, see the guidelines below, among others:

- The clinical guidelines from the Organisation of Danish Medical Societies
- National and European clinical guidelines, including those from ESPEN
- The Danish Health Authority's national clinical guidelines
- The Danish Health Authority's recommendations for cross-sectoral care, e.g. for people with heart disease, COPD, type 2 diabetes and chronic lower back pain
- The framework plans for nutritional and diet therapy from the Danish Professional Society of Clinical Dietitians
- The Danish Health Authority's guidelines 'Malnutrition: Detection, treatment and follow-up of individuals and patients with nutritional risks'
- 'Recommendations for the Danish institutional diet' from the Danish Veterinary and Food Administration and the Danish Health Authority
- 'The National Diet Handbook' from the Danish Diet and Nutrition Association, the Danish Veterinary and Food Administration and the Danish Health Authority, with specific food and drink choices.

7.5. Skills

It is a requirement that the initial assessment of the nutrition action services that the individual person needs be carried out by healthcare professionals and/or nutrition professionals with appropriate skills.²⁵

It is a requirement that dietary guidance be provided by healthcare professionals and/or nutrition professionals with appropriate skills.²⁶

It is a requirement that diet therapy, whether it is individual or group-based, be performed by healthcare professionals with skills similar to those of a certified clinical dietitian.

²⁵⁻²⁶ In principle, skills equivalent to a professional healthcare qualification at the medium-length higher education level. Healthcare professionals who do not have a professional healthcare qualification at the medium-length higher education level, e.g. social and healthcare assistants, may fulfil the skills requirements via their basic training, supplemented by other relevant upskilling if appropriate.

8. Preventive conversation about alcohol

Alcohol is a substance that affects virtually every organ in the body. High alcohol consumption increases the risk of premature death and of more than 200 diseases, including several cancers, liver disorders and diseases of the digestive system. It also affects mental health, and high alcohol consumption can lead to dependence and to major social, family and societal consequences.

For these reasons, the municipality must offer preventive conversations about alcohol to residents who are referred by general practitioners, hospitals or other municipal administrative areas where early detection of and conversations about alcohol take place.

Early detection and conversations with residents who have alcohol problems can take place where there is opportunity to talk about alcohol with respect for the resident's openness to talk about it. This will naturally be in places where municipal employees meet residents directly, e.g. social services, job centres, healthcare, home care, care homes and health centres. A conversation about alcohol can of course form a natural part of individual conversations with residents who first come to the municipality to discuss health-related problems.

The Danish Health Authority's advice and implementation materials for supporting the municipalities in early detection and dialogue about alcohol with residents can be found on the Danish Health Authority's website: [Dialogue about alcohol – advice and implementation material – Danish Health Authority](#)

The classification of alcohol problems uses the following definitions:

- Excessive alcohol consumption: consumption is higher than the Danish Health Authority's recommendations of no more than 10 units per week for both women and men
- Harmful alcohol consumption: consumption that has caused physical or mental harm (including impaired judgement and behaviour) and has lasted at least one month or taken place repeatedly within one year, where the person does not meet the diagnostic criteria for alcohol dependence (International Classification Diagnosis System (ICD-10))
- Alcohol dependence: a combination of physiological, attitudinal and cognitive disorders associated with alcohol consumption where the use of alcohol has achieved a dominant place in the person's everyday life (the diagnostic criteria can be found in ICD-10).

8.1. Target group

It is a requirement that municipalities offer preventive conversations about alcohol to residents who may benefit from this on the basis of a health assessment.

The target group is people with excessive or harmful alcohol consumption. However, there may also be residents who drink less than the unit limit but still have a problematic alcohol-drinking pattern and may benefit from the service.

Preventive conversations about alcohol are offered directly, without a prior clarifying conversation, to residents who wish to change their alcohol consumption and habits because it is important quickly to address the motivation that exists to change their behaviour. During the pathway, a clarifying conversation may be offered if it is found to be necessary. A preventive conversation about alcohol may also be arranged on the basis of the clarifying conversation.

8.2. Content elements

Screening

It is a requirement that the preventive conversation about alcohol be initiated with a screening tool, illustrated below using AUDIT (Alcohol Use Disorder Test).

The AUDIT form can be found on the Danish Health Authority's website: [Dialogue about alcohol – advice and implementation material – Danish Health Authority](#)

The results of the screening provide guidance for which service should be offered to the individual person:

- If the person scores 8–15 on the AUDIT form, the screening indicates excessive consumption. If the person scores 16–19, this indicates that harmful alcohol consumption is likely. In either case, a preventive conversation about alcohol is offered.
- If the person scores 20 or more on AUDIT or if the person also has a mental health disorder in parallel with excessive or harmful consumption of alcohol, they will be referred for alcohol treatment. The person will be informed of the alcohol treatment options and the basic rules of alcohol treatment, e.g. rules regarding freedom of choice, free treatment, option of anonymity, etc. Information on local voluntary support organisations will also be provided.

For people with alcohol dependence and a mental health disorder, special care should be taken to inform the treating doctor of the result of the screening, with the person's consent, regardless of whether it is carried out at the hospital or by a general practitioner and regardless of whether the person was referred or requested the preventive conversation about alcohol.

If the person screens as positive for harmful consumption or alcohol dependence and is also pregnant, they should be referred, with their consent, to the region's family outpatient clinic and to the alcohol treatment centre. There will also normally be grounds for notifying the municipality's child and family department.

Preventive conversation about alcohol

The purpose of the preventive conversation about alcohol is to provide advice and support for appropriate behaviour with alcohol, including increasing the person's self-care, and to advise and support them on how to achieve changes in alcohol habits.

A preventive conversation about alcohol requires an empathic and non-moralising form of conversation, ideally using techniques from 'The Motivational Conversation'.

It is recommended that the preventive conversation about alcohol contain several (or all) of the following elements:

- A brief examination of the nature of the alcohol problem
- Information about the potential role of alcohol consumption in the problems the individual person has, including physical and mental health, family life, children's well-being, working life, quality of life, etc.

- The effect of alcohol on everyday life, including family, networking, work, etc.
- Health risks associated with alcohol consumption
- Effects on the body from drinking alcohol
- Increase in motivation to reduce consumption
- Drawing up goals for reduction and possible cessation
- Recommendation of continuous monitoring of alcohol intake (diary) if reduction rather than cessation is chosen
- Dialogue and possible advice on specific reduction or cessation strategies
- Seeking of support where necessary
- Offer of follow-up.

If the person has a very high level of alcohol consumption, a medical assessment of the potential need for withdrawal treatment may be required before the process of alcohol cessation is initiated. A medical assessment may also be required to determine whether they will benefit from additional medicinal treatment. In either case, they will be referred to their general practitioner or to a doctor associated with an alcohol treatment centre.

8.3. Format, scope and duration

It is recommended that the preventive conversation about alcohol be offered both in person and virtually, with the option to hold it outside normal working hours.

It is a requirement that the preventive conversation about alcohol be held individually.

It is recommended that a follow-up conversation be offered after the preventive conversation about alcohol. A single conversation is often enough for the person to reduce their consumption themselves or contact an alcohol treatment centre for help with doing so, but follow-up conversations may also be needed.

If the conversation has not achieved a sufficient effect, there may be a need to refer the person to an alcohol treatment centre for alcohol treatment. This also applies if the person is ambivalent and their motivation to change their alcohol consumption needs to be determined. In such cases, it may also be beneficial to involve relatives.

8.4. Particular disease-specific considerations

People with mental health disorders will be referred for alcohol treatment.²⁷ People receiving medicinal treatment should discuss their medication with their doctor when making major changes to their alcohol consumption because the effect of some medicines is affected by alcohol intake.

²⁷ See also the guidelines [Assessment for integrated treatment of people with concomitant mental disorder and substance abuse problems – Danish Health Authority](#)

8.5. Skills

It is a requirement that employees carrying out preventive conversations about alcohol have the skills to conduct these conversations to a high-quality standard and to conduct the initial screening and assessment. This requires the employee to have the following skills:

- Knowledge of and training in the methods 'Preventive conversation about alcohol' and 'The Motivational Conversation'
- Knowledge of and training in screening tools and the interpretation of screening results
- General knowledge about alcohol and its significance for health, social life and relatives, including children
- Knowledge of the rules for alcohol treatment
- Knowledge of treatment sites and of local voluntary support organisations in the person's local area
- Knowledge of alcohol treatment, including family-oriented treatment, medicinal treatment and withdrawal treatment
- Knowledge of the concepts of dependence and abuse and of the factors affecting the occurrence of dependence and abuse.

It is recommended that the preventive conversation about alcohol be carried out by professionals with social or health qualifications (at the medium-length higher education level or equivalent skills),²⁸ preferably supplemented with experience in alcohol treatment, and/or a qualification in alcohol treatment or substance abuse treatment.

²⁸ 'Equivalent skills' means professionals who do not have a professional healthcare qualification at the medium-length higher education level, but who may fulfil the skills requirements via their basic training, supplemented by other relevant upskilling if appropriate.

9. Monitoring and quality development

All residents with chronic diseases must have access to municipal preventive services within the above action areas. The common thread among the preventive services provided (across all the municipalities in Denmark) is that they are intended to support residents in managing life with a chronic disease.

Systematic and uniform documentation and monitoring of preventive services help to create the basis for continuous quality development of municipal preventive services. In addition, the aim is to form a basis for ongoing adaptation of the services offered, including the presence of the right skills and dimensioning of capacity, and to ensure effective organisation and resource utilisation in relation to the local context. Monitoring will involve a follow-up of selected indicators and may also form a basis for research into the effect of municipal preventive services.

The *Joint initiative for data in the local healthcare system*²⁹ programme is intended to improve the use of data from the local healthcare system for the purposes of quality development and coherent patient pathways by means of national collection and presentation of data from municipalities and other parties. It is expected that the initial data will appear in national registers in late 2025. In parallel, work is being done to establish indicators for follow-up at a national level.

9.1. Monitoring and quality development in municipal preventive services

The municipalities must be kept up to date on information about residents' needs and services received as well as the courses carried out. The municipalities must systematically follow and, on an ongoing basis, document information about residents and services in the preventive services they offer. The documentation must form a basis for planning, follow-up and ongoing quality development and research.

Preventive services will thus be documented in accordance with their registration in the municipal electronic care records (EOJ) and thus in line with the requirements for reporting from the EOJ to FK-Gateway from the end of 2025. The documentation requirements will include data standards, such as FSIII ('shared terminology') and the Joint Municipal Gateway (FK-Gateway).

It is a requirement that the municipalities make use of available data about their populations. Population data may be compared with data about those residents who are receiving the preventive services provided by the municipality.

This means that the municipality can use population data to monitor participation in the municipality's preventive services among all residents with chronic diseases, for the purpose of assessing the need for services and planning etc. Population data can be found in e.g. 'Health data across sectors' (see box below).

Comparable municipal data on differences in availability and quality across municipalities can be used as a basis for learning and quality development locally, across municipalities and across sectors. Municipalities can monitor their own service and those of others by using the systems provided by the state and the regions, e.g. 'Health data across sectors', national, regional and municipal health profiles, STOPbasen and K-PRO.

²⁹ See the section on *Data across the local healthcare system* in the Agreement of 8 June 2021 between the Danish Government and Local Government Denmark (KL) on the municipalities' finances for 2022.

In these systems, municipalities can also monitor their own residents' health behaviour and health status as an indicator of the development in the need for the municipality to provide preventive services. See the box below for a description of data sources. Municipalities can also include additional and supplementary data sources.

It is recommended that the municipalities draw up indicators based on the complete data set and that the following output data specifications be recorded by the municipalities:

- Which residents are being referred to the preventive services
- What the reason for the referral is,³⁰ if available
- What services are in place
- What the duration of the pathway is, including reasons for dropping out
- Conditions before and after services, using tests if appropriate.

Municipalities can develop the quality of their own preventive services by continuously referring to announcements by the authorities and communicating with municipal networks about e.g. the knowledge and best practice surrounding educational practice, skills for healthcare professionals, any disease-specific considerations and methods and techniques supporting practice, such as dialogue and decision-making support tools. Municipalities would also benefit from discussing and developing their practice in their own local quality organisations, as well as across municipalities.

Municipalities can use different methods and models in their quality development. The improvement model is used in many municipalities as a framework for driving quality development. Local Government Denmark (KL) has also launched the 'Quality in the Municipalities' (KIK) project,³¹ which could help to support work on data-based quality development locally within the municipalities.

Municipalities, hospitals and general practitioners could benefit from anchoring quality development agreements under the auspices of the health clusters, in light of the work also being done through the health agreements. In addition, there could also be a focus on referrals etc. in other cross-sectoral forums, such as the Municipalities' and Doctors' Committees (KLU), where the municipality can maintain a dialogue locally with general practitioners.

Health data across sectors

The 'Joint initiative for data in the local healthcare system' programme was launched in 2023 with the purpose of collecting national data from the local healthcare system, including, in the longer term, data on preventive services in the municipalities. This is intended to lead to the establishment of a national data basis in the form of health registers that will provide an insight into the activity and quality of general practitioners, medical specialists and municipalities. For example, it will be possible to link municipal data, such as data on activities in the area of prevention, with data from hospitals, among other institutions, and in this way to follow residents' pathways in the primary and secondary healthcare system. The programme is also intended to support the use and supply of data in an accessible way to operators in the healthcare system, including the health clusters. This is in order to support data-driven quality development, coherent pathways, population overview and development, planning, etc.

The data sources are displayed via the 'Health data across sectors' digital solution provided by the Danish Health Data Authority, which can be accessed by operators in the healthcare system. For example, data on chronic diseases, preventable hospitalisations, number of hospital admissions, etc. can be compared and displayed in the digital solution. Data on preventive services will be added to the digital solution when the data becomes available.

³⁰ The reason for the referral is not always found in the referral source

³¹ [KIK – Quality in the Municipalities \(kldk\)](#)

Implementation of FSIII ('shared terminology')

The implementation of the common municipal data standard FSIII ('shared terminology')³² creates the conditions for uniform registration, which is necessary in order to obtain information across the 98 municipalities. The municipalities must record information about individual residents' conditions and services received, as well as supplementary information, and report it to FK-Gateway.³³

9.2. Research

It is recommended that new knowledge be generated as a basis for evaluating and adapting the content, target group and organisation of the services. Knowledge about efficacy/effect first needs research, and therefore requires municipalities to contribute to collaboration with universities, vocational institutions, regional research institutions and hospitals, as well as analysis and research institutions. It may be advantageous for multiple municipalities to contribute together as part of larger research initiatives to generate sufficient volume and quality in the projects.

The regions and municipalities must, in interaction with government authorities and in dialogue with users, ensure continuous quality development and efficient use of resources in the healthcare system through education, research, planning and cooperation, etc.; see section 4 of the Danish Health Act. In connection with this, the municipalities can usefully work together with the regions, which have an obligation to research and have expertise regarding research, monitoring and evaluation, as well as an obligation to advise municipalities on their services in relation to health promotion and prevention; see sections 119(4) and 194 of the Danish Health Act.

³² In 2019, the municipalities developed FSIII ('shared terminology') classifications for the services offered by the municipalities under section 119 of the Danish Health Act on health promotion and prevention and rehabilitation after hospitalisation (section 140 of the Danish Health Act).

³³ [indberetningsvejledning-til-gatewayen-10.pdf \(kl.dk\)](#)

References

Rehabilitation Forum Denmark. Hvidbog om rehabilitering (White paper on rehabilitation). 2022.

Danish Health Authority. Vidensgrundlag for anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom (Basic information for recommendations for preventive services for people with chronic diseases). 2016.

World Health Organization. International Classification of Functioning, Disability and Health (ICF).

Danish Health Authority. Patientuddannelse - en medicinsk teknologivurdering (Patient education – a medical technology assessment). 2009.

Danish Health Authority. Kvalitetssikring af patientuddannelse (Quality assurance of patient education). 2012.

Danish Health Authority. National klinisk retningslinje for hjerterehabilitering (National clinical guideline on cardiac rehabilitation). 2013.

Danish Health Authority. National klinisk retningslinje for rehabilitering af patienter med KOL (National clinical guideline for the rehabilitation of patients with COPD). 2014.

Danish Health Authority. National klinisk retningslinje for udvalgte sundhedsfaglige indsatser ved rehabilitering til patienter med type 2-diabetes (National clinical guideline for selected healthcare services in rehabilitation for patients with type 2 diabetes). 2015.

World Health Organization & The World Bank. World Report on Disability. 2011.

Text of the 2022 agreement on health reform. 2022.

Sølvhøj IN, Cloos CØ, Schneekloth Jarlstrup N, Holmberg T. Monitorering af kommunernes forebyggelsesindsats 2017: Arbejdet med Sundhedsstyrelsens forebyggelsestiltal siden 2013 og anbefalinger til borgere med kronisk sygdom Syddansk Universitet (Monitoring of municipalities' preventive services 2017: Work on the Danish Health Authority's prevention packages since 2013 and recommendations to residents with chronic diseases, University of Southern Denmark). Danish National Institute of Public Health, 2017.

World Health Organization. Rehabilitation.

Target group

Danish Health Authority. Forløbsprogrammer for kronisk sygdom – den generiske model (Chronic disease pathway programmes – the generic model). 2012.

Organisation

Gravesen DT. Pædagogik – Introduktion til pædagogens faglighed (Pedagogy – Introduction to the teacher's professionalism). Copenhagen: Hans Reitzels Forlag, 2015.

Danish Health Authority. Anbefalinger for behovsvurdering i den afklarende samtale (Recommendations for needs assessment in the clarifying conversation). 2019.

Danish Health Authority. Social ulighed i mødet med sundhedsvæsenet – en litteraturgennemgang (Social inequality in encounters with the healthcare system – a literature review). 2022.

Grabowski D. Sundhedspædagogik i patientuddannelse: En litteraturbaseret gennemgang af udvalgte sundhedspædagogiske begrebers anvendelse i patientuddannelse (Health pedagogy in patient education: A literature-based review of the use of selected health pedagogy concepts in patient education): Region of Southern Denmark; Steno. 2010.

Grøn L et al. Egenomsorg og patientuddannelse i grænsefladen mellem medicin og humaniora (Self-care and patient education in the interface between medicine and the humanities). Danish Health Institute 2012.

Grøn L et al. Sociale forandringsfællesskaber: en guide til arbejdet med egenomsorg i patientuddannelser (Social change communities: a guide to working on self-care in patient education). Region of Southern Denmark: Danish Health Institute, 2012.

Jensen BB. Kernebegreber i Sundhedspædagogikken. Forebyggende sundhedsarbejde: baggrund, analyse og teori, arbejdsmetoder (Core concepts in health pedagogy. Preventive health work: background, analysis and theory, working methods). 2016.

Marselisborg Centret EK. ICF baseret redskab til beskrivelse af den samlede helbredstilstand og rehabiliteringsbehov hos patienter og borgere med kronisk sygdom (ICF-based tool to describe the collective health status and need for rehabilitation in patients and residents with chronic diseases). 2014.

Schiøler G, Dahl T, World Health Organization, Danish Health Authority. ICF – international klassifikation af funktionsevne, funktionsevnenedsættelse og helbredstilstand (ICF – International Classification of Functioning, Disability and Health). 2003.

Danish Health Authority. Monitorering & Medicinsk Teknologivurdering. Patientuddannelse: en medicinsk teknologivurdering (Monitoring & Medical Technology Assessment. Patient education: a medical technology assessment). 2009.

Danish Health Authority. Kvalitetssikring af patientuddannelse (Quality assurance of patient education). 2012.

West R, Brown J. A synthetic theory of motivation. In: Theory of addiction. 2nd edition. Chichester, West Sussex, UK: 2013.

Danish Diabetes Association, Region of Southern Denmark, Steno Diabetes Center. Guide til sundhedspædagogiske værktøjer. Undervisning af sårbare personer med kronisk sygdom (Guide to health pedagogy tools. Educating vulnerable people with chronic diseases). 2015.

Disease management

Danish Health Authority. Patientuddannelse - en medicinsk teknologivurdering (Patient education – a medical technology assessment). 2009.

Danish Health Authority. Kvalitetssikring af patientuddannelse (Quality assurance of patient education). 2012.

Danish Health Authority. Egen behandling ved kroniske sygdomme – anbefalinger, der understøtter udbredelse (Self-treatment for chronic diseases – recommendations that support dissemination). 2012.

Danish Health Authority. National Klinisk Retningslinje for hjerterehabilitering (National clinical guideline on cardiac rehabilitation). 2013.

Danish Health Authority. National Klinisk Retningslinje for rehabilitering af patienter med KOL (National clinical guideline for the rehabilitation of patients with COPD). 2014.

Danish Health Authority. National Klinisk Retningslinje. Rehabiliterende indsatser over for patienter med type 2-diabetes (National clinical guideline. Rehabilitation services for patients with type 2 diabetes). 2015.

Danish Health Authority. Anbefalinger for tværsektorielle forløb for mennesker med KOL (Recommendations for cross-sectoral care for people with COPD). 2015.

Danish Health Authority. Anbefalinger for organisering af forløb for mennesker med multisygdom (Recommendations for organising pathways for people with multimorbidity). 2023.

Nicotine weaning

Kjaer NT, Ewald T, Rasmussen M, Juhl HH, Mosbech H, Olsen KR. The effectiveness of nationally implemented smoking interventions in Denmark. *Preventive medicine* 2007;45(1):12-14.

Danish Cancer Society. Røgfrit Liv – Individuelt rygestop (Smoke-free life – Quitting smoking individually). 2018.

Danish Cancer Society. Røgfrit Liv – Rygestop i grupper (Smoke-free life – Quitting smoking in groups). 2020.

Danish Cancer Society. Røgfrit Liv – Kvit røgen i seks trin (Smoke-free life – Quit smoking in six steps). 2020.

Lancaster T, Stead LF. Individual behavioural counselling for smoking cessation. *Cochrane database of systematic reviews* 2005(2):CD001292.

McEwen A. Standard Treatment Programme – A guide to providing behavioural support for smoking cessation. 2014.

National Center for Chronic Disease Prevention and Health Promotion (US) Office on Smoking and Health. The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General. Atlanta (GA).

Olsen KR, Bilde L, Juhl HH, Kjaer NT, Mosbech H, Ewald T, et al. Cost-Effectiveness of the Danish Smoking Cessation Interventions: Subgroup Analysis Based on the Danish Smoking Cessation Database. *The European Journal of Health Economics* 2006;7(4):255-264.

Rasmussen M, Bertel NF, Tønnesen H. Rygestopbasens årsrapport for aktiviteter afholdt i 2013 samt 2012 med opfølgning i 2013 (Annual report of the smoking cessation database for activities held in 2013 and 2012 with follow-up in 2013). 2014.

Stead LF, Lancaster T. Group behaviour therapy programmes for smoking cessation. *Cochrane Database Systemic Review*. 2005.

Danish Health Authority. Behandling af tobaksafhængighed: anbefalinger til en styrket klinisk praksis (Treatment of tobacco dependence: recommendations for strengthened clinical practice). 2011.

Danish Health Authority. Forebyggelsespakke – tobak (Prevention package – tobacco). Version: 1.0. 2012.

Danish Health Authority. National klinisk retningslinje for hjerterehabilitering (National clinical guideline on cardiac rehabilitation). 2015.

Danish Health Authority. Rygning og rygestop blandt borgere med psykiske lidelser – en guide til rygestoprådgivere (Smoking and smoking cessation among people with mental health disorders – a guide for smoking cessation advisors). 2022.

Danish Health Authority. Danskernes rygevaner (Smoking habits of Danes). 2022.

Danish Health Authority. Rygestopguide (Guide to quitting smoking). 2023.

Danish Health Authority. Sygdomsbyrden i Danmark – Risikofaktorer (The burden of disease in Denmark – Risk factors). 2023.

Thomson H. Competences required for delivering a Standard Treatment Programme – Matches to the NHS Knowledge and Skills Framework. 2012.

Danish Council for Health Promotion and Disease Prevention. Nikotinformbrug blandt børn og unge – konsekvenser og forebyggelse (Nicotine consumption among children and adolescents – consequences and prevention). 2022.

West Rea. NCSCT Training Standard – Learning Outcomes for Training Stop Smoking Practitioners. 2013.

Danish Health Authority. Rygning og rygestop blandt borgere med psykiske lidelser (Smoking and smoking cessation among people with mental health disorders). 2022.

Physical activity

Beyer N, Lund H, Klinge K. Træning – i forebyggelse, behandling og rehabilitering (Exercise – in prevention, treatment and rehabilitation). 2nd edition. 2011.

Højgaard B. Til anbefalinger for patientrettede forebyggelsestilbud i forhold til fysisk træning i kommunerne (On recommendations for patient-directed preventive services relating to physical exercise in municipalities). 2015.

Capital Region of Denmark. Anbefalinger til superviseret fysisk træning af mennesker med type 2-diabetes, KOL og hjerte-kar-sygdom (Recommendations for supervised physical exercise by people with type 2 diabetes, COPD and cardiovascular disease). 2013.

Stig Mølsted CH. Anbefalinger til superviseret fysisk træning af mennesker med type 2-diabetes, KOL og hjerte-kar-sygdom (Recommendations for supervised physical exercise by people with type 2 diabetes, COPD and cardiovascular disease). 2013.

Danish Healthy Cities Network. Motion på recept – erfaringer og anbefalinger (Exercise on prescription – experience and recommendations). 1st edition. 2007.

Danish Health Authority. Fysisk aktivitet – håndbog i forebyggelse og behandling (Physical activity – handbook on prevention and treatment). Version 3.1. 2011.

Danish Health Authority. Fysisk træning som behandling – 31 lidelser og risikotilstande (Physical exercise as treatment – 31 disorders and risk conditions). 2018.

Danish Health Authority. Træningsguide for mennesker med demens (Exercise guide for people with dementia). 2021.

Danish Health Authority. Fysisk aktivitet for voksne (18-64år) – viden om sundhed og forebyggelse (Physical activity for adults (18-64 years) – information about health and prevention). 2023.

Danish Health Authority. Fysisk aktivitet for ældre (65+år). Viden om sundhed og forebyggelse (Physical activity for older people (65+ years). Information about health and prevention). 2023.

Nutrition action

Beck AM. Notat til anbefalinger for kommunale forebyggelsestilbud til patienter med kroniske sygdomme i forhold til en ernæringsindsats (Note on recommendations for municipal preventive services for patients with chronic diseases in relation to a nutrition action service). 2015.

Den Nationale Kosthåndbog (The National Diet Handbook). Link: <https://xn--kosthdbogen-xcb.dk/>.

European Society for Clinical Nutrition and Metabolism. Guidelines and Consensus Papers. 2022.

Danish Professional Society of Clinical Dietitians. Rammeplaner for ernærings- og diætbehandling (Framework plans for nutritional and diet therapy). Link: <https://kost.dk/fakd/rammeplaner>.

Danish Health Authority, DTU National Food Institute & Ministry of Environment and Food of Denmark. Anbefalinger for den danske institutionskost (Recommendations for the Danish institutional diet). 2015.

Danish Health Authority. Vidensgrundlag for anbefalinger for forebyggelsestilbud til borgere med kronisk sygdom (Basic information for recommendations for preventive services for people with chronic diseases). 2016.

Danish Health Authority. Anbefalinger for tværsektorielle forløb for mennesker med type 2-diabetes (Recommendations for cross-sectoral care for people with type 2 diabetes). 2017.

Danish Health Authority. Anbefalinger for tværsektorielle forløb for mennesker med hjertesygdom (Recommendations for cross-sectoral care for people with heart disease). 2018.

Danish Health Authority. Anbefalinger for tværsektorielle forløb for mennesker med KOL (Recommendations for cross-sectoral care for people with COPD). 2017.

Danish Health Authority. Forløbsprogram for rehabilitering og palliation i forbindelse med kræft (Pathway programme for rehabilitation and palliative care relating to cancer). 2018.

Danish Health Authority. Underernæring: Opsporing, behandling og opfølgning af borgere og patienter i ernæringsrisiko (Malnutrition: Detection, treatment and follow-up of individuals and patients with nutritional risks). 2022.

Danish Veterinary and Food Administration. Over 65 år: Hvad skal du spise og drikke? (Over 65 years old: What should you eat and drink?).

ESPEN Guidelines & Consensus Papers. Link: <https://www.espen.org/guidelines-home/espen-guidelines>.

Nationale Kliniske Retningslinjer (NKR) (National Clinical Guidelines).

NICE Dietary Guidelines.

Danish Professional Society of Clinical Dietitians. Rammeplaner for ernærings- og diætbehandling (Framework plans for nutritional and diet therapy).

Preventive conversation about alcohol

Kaner E, Bland M, Cassidy P, Coulton S, Dale V, Deluca P, et al. Effectiveness of screening and brief alcohol intervention in primary care: pragmatic cluster randomized controlled trial. *British Medical Journal* 2013;346(7892):X14.

O'DONNELL A, ANDERSON P, NEWBURY-BIRCH D, SCHULTE B, SCHMIDT C, REIMER J, et al. The Impact of Brief Alcohol Interventions in Primary Healthcare: A Systematic Review of Reviews. *Alcohol and Alcoholism* (Oxford, Oxfordshire) 2014;49(1):66-78.

Petersen GL, Kesmodel US, Strandberg-Larsen K. Fosterskadende effekter af alkoholforbrug under graviditeten (Harmful effects to the foetus of alcohol consumption during pregnancy). 16 March 2015.

Swedish National Board of Health and Welfare. Nationella riktlinjer för sjukdomsförebyggande metoder 2011 (National guidelines for disease prevention methods 2011). 2011.

Swedish National Board of Health and Welfare. Nationella riktlinjer för sjukdomsförebyggande metoder 2011 – tobaksbruk, riskbruk av alkohol, otillräcklig fysisk aktivitet och ohälsosamma matvanor (National guidelines for disease prevention methods 2011 – tobacco use, high-risk alcohol use, insufficient physical activity and unhealthy food habits). 2011.

Danish National Institute of Public Health. Alkoholrelaterede helbredssekvenser - en systematisk litteraturgennemgang af nyeste evidens (Alcohol-related health consequences – a systematic literature review of the latest evidence). 2020.

Danish Health Authority. Forebyggelsespakke. Alkohol (Prevention package. Alcohol). 2012.

Danish Health Authority. Alkohol og helbred (Alcohol and health). 2013.

Danish Health Authority, Danish College of General Practitioners. Spørg til alkoholvaner (Ask about alcohol habits). 2010.

Danish Health Authority. Dialog om alkohol – Rådgivnings- og implementeringsmateriale (Dialogue about alcohol – advice and implementation material). 2022.

World Health Organization. Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm. 2009.

World Health Organization. Handbook for action to reduce alcohol-related harm. 2009.

World Health Organization. Global status report on alcohol and health. 2011.

World Health Organization. Global status report on alcohol and health. 2014.

Danish Health Authority. Visitation til integreret behandling af mennesker med psykisk lidelse og samtidig rusmiddelproblematik (Assessment for integrated treatment of people with concomitant mental disorder and substance abuse problems). 2023.

Monitoring and quality development

Local Government Denmark (KL), FSIII ('shared terminology'). Fælleskommunalt indsatskatalog – sundhedsfremme og forebyggelse (SUL §119) (Joint municipal catalogue of services – health promotion and prevention (section 119 of the Danish Health Act)). Version 1.

Local Government Denmark (KL). Vejledning til KLGateway – indberetning af strukturerede Fælles Sprog III data (Guidance for KL-Gateway – reporting of structured FSIII ('shared terminology') data).

Local Government Denmark (KL). KIK – Kvalitet i Kommunerne (Quality in the municipalities).

KiAP (Quality in General Practice). Klyngepakke: Almen Praksis' samarbejde med kommunale forebyggelses- og rehabiliteringstilbud (Cluster package: Collaboration of general practitioners with municipal preventive and rehabilitation services).

Danish Health Data Authority. Samlet indsats for data i det nære sundhedsvæsen (Joint initiative for data in the local healthcare system). 2023.

Danish Health Data Authority. Sundhedsdata på tværs (Health data across sectors). 2023.

Danish Health Authority. Forskning til styrkelse af indsatsen i det primære sundhedsvæsen – en national strategi (Research to strengthen services in the primary healthcare system – a national strategy). 2022.

Local Government Denmark (KL). Indberetning til gatewayen (Reporting to the gateway).

Appendix 1: Terms of reference

Terms of reference for the working group on quality standards for preventive services for people with chronic diseases

Background

A number of factors, including changes in the disease picture and demographic change, mean that many Danes are living with one or more chronic diseases. These people often need health services in the primary healthcare system, where at present there can be inequalities across municipalities in terms of quality, availability, systematics and monitoring.

The healthcare reform agreement³⁴ describes a transition to a more cohesive, local and strong healthcare system, which is necessary in order to strengthen services for people including the elderly and those with chronic diseases and mental disorders. One essential part of the transition is to strengthen the quality of the health services offered in the primary healthcare system by means of a national quality plan that supports geographically uniform availability and quality.

Against this backdrop, the Danish Health Authority has been tasked with drawing up a quality standard containing professional quality requirements and recommendations for municipal healthcare services relating to exercise, changes in diet and patient education for people with chronic diseases such as COPD, diabetes, cardiovascular disease and musculoskeletal disorders.

The working group's tasks

The Danish Health Authority is establishing a working group tasked with advising the Danish Health Authority on drawing up the quality standards for preventive services for people with chronic diseases.

The purpose of the quality standards is to convey information about how best to organise the municipal services in key areas of prevention, and to set minimum requirements and recommendations for services so that people across the country can be provided with preventive services of a uniform and high-quality standard.

The work is based on the Danish Health Authority's 'Recommendations for preventive services for people with chronic diseases' (2016). The Authority's other publications about prevention services and chronic disease, such as the national clinical guidelines, will also be included in the work.

The quality standards will therefore build on existing recommendations and guidelines, but there is also a significant focus on working to make the quality standards up to date and innovative in order to address the current challenges and trends in the healthcare system. A central focus of the work will be the distribution of digital solutions in the preventive services offered, with the purpose of creating a flexible healthcare system, differentiating the services offered, freeing up resources and creating more geographical equality in healthcare. Digital solutions, such as home monitoring, can help residents better understand their chronic disease so they can prevent it from being aggravated.

³⁴ [Agreement on health reform \(sum.dk\)](#)

Members of the working group are expected to contribute their knowledge of the evidence and efforts in the area, to enter into discussions at working group meetings and to prepare small written contributions and comments on the draft quality standards drawn up by the Danish Health Authority.

Composition of the working group³⁵

- Danish Regions (1)
- Regions (2)
- Local Government Denmark (KL) (1)
- Municipalities (4)
- Danish Patients (2)
- Danish College of General Practitioners (1)
- Danish Society for Physiotherapy (1)
- Danish Nursing Society (1)
- Danish Professional Society of Nurses in the Municipalities (1)
- Danish Society of Public Health (1)
- Danish Occupational Therapy Societies (1)
- Danish Professional Society of Clinical Dietitians (1)
- Danish Health Data Authority (1)
- Danish Ministry of the Interior and Health (1)

Danish Regions and KL are asked to appoint regional and municipal representatives respectively. The Danish Health Authority can add members to the working group if necessary.

The Danish Health Authority holds the positions of chair and secretary of the working group.

The working group's meetings

Three meetings are expected to be held in the working group. The Danish Health Authority will draw up the agenda and draft for the meetings, which the working group will discuss and qualify.

The Danish Health Authority will take minutes of the working group's meetings. The minutes will be submitted for comment no later than two weeks after the meeting is held in order to obtain the group's remarks and written approval within a set time frame.

Schedule and meeting dates

The work will commence at the start of 2023 and is expected to be completed by the end of 2023.

The first meeting will be held on Thursday 13 March 2023 from 11:00 to 14:00.

The second meeting will be held on Wednesday 7 June 2023 from 11:00 to 14:00.

Details of the third meeting are to follow.

The meetings will be held at the Danish Health Authority's external meeting centre at Islands Brygge 57, DK-2300 Copenhagen S.

³⁵ In April 2023, a representative from FOA (trade union and unemployment insurance fund) also joined the working group.

Appendix 2: Members of the working group

Representative	Organisation
Trine Klindt	Danish Professional Society of Clinical Dietitians (FaKD)
Christian Korner	Danish Ministry of the Interior and Health
Amalie Bækgaard Kristiansen	Danish Ministry of the Interior and Health
Line Lindahl-Jacobsen	Danish Occupational Therapy Societies
Nana Folmann Hempler	Danish Society of Public Health
Lars Hermann Tang	Danish Society for Physiotherapy
Merete Rudolfsen	Danish Professional Society of Nurses in the Municipalities
Line Hansen	Danish Health Data Authority
Anna Boje	Danish Regions
Søren Thorgaard Skou	Danish Regions
Anette Brink	Danish Regions
Malene Deelee	Danish Patients
Signe Riis	Danish Patients
Annette Wandel	Danish Patients
Trine Vahlberg Holmberg	Local Government Denmark (KL)
Morten Just	Local Government Denmark (KL)
Louise Vestring	Local Government Denmark (KL)
Birgitte Holm Andersen (until 18 Aug 2023) Subsequently Mette Odgaard Holck	Local Government Denmark (KL)

Anne-Sofie Fischer Petersen	Local Government Denmark (KL)
Trine Hjetting	Danish Nursing Society
Inger Højvig (did not attend the meetings but received material for comment)	Danish College of General Practitioners
Sofie Tolstrup	FOA

Secretariat	Organisation
Nanna Læssøe (chair)	Danish Health Authority
Line Riddersholm	Danish Health Authority
Elsa Eriksen	Danish Health Authority
Mie Lind Berg	Danish Health Authority
Rasmus Baagland	Danish Health Authority

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