EIPonAHA repository of innovative practices catalogue

This document has been produced by Funka in the context of the WE4AHA CSA, supporting the EIP on AHA community.

Date: 19th January 2021

Contact email: we4aha@funka.com

Introduction

This catalogue has been compiled based on the European Innovation Partnership on Active and Healthy Ageing Repository of innovative practices online tool in its state of January 2021.

Electronic Health Records (EHR) – 2016-2020

Doctors - comfortably access very accurate and reliable health records of their patients (with informed consent), which aids them to make successful diagnosis and plan further treatment
Patients – electronically access their full health records and there is a better communication between them and their doctors; (2) make decisions which information can be shared with their other doctors and which not;
Ministry – has accurate statistics about many variables for evidence-based Policy decision making
Implementation started in 2019
It is mandatory for every in- and out-patient facility which provide medical services within the framework of any governmental medical program;
The implementation process is still on-going.

Keywords:
digital health, HER
Website:
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Georgia
Regions involved:

Organisation

Organisation name:
Ministry of IDPs from Occupied Territories, Labor, Health and Social Affairs of Georgia

Organisation address:
144, Ak. Tsereteli Ave. Tbilisi 0119
Kind of organisation:
National public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Citizens
Source of funding:
Local funding

Contact details

Name:
Mikheil Janiashvili
Email:
mic@moh.gov.ge

E-Prescription – 2016-2020

Doctors - easily and comfortably prescribe drugs electronically
Pharmacies - check prescriptions electronically and make sales with accuracy
Patients - can electronically check prescribed drugs and control validity of their prescriptions
Ministry – has accurate statistics about drug consumption, especially antibiotics and information about sales of drugs
Implementation started in 2018;
It is mandatory for every in-patient facility in the capital, but doctors outside Tbilisi are also successfully using e-prescription;
The system is planned to be implemented throughout the country in the following year

Keywords:
digital health, electronic prescription
Website:
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Georgia
Regions involved:

Organisation

Organisation name:
Ministry of IDPs from Occupied Territories, Labor, Health and Social Affairs of Georgia
Organisation address:
144, Ak. Tsereteli Ave. Tbilisi 0119
Kind of organisation:
National public authorities

Viability

Time for deployment:
Between one year and three years

Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Citizens
Source of funding:
Local funding

Contact details

Name:
Mikheil Janiashvili
Email:
mic@moh.gov.ge

peer-to-peer Telemedicine Ecosystem

DoctorsHello is a peer-to-peer ecosystem, which provides innovative telemedicine services developed to support real-world healthcare based on real-time distributed data. DoctorsHello counts on ATLAS™ and Durus. Atlas is the backbone platform of an innovative SaaS that can integrates all the required modules supporting real-world Telemedicine Services. It's been developed as a middleware backbone to bring Biosignal Devices data, EHR data, third-party structures (via APIs, HL7 integration etc.) into one place. Durus™ Pro is an innovative scalable telemedicine node available on a dedicated tablet (Samsung - Galaxy Tab Active Pro). Durus™ Pro supports a PPG method for measuring and monitoring Heart rate, Heart Rate Variability markers, SPO2, and enables a connection Gateway based on BLE® technology to connect and measure the temperature, blood pressure and other vital signs via well-established external devices.

Keywords:
telemonitoring, telemedicine, peer-to-peer, medical ecosystem
Website:
https://doctorshello.com/
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Europe
Regions involved:

Organisation

Organisation name:
SYSTSERV
Organisation address:
31-33 Gounari Av.
Patras, 26221,
Greece
Kind of organisation:
Private companies

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
Real-time telemonitoring, Home monitoring for those with difficulties in mobility, continuous monitoring for chronic diseases, instant assistance for emergency cases.
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities
Source of funding:
Private funding

Contact details

Name:
Hara Pylarinou
Email:
pylarinou@systserv.com

Social housing “Pantera Rosa”- Caring with solidarity and Internet of Things (IoT)

Cooperativa Sole manages a social housing experience called “Condominio Solidale Pantera Rosa”, which is actually hosting 35 people, including 6 in age between 65/70. They are people with different frailties (social, economic, psychological and health), of different ethnicity and from different age classes (intergenerationality), whose desire of belonging, protection and relationship the Condominium aims to respond. This heterogeneity reflects our working method called “Human 360”, according to which all the aspects of humanity need to be taken into account in providing care and welfare services. Therefore, Cooperativa Sole guarantees the provision of integrated services with regard to social, psychological and health issues, also by using technological devices. The uniqueness of the project lies in the adoption of IoT and wearables, in the multidisciplinarity of the working team involved in the process and in the aim of designing a sense of community.

Keywords:
community, internet of things, community nurse, health, wellbeing, intergenerational, multidisciplinarity, experimentation
Website:
http://www.solecooperativa.com/2019/11/29/pantera-rosa-un-condominio-solidale-2-…
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Emilia-Romagna

Organisation

Organisation name:
Cooperativa Sole
Organisation address:
Operational Headquarters:
Via della Cooperazione, 8 - 47043 Gatteo (FC)

Registered office: Via Siemens, 23 - 39100 Bolzano (BZ)
Tel. 0541/933823 | Fax 0541/1788150
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
More than 5.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
The piloting lasted 6 months. In this period, we have observed the following impacts:

- Improvement in predictive assistance (thanks to the instantaneous detection of anomalies in habits and behaviours) and more effective nursing prevention;
- New mindset by socio-health operators, much more inclined towards innovation and the use of technology as an active component of their activities;
- Guarantee safety and autonomy at home;
- Less access to hospital thanks to monitored apartment buildings;
- Higher levels of user engagement in their health protection;
- Improvement of psychological well-being.

Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Nurses, Day care centres, Large-sized industry, Research centres, National public authorities, WHO, Regional public authorities, Local public authorities

Source of funding:

Private funding

Contact details

Name:

Alice Sanna & Samuele Verucchi

Email:

innovazione@solecooperativa.it

Andalusian Health Population Database (Base Poblacional de Salud)

The Andalusian Public Healthcare System has adopted the Andalusian Health Population Database as a corporate information system. This database is a population-based Health Information System since it allows data to be collected from every individual that is part of Andalusian population (those included in the User Database of the Andalusian Public Health System). The core of the information is provided by User Database and is complemented by diagnostic information and the use of health resources from the different primary and specialized care areas. Among the administrative-clinical sources, the digital medical history of Primary Care and the hospital Minimum Basic Data Set - MBDS (hospitalization, medical and surgical day hospitals and emergencies) stand out. The use of resources, measured in different units and valued in euros, includes Primary Care and the different processes of hospital care and the consumption of pharmacy, dialysis sessions and medical transport.

Keywords:
Medical record linkage, electronic health records, Data warehouse, Data analysis, Health information systems, Organization and administration, Research
Website:
https://web.sas.junta-andalucia.es/servicioandaluzdesalud/profesionales/sistemas…
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Andalucía

Organisation

Organisation name:
Regional Ministry of Health and Families of Andalusia
Organisation adress:
Avenida de la Innovación, Edificio Arena 1 – 41004-SEVILLA-España
www.juntadeandalucia.es/salud/sites/csalud/portal/index.jsp

Kind of organisation:
Regional public authorities

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Data from 13 million people who have been users between 2001 and 2019 are included, with 435.5 million diagnoses. 88.7% of these diagnoses were generated by the automatic encoder. The data is presented through predefined reports or dynamic queries, both exportable to CSV files for treatment outside the system. Expert analysts can directly access databases and extract using SQL or directly process data with external tools.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Private companies, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Academia, Regional public authorities
Source of funding:
Regional funding

Contact details

Name:
Ana M Carriazo
Email:
ctri.csafa@juntadeandalucia.es

DoctorsHello Medical Ecosystem

DoctorsHello is a social forces based community consisted of health related users and citizens, supported by structures and innovative technologies that create value for all members. The interactive “Connect Collaborate Share” platform provides digital tools and technologies to enable HealthTech businesses and healthcare professionals support collaboration and better decisions, provide added value services, and reach effectively to medical discovery through rich data, research and education.

Keywords:
Collaborative practices, collaborative tools, Tele-care, tele-health, Tele-medicine, digital health
Website:
https://doctorshello.com/
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Europe
Regions involved:
Ελλαδα (Ellada)

Organisation

Organisation name:
DoctorsHello
Organisation address:
31-33 Gounari Avenue
Patras, 26221
Greece
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Day care centres, Home care centres, Nursing homes, Housing organisations, Private companies, Academia, International/European public authorities, National public authorities, WHO, Regional public authorities, Local public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
The integrated performance subsystem monitors the impact of related infrastructures, technologies, services, procedures, interactions within the ecosystem periodically. Apart form the simulation modelling, there are specific time and cost parameters used for the quantitative analysis and societal parameters used for the qualitative analysis. Real-life data has been collected during the 3-month operation and prior validation period.
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Day care centres, Home care centres, Nursing homes, Housing organisations, Private companies, Academia, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities
Source of funding:
For profit

Contact details

Name:
Hara Pylarinou
Email:
info@doctorshello.com

VirtuALL (Innovation | Ageing | Quality of Life)

The VirtuALL project (Innovation, Ageing, Quality of Life) aims to develop innovative responses with the latest scientific and technological knowledge for the elderly population, contributing to ageing in place and combating ageism. We have the goal to create six ecosystems in Municipalities of Center of Portugal (Cantanhede, Figueira da Foz, Mealhada, Mira, Montemor-o-Velho and Penacova) to promote the active and healthy ageing through the social innovation and technologies. In these ecosystems we will provide different solutions for physical and cognitive stimulation and also for socialization, with the inclusion of an augmented reality gaming platform (PEPE - Portable Exergames Platform for The Elderly), a portable balance and pressure platform with visual biofeedback technology and 2D and 3D games (PhysioSensing) and tablets.
This project started in April/2019, have a duration of 30 months and involved diverse players such: Local Action Group, municipalities, academic, start-up and local community. It's a financial project promoted by AD ELO, funded under the Portugal Inovação Social (European Social Fund).

Keywords:
Active ageing, Social Innovation, Tecnologie
Website:
http://www.adelo.pt/programas/index.php
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Portugal
Regions involved:
PORTUGAL, Centro (PT)

Organisation

Organisation name:
AD ELO - Associação de Desenvolvimento Local da Bairrada e Mondego
Organisation address:
Rua António Lima Fragoso, Nº 22,

3060-216 Cantanhede, Portugal

Kind of organisation:

Other, please specify

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

No knowledge about evidence. No evaluation or documentation of effect has been carried out

Maturity level:

The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.

Time of impact:

Low impact – e.g. impact has been seen only while a pilot project was running

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Primary care centres, Day care centres, Informal caregivers, Academia, Local public authorities, Local Action Group, LAG

Source of funding:

European funding

Contact details

Name:

Mónica Sousa

Email:

m.sousa@adelo.pt

Project ECHO (Extension of Community Healthcare Outcomes)

Project ECHO® (Extension of Community Healthcare Outcomes) http://ECHO.unm.edu is a pioneering telementoring programme which was developed in the School of Medicine at the University of New Mexico (UNM). See more on ECHO origins: https://www.youtube.com/watch?v=2lBfyOlL4_s

Project ECHO is a tele-mentoring programme which is designed to facilitate the sharing of specialist knowledge in order to improve the quality of care to patients. It brings GPs, nurses and other healthcare professionals together to participate in guided practice discussions via videoconference with specialist mentors. Participants benefit through case-based learning and the sharing of evidence-based, best practice guidance. Clinicians participating in ECHO sessions acquire new skills and support to treat their patients who otherwise would have to be referred to other specialists. Patients with complex chronic long term conditions including dementia, diabetes and neurological conditions can then get specialist supported care in their local communities.

ECHO uses a hub and spoke model. The hub is normally a multidisciplinary team who sit together at the same location as dedicated IT support, admin support with dedicated IT equipment. Spokes generally join the ECHO sessions remotely. All participants will come together at the outset to agree curriculum topics, dates, times and case presenters.

The ECHO hub and spoke model has been shown to be an effective way of improving access to specialist supported care and improving patient outcomes.

The ECHO model develops knowledge and capacity by:

1. Using video conferencing technology to leverage scarce resources and create knowledge networks
    - Allowing participants easier access to training
    - Allowing access to training from your place of work at agreed dates & times
    - Access to recordings for network participants only
    - Dedicated information repository/resource library for your network
2. Improving outcomes by reducing variations in processes of care and sharing best practices
    - Sharing annonomised case based discussions
    - Teaching on guidelines/good practice
    - Improving collaborative decision making
3. Data/Evaluation
    - Support from ECHO dedicated research fellow
    - Uses MRC Logic Model

In Northern Ireland, ECHO has now moved in to social care also and other areas such as social prescribing and safeguarding of looked after children.

Keywords:
Community of learning, Community of practice, Networks of care providers, Multidisciplinary teams, Specialised care in local community, Sharing specialist knowledge across primary and secondary care, Tele-mentoring, Collaborative problem solving, Peer support, Case based learning, Support networks, Safe learning space
Website:
https://echonorthernireland.co.uk/
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Europe, Africa, Asia, North America, Australia, South America
Regions involved:

Organisation

Organisation name:
Health and Social Care Board
Organisation address:
12-22 Linenhall St.
Belfast
BT2 8BS
Northern Ireland
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Overall, the outcomes that networks (30) hope to achieve in the short-term have included:

- Improved knowledge: of a condition, symptom management, medication management, red flags.
- Improved confidence: to diagnose or manage a condition, prescribe, manage patients without making a referral or making a more informed referral.
- Improved awareness: of guidelines or pathways, referral procedures (when to refer).
- Improved relationships and communication: between primary and secondary care and other professional boundaries, and/or across sectors
- For participants to feel more supported and less isolated: through access to peer support and the opportunity to network and build relationships with colleagues.
- ECHO identified by participants as a suitable model for delivering education and support.

The longer-term outcomes or impacts that networks hope to achieve have included:

- Increased capacity to manage patients within primary care.
- Improved management of patients whilst on waiting lists.
- Reduced demands for secondary care where appropriate / prevention of unnecessary admissions to hospital.
- Improvement in the quality of referrals to secondary care.
- Improvement in the quality of care delivered to patients, service users, and/or carers.
- Improvement in communication with patients and carers.
- Scoping of opportunities to innovate and transform care.

Overall, our findings indicate that the networks have been successful in achieving their short-term objectives to include increased knowledge and confidence. Participants have also reported feeling more supported through the ability to link with their colleagues for peer support and share knowledge and experience through case-based learning. Survey respondents have also reported that relationships between primary and secondary care and/or across sectors have improved. Impacts on practice have also been identified.

All of these benefits continued to be realised after the pilot, for the people involved in the pilot and their colleagues and patients.

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Nursing homes, Regional public authorities

Source of funding:

Regional funding

Contact details

Name:

Martin Hayes

Email:

Martin.Hayes@hscni.net

Northern Ireland Electronic Care Record, including patient portal

The NIECR is a web-based portal system using Orion Health technology which gives health and social care professionals a single, secure overview of key information about their patients or clients. It extends to the entire Northern Ireland population of 1.8 million. Previously, information was held on paper and a variety of electronic systems across Northern Ireland's Health and Social Care system, which meant that health and social care professionals had a fragmented view of service user information. NIECR solves this problem by aggregating the information already held on clinical systems across Northern Ireland without the need to replace those existing source systems. This aids better, faster, safer decision making and improves the quality and efficiency of the services provided.
NIECR enables the secure communication and sharing of key patient data by integrating 500,000 daily messages in real-time from the following HSC systems across acute, community, primary health and social care:

- 8 Patient Administration Systems - Encounter details
- 8 clinical documents systems
- 10 Emergency Department systems
- 5 Out of Hours providers
- 6 Laboratory systems
- 3 Radiology systems
- 350 GP systems – Drugs, Allergies and eReferrals
- Master Patient Index

A patient portal facility is currently being implemented as part of NIECR. Known as My Care Record the portal gives patients access to view specific information regarding their healthcare in a digital format. Through the portal patients can view hospital appointments, have access to a relevant health library, engage with clinicians in goal-setting and document-sharing and view personal information on medication and laboratory results.

Keywords:
Better access to full clinical information, Comprehensive digital care record for every patient, Integrated health and care infrastructure, Improved safety and quality of care, Improved patient experience, Patient-centric
Website:
http://www.ehealthandcare.hscni.net/niecr/niecr.aspx
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
United Kingdom
Regions involved:
Northern Ireland

Organisation

Organisation name:
Business Services Organisation
Organisation address:
2 Franklin St.
Belfast, BT2 8DQ
Northern Ireland
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
An NIECR Benefits Review has been commissioned. A snapshot of this research includes;

- 98% of service users felt that NIECR had improved patient safety
- 97% felt that NIECR had improved the quality of patient care
- 96% felt that the project had resulted in a better clinical outcome at least once.

- 80% of responders to the research indicated that NIECR had saved them time on a daily basis.
- 94% fle that NIECR had improved access to information
- 63% felt that there had been a reduction in admin time, and 54% felt there had been a reduction I wasted clinical time
- 49% identified a reduction in unnecessary delays for patients
- 45% felt there was a reduction in unnecessary Laboratory tests
- 30% identified a reduction in unnecessary Radiology tests
- 97% of users indicated that using the system had reduced the number of phone calls and faxes made and received.

In addition an NIECR Outpatient Clinical Audit was commissioned in October 2019. This identified that:70% of patients audited had the need for lab and imaging tests removed, and quantified potential savings as a result.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Regional public authorities

Source of funding:

Regional funding

Contact details

Name:

Stepjhen Beattie

Email:

Stephen.Beattie@hscni.net

Dementia Apps Library

A new digital service offering support for people living with dementia and their carers - apps4dementia library, hosts a selection of safe and trusted mobile apps which provide people affected by dementia and their carers with information and guidance on the condition, advice on self-care and how to carry on with their day-to-day activities for as long as possible.
Developed in conjunction with app evaluator, ORCHA, the site offers a range of applications which have been independently checked and reviewed for data privacy, clinical assurance and user experience.
Users will find the 10 best rated apps that provide guidance and information to help with sleep, communication, keeping minds active, and reminders as well as apps that support carers to care for their loved ones. The library has been developed alongside people living with dementia and their carers, as well as health professionals, who have provided feedback on design and content. The initiative is part of the Dementia eHealth and Data Analytics Pathfinder Programme, which uses data and technology to inform better services, support people with dementia and help plan for the future

Keywords:
Mobile health apps, Online Information, Quality information, Certified Applications, Dementia guidance
Website:
https://apps4dementia.orcha.co.uk/
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
United Kingdom
Regions involved:
Northern Ireland

Organisation

Organisation name:
Health and Social Care Board

Organisation address:
12-22 Linenhall St.
Belfast, BT2 8BS
Northern Ireland
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
No knowledge about evidence. No evaluation or documentation of effect has been carried out
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The drive towards more digital enabled care within healthcare systems around the world is changing the way healthcare is delivered. There are over 366,000 health & fitness related apps currently on App stores and 5m downloads per day so it is extremely difficult to deny the rising popularity of the industry.
Currently it is estimated that 80% of Professionals are using Smart Phones and Medical Apps and 40% of Clinicians believe health technologies can reduce the number of visits to GP surgeries. However, healthcare professionals want safe and trusted apps and the apps library can provide the mechanism to evaluate apps.
Increasingly greater numbers of older people are becoming digitally literate and have access to smartphones/tablets and the internet.
There is greater evidence of the impact of using mobile apps in supporting people affected by dementia and their carers.

Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Small-sized industry, Academia, NGOs, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses, Advocacy organisations others
Source of funding:
Regional funding

Contact details

Name:
Soo Hun
Email:
Soo.Hun@hscni.net

Dementia Analytics Research User Group

Better standards of health care mean that people are living longer. This also means that the number of people living with dementia is increasing. To offer effective support to people with dementia and their carers we need to know the number of people who are assessed for dementia, how they access a diagnosis, what services are offered before and after assessment and how accessible and helpful these services are. To answer these and the many other important questions associated with a person's journey with dementia we need to collect the appropriate data.

The Dementia Analytics Research User Group (DARUG) was set up in March 2018 to enable commissioners, health professionals, researchers, academics, voluntary and community representatives, people living with dementia and carers to come together once a month to discuss and share information about dementia. Over time we have built a community of practice where collaborations have developed as a consequence of the shared interest and motivation to improve the quality of life for people living with dementia and their carers.

A number of data analytics projects, aimed at improving our understanding of dementia in Northern Ireland have received funding under the Dementia eHealth and Data Analytics Pathfinder Programme. This programme is part funded by the Northern Ireland Executive Office, Atlantic Philanthropies and the Department of Health. The programme focuses on using data to enable better understanding of the needs of people with dementia and their carers to inform better services and support and help with planning to meet predicted future needs. The call for funding solicited proposals consistent with the aims of the Northern Ireland Regional Dementia Care Pathway (Health and Social Care Northern Ireland, 2018)

The 11 projects that have been successfully awarded funding through the eHealth and Data Analytics Dementia Pathfinder Programme are summarised below in the URL below:
http://www.hscboard.hscni.net/our-work/ehealth-and-external-collaboratio...
https://view.pagetiger.com/DARUG/newsletter-june-2019

The DARUG programme implements agile methodology and the project leads update on progress at regular sprints. This enables feeback from the community and affords the opportunity to shape the future direction of the project. Personal and Public Involvement (PPI) was built into the process from the initial stages of the project proposal evaluation and there is regular ongoing PPI engagement to help to shape the direction of the project.

The concept of DARUG has been overwhelmingly positive. In the first instance people vote with their feet and there has been consistent attendance and engagement from the group throughout the past 21 months. Some quotes from attendees about their experience with DARUG.

"DARUG is unique. There is no other forum that has the range of disciplines and services coming together to discuss data in dementia. This range of ideas improves our knowledge and understanding of dementia data and what we can do with this data."
"PPI and the voice of people with dementia and carers shape DARUGs' priorities and work."
The outcomes of the projects are now emerging and the results are being presented at local, national and international conferences, together with papers accepted and submitted for publication in peer reviewed journals.

Keywords:
dementia, Data Analytics, Communities of Practice, People living with dementia, health informatics, dementia research
Website:
http://www.hscboard.hscni.net/our-work/ehealth-and-external-collaboration/darug/
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
United Kingdom
Regions involved:
Northern Ireland

Organisation

Organisation name:
Digital Health & Care NI
Organisation address:
Digital Health & Care NI, Health and Social Care Board
Level 1,
12-22 Linenhall Street,
Belfast, BT2 8BS
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
There are plans to draft up an annual workplan for DARUG group moving forward which will enable to results of the various data analytics projects to deliver impact and realise benefits to the planning, commissioning and delivery of dementia services across NI that will improve quality of care for people living with dementia and their carers.
The results of DARUG outputs will also be used to inform policy and impact the implementation of the dementia care pathway.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Nursing homes, Informal caregivers, Private companies, Small-sized industry, Research centres, Academia, NGOs, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Health Informatics staff
Source of funding:
Regional funding

Contact details

Name:
Ms Soo Hun
Email:
Soo.hun@hscni.net

EmmaCOPD

600.000 people in the Netherlands have COPD. Because of lung attacks (exacerbations) 30.000 of them spend 200.000 days in hospital yearly, a societal cost of € 150 million. EmmaCOPD, a COPD lung attack recognition and rehabilitation application on top of the Emma platform prevents most hospital readmissions. The application may currently be amongst the most effective solutions to reduce the number of days COPD patients spend in hospital (avg. hospital stay reduction in test group above 80%). The application was developed with the help of Bravis Hospitals in Bergen op Zoom and Roosendaal and has been validated since April 2018 by the team of Prof. Niels Chavannes of Leiden University Medical Center.

Keywords:
COPD, exacerbation, readmission reduction, smartwatch, digital therapeutics
Website:
https://www.medicinemen.eu/en/
Initiative status:
Completed

Background

Geographical scope:
National level
Countries involved:
Netherlands
Regions involved:
Noord-Nederland, Oost-Nederland, West-Nederland, Zuid-Nederland

Organisation

Organisation name:
Medicine Men BV
Organisation address:
Hollandse kade 27-B
Abcoude
The Netherlands
Kind of organisation:
Private companies, Small-sized industry

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:

Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Patients all reported beter quality of life and less isolation. The Emma platform allows ALL informal and professional carers in ANY care organisation to communicate with the patient and to view all sensory and health parameters. EmmaCOPD reuced hospital admissions and shortens hospital stay.

Due to its effectiveness it reduces the need for professional care.

Transferability level:

The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Home care centres, Informal caregivers, Private companies, Research centres, Academia, National public authorities , WHO

Source of funding:

Private funding

Contact details

Name:
Oscar van Dijk
Email:
oscar@medicinemen.eu

Technology Supported Setf Care (at Scale)

Partnering with healthcare, third sector and industry, the NHS in Liverpool has added capacity to community nursing services by building a remote telemetry hub. This hub, which is clinically staffed, provides patients (and their families) with:

- education
- information & advice
- support

to enable them to manage their long-term health conditions e.g. COPD, heart failure and diabetes. Patients (and/or families) use digital, peripheral devices to record vital signs which are monitored by clinical practitioners in the hub who use the data to decide upon the appropriate intervention.

This is a mainstreamed, core funded service which has increased service capacity by in excess of 12,000 patients over the last 2 years, and currently supporting 1,100 at any one time.

https://www.youtube.com/watch?v=fiw4zHefZXY

Keywords:

Digital, digital health, self-care, self-service, telemetry, remote, clinical, hub, COPD, heart failure, diabetes, NHS, Telehealth

Website:

https://www.liverpoolccg.nhs.uk/about-us/smart-health-care/

Initiative status:

On-going

Background

Geographical scope:

Regional level

Countries involved:

United Kingdom

Regions involved:

Merseyside, Liverpool

Organisation

Organisation name:

NHS Liverpool Clincial Commissioing Group

Organisation address:
The Department.
2 Renshaw Street
Liverpool
UK, L1 2SA
Kind of organisation:
Local public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Positive impact has been achieved in a number of the areas identified in this question.
As stated above there has been positive impact upon the lives of patients and their families. Their health has improved and likelihood of hospitalisation as a result of condition exacerbation reduced. This has primarily resulted from the fact that patients/families are better informed and educated about their condition and its treatment. Patients understand more and are more confident in management of their wellbeing. 52% of patients report an improvement in lifestyle and 79% improved health or better health management. This also has the effect of increasing their control and independence offering patients/families the potential to actively participate in employment (adding micro and macro-economic impact)
This initiative has also increased:

- capacity of local services to respond to increasing scale and complexity of health/care need. Nursing ratios for the patient cohort has reduced from 1 nurse to 35 patients to 1 nurse to over 200 patients! This is transformative in nature.

- levels and variety of local employment in that new types of worker have been introduced to the NHS (clinical hub) and Docobo technology partner

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Nursing homes, Informal caregivers, Private companies, Regional public authorities, Local public authorities

Source of funding:

National funding

Contact details

Name:

Paul Clitheroe

Email:

paul.clitheroe@liverpoolccg.nhs.uk

Let food be your medicine!

Gene expression, gut microbiome, eating habits, lifestyle and medical status are personal identifiers that can be used as predictors for building precise nutritional plans
Our solution is going to empower peoples to participate more fully in their own care and make the lives of clinicians far better. The point that is essential is recognizing that each human being is unique and they have different nutritional needs.
We develop the world's first free prevention tool through digital health platform for nutrition assessment. Using a patent-pending algorithm based on standard/personal nutritional needs, eating pattern and other data users can determine the exact quantity of food and supplements to cover nutrient deficiencies.
For deep personalization, based on nutrigenetic, microbiome and screening tests user can have a PERSONALIZED PREVENTION or THERAPEUTIC NUTRITIONAL SOLUTION.

Keywords:
Malnutrition Elderly Nutritional assessment Genetics
Website:
https://www.nutricare.life/
Initiative status:
Planned

Background

Geographical scope:
International level
Countries involved:
Europe
Regions involved:
Polska, România

Organisation

Organisation name:
Smart EpiGenetX
Organisation address:
Pipera Bld. 4C
Kind of organisation:
Private companies, Micro-sized industry

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Primary care centres, Specialised physicians, General practioners, Private companies

Source of funding:

European funding

Contact details

Name:

Bogdan Ivanov

Email:

bogdan.ivanov@genetx.eu

PROJET R/THELME

voilà 25 ans je me suis trouvé face à deux villages distant de 1KM les gens vivais beaucoup plus longtemps dans l' un que dans l'autre dans un environnement égal 25 ANS de recherche pour commencer à comprendre cette équation

Keywords:
Le Prolongement De La Vie
Website:
http://cortes.cth@gmail.com
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Europe
Regions involved:

Organisation

Organisation name:
Chercheur
Organisation address:
143 impasse de l'étang
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

la civilité des personnes sur qui j'ai fais ces recherches me montre que leur longévité étaient bien au dessus de la moyenne de l'époque

Transferability level:

Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Research centres, Academia, International/European public authorities

Source of funding:

Other, please specify

Contact details

Name:

CORTES

Email:

cortes.cth@gmail.com

Catalan open innovation hub on ICT-supported integrated care services for chronic patients

The Catalan Open Innovation Hub on ICT-supported integrated care services for chronic patients aims to foster a collaborative network at European level in terms of generation, deployment and evaluation of digitally-supported innovative health services.
The practice is conceived to serve the entire population of Catalonia (7.5M citizens), Spain (ES). However, the target group are chronic patients with focus on multimorbidiy management and on coordination with social support and dependence. Accordingly, it encompasses both vertical (specialized vs. community-based care) and horizontal (healthcare vs. social support) integrations, combining a population-health orientation with a collaborative adaptive case management approach.
The Catalan Open Hub promotes and assesses the transfer of care complexity from hospital-based to community-based care aiming at generating health value both at provider and at health system level with a triple aim approach (i.e., Improve Population Health, Improve Care Experience and Reduce per Capita Cost). Ultimately, the practice fosters the transfer of biomedical knowledge and technologies to healthcare service providers, health-related actors and industry. The initiative would like to generate a significant contribution of Catalonia toward a more efficient healthcare scenario in the 21st Century, based on the following strategic areas:
Deployment and assessment of ICT-supported integrated care services. Priority is given to services focused on prevention, enhancement of patients' resilience to disease and rehabilitation.
Application of holistic strategies for subject-specific risk prediction that consider multi-level covariates influencing patient health in order to increase predictive power and enhance clinical decision-making based on sound estimates of individual prognosis.
Alignment with the Big Data Analytics Master Plan promoted by the Catalan Health System (SISCAT) fostering adoption of cloud-based services in real world settings.

Keywords:
integrated care, digital health, care pathways, multimorbidity, chronic disorders
Website:
http://incasym.com
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Cataluña

Organisation

Organisation name:
Institut d'Investigacions Biomediques August Pi i Sunyer (IDIBAPS); Hospital Clinic de Barcelona (HCB) & Universitat de Barcelona (UB)
Organisation address:
IDIBAPS (http://www.idibaps.org/) - Carrer del Rosselló, 149, 08036 Barcelona
HCB (https://www.clinicbarcelona.org/ca) - Carrer Villarroel, 170, 08036 Barcelona
School of Medicina-UB (http://www.ub.edu/medicina/(- Carrer de Casanova 143, 08036 Barcelona)
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Research centres, Academia

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 1.000 – 5.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Evidence of impact during the period 2011-2015 (from the introduction to the Catalan Health Plan 2016-2020)

- Health-preserved expect. survival to expect. survival ratio: from 78 to 82.1%
- Percentage reduction of referrals to specialized care: - 50%
- Reduction of hospitalisations: - 7,500 admissions
- Reduction of 30-d re-admission rate in chronic patients: -9% (13% cases)
- Reduction of emergency room admissions in chronic patients: -40%
- Reduction in mortality rate of cardiovascular and respiratory disorders: -15%
- Improvement of activity of home hospitalization: + 53% (12,600 cases/yr.)
- Improvement of activity of palliative care: 100% coverage
- Improvement of coverage of ePrescription: 97% population

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Private companies, Micro-sized industry, Small-sized industry, Medium-sized industry, Research centres, Academia, NGOs, Regional public authorities, Local public authorities

Source of funding:

Regional funding

Contact details

Name:

josep roca

Email:

jroca@clinic.cat

Interoperability between social and health information systems

The aim of Interoperability social and health information systems is to implement in the Basque Health System an instrument to establish a common language among health and social fields. This tool allows the interoperability of social and health information systems, enabling both professionals to make a common assessment of people with health needs (target groups). InterRAI-CA involves a coordinated action between Social and Health Care professionals (who lead and support the implementation and training), 48 Municipalities, 92 Health Centers, 3 Provincial Councils, 1 Private Entity, 3 regional organizations (Osarean, Beti on and SIAC) dependent on the Basque Council of Social and Health Care, who validates the approach. Nowadays, the project has more than 376 tool users, and set up almost 150 coordinated Social-Health Care teams, to encourage the development of new protocols for coordinated Social-Health Care and to evaluate the experience of implementation of this tool. It is achieved through the development of information and training materials, briefings in all Basque Social and Health System, training sessions, implementation, support to professionals and Tool implementation - Setting-up coordinated Social-Health Care teams This commitment is aligned with the objective “B3.2. Evidence on innovative integrated care solutions

Keywords:
Interoperability, social and health sectors, shared information systems
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
País Vasco

Organisation

Organisation name:
Kronikgune - Institute of health services research

Organisation address:
BEC Dorrea ,Ronda de Azkue, 1, 48902
Barakaldo(Bizkaia)
Basque Country
Spain
Kind of organisation:
Research centres

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The development of interoperability is fundamental for inter-institutional and social and health team work. At this moment we are developing a pilot project for the development of a shared work agenda for both social and health agents. The development of this one-year pilot, which ends in September 2019, will provide information on the implementation times, technical and cultural, of social and health work.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, General practioners, Nurses, Regional public authorities, Local public authorities
Source of funding:
Regional funding

Contact details

Name:
Ane Fullaondo
Email:
afullaondo@kronikgune.org

Advanced Risk Modelling for Early Detection

Aspects of health and social care

The shifting demographics will continue to have a significant impact on the demand for health and social care services. There is a gap between normal, independent living and the telecare services someone receives after a major fall and / or hospitalisation. This practice focuses on allowing a person to use ubiquitous and non-stigmatising consumer technologies to act preventatively, pre-empting negative events and remaining independent for longer.

General and specific objectives

By identifying at-risk individuals sooner, there is potential to improve quality of life and save millions of pounds from the public purse, by changing care delivery, increasing self-management and reducing hospital admissions.

Specifically, to recruit 150 users in year 1 (completed), 750-1,000 users in year 2 (in progress) and 7,500-10,000 in year three.

Main methods, processes and organisation

ARMED focuses on key metrics associated with frailty and risk of falling, such as low grip strength, muscle mass, hydration levels, low heart rate and heart rate variability. These can easily be monitored and measured from the comfort of an individual's own home using the latest wearable technologies.

Data captured helps identify a variety of frailty indicators that would have previously gone unnoticed, such as Service Users who are significantly dehydrated or have a reduction in grip strength. It helps identify risk trends through Service User weight loss or a reduction in muscle mass, despite an increase in weight and direct fat. It highlights restlessness at night, which flags up ongoing risk during the day.

https://www.youtube.com/watch?v=4nvEvALlXac&feature=youtu.be

Keywords:

digital, care, independent living, Falls, prevention, low stigma

Website:

https://www.cm2000.co.uk/solutions

Initiative status:

On-going

Background

Geographical scope:

Regional level

Countries involved:

United Kingdom

Regions involved:
Scotland

Organisation

Organisation name:
Digital Health and Care Institute
Organisation address:
1st Floor, Suite B, Inovo Building, 121 George Street, Glasgow, G1 1RD
Kind of organisation:
Research centres

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Many of the above impacts are qualitatively observed over the last eighteen months.
The main case for extension is the robust cost / benefit in terms of reduced hospitalisations due to falls.
The costs resulting from the falls have been calculated for every three users:

- 4 X GP Call Outs = £612
- 2 X Ambulance Call Outs = £838 (It is acknowledged that this is a "whole system" cost and not one direct to the HSCP)
- 1 X Overnight Hospital Admission = £559
- 3 X Same Day Hospital Discharge = £813
- 3 packages of care approximated at 10 hours per week at an hourly rate of £17.40 per hour provisioned over a 52-week period. This equals a cost of £522 per week which over a 52-week period equates to £27,144 for the 3 service users.

Total costs for 3 individuals = £29,996 versus a cost of ARMED at £1,080 which represents a 27: 1 save to spend ratio.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Informal caregivers, Housing organisations, Small-sized industry

Source of funding:

For profit

Contact details

Name:

Chaloner Chute, Chief Technology Officder

Email:

chalonerchute@dhi-scotland.com

Attend Anywhere

Aspects of health and social care:

The Scottish Government's Technology Enabled Care (TEC) Programme was established in 2015, with the aim to increase the use of video conferencing (VC) technologies for health and care consultations. In late 2015, the team became aware of new product, Attend Anywhere, that uses browser-based technology to deliver a video consulting solution which greatly simplified the video consultation workflow and provided a simpler technical solution.

General and specific objectives:

The initial objectives of the Attend Anywhere programme were to establish a video consulting service across Scotland, providing 50 clinics across health, care and the third sector, with the aim of reducing travel, improving efficiency and supporting service change. It drew on best practice from Australia and the United States.

Main methods, processes and organisation:

The Attend Anywhere system provides a video clinical environment that can be accessed by a member of the public using a web browser on their own device, be it a laptop, tablet or smartphone. Attend Anywhere provides a single, consistent entry point on the service's webpage, where patients enter an online waiting are for their appointment. Staff manage their clinics as usual. Video appointments are handled through existing processes and systems and run like any other consultation. Patients attend appointments via the clinic's website and wait in their own private room, in the waiting area. No account, special software, or dial-in details are needed. Clinicians prepare to engage with their patients as normal, except they join patients via the clinic's online waiting area instead of its physical one. Health Services have access to all the support, advice, and resources they need to help with adoption and use of Attend Anywhere.

Keywords:

attend anywhere, clinics, consultations, virtual, video-conferencing

Website:

https://nhs.attendanywhere.com/resourcecentre

Initiative status:

On-going

Background

Geographical scope:

National level

Countries involved:

United Kingdom

Regions involved:
Scotland

Organisation

Organisation name:
Scottish Government
Organisation address:
St. Andrew's House, Regent Rd, Edinburgh EH1 3DG, United Kingdom
Kind of organisation:
National public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The following impact was observed for NHS Scotland:

- Making travel optional for patients in a way that is scalable and sustainable
- Reduced requirement for extra resources or systems to support video consulting
- Increased range of services available, especially outside urban areas
- Significantly reduced barriers and constraints to offering video call access to existing services
- Health-grade quality security, privacy and data protection
- Easier transfer of patients between healthcare services
- Improved access to care and save of time and money.

- Reduction is staff and citizen travel leading to cost reduction and reduced carbon emissions

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Primary care centres, Specialised physicians, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Private companies, Research centres, Academia, Advocacy organisations patients/users

Source of funding:

National funding

Contact details

Name:

Hazel Archer

Email:

Hazel.archer@gov.scot

Game based Neurological Tele-Rehabilitation

REHABILITY is the suite of serious games co-designed with specialists and patients post stroke, with Multiple Sclerosis or Parkinson disease. A best practice connected health solution, REHABILITY allows patients to take part in rehabilitation therapy both within a specialist facility and from home with continuous remote medical support. It combines physical with cognitive exercise (simultaneously if required), and medical staff can quickly personalise the exercises for each single patient in each phase of the therapy in a very fine grained, yet simple way.
The product has proven research to show that it motivates elderly people to comply with the prescribed therapy, thus supporting adherence: the research results have been published in several scientific papers.
The product is culturally neutral and multi-lingual, being able to address people from very many different countries (it is also being used in SE Asia).
For ease of use and cost reduction, particularly for use @home, REHABILITY uses off-the-shelf affordable consumer technology: it runs on PC, TV and tablet and works with several motion tracking systems.
Although already proven and stable, the product is being continuously enhanced, taking into account the suggestions and needs of customers who thereby can influence the production pipeline.

Keywords:
Rehabilitation, connected care, adherence, telemedicine, personalised medicine, active ageing
Website:
http://www.rehability.me
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Europe, Asia
Regions involved:

Organisation

Organisation name:
imaginary srl
Organisation address:
piazza Caiazzo 3
20124 Milano Italy
Kind of organisation:
Small-sized industry

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, Day care centres, Home care centres, Nursing homes, Regional public authorities, Local public authorities
Source of funding:
European funding

Contact details

Name:
Lucia Pannese
Email:
lucia.pannese@i-maginary.it

ICT services for Life improvement for Elderly

Almost 10 million Europeans live with Parkinson's, Alzheimer's and other dementias today. As a result of ageing, the number of people affected by one of those conditions is forecasted to double by 2030, making them a major health challenges. Those people want to live at their own homes, but because of their symptoms, they face difficulties in the daily life both in managing their own care and in living independently.
ICT4Life is a three-year project funded under Horizon 2020, the EU Framework Programme for Research and Innovation, with the ambition of providing new services for integrated care employing user-friendly ICT tools, ultimately increasing patients' quality of life and autonomy at home. To reach this goal, ICT4Life is conducting breakthrough research and radical innovation and will implement the ICT4Life Platform. Such a platform will deliver a series of innovative services to patients affected by Parkinson's, Alzheimer's and other dementias but also to health professionals and formal and informal carers. All solutions are developed following a user-centred methodology and tested in real life scenarios.
The real case scenarios concern three European countries: France, Hungary and Spain to test ICT4Life services, measure the effects of treatment and evaluate project developments and acquired knowledge about co-morbidities related to these diseases. The project consortium brings together nine partners representing academia, industry and users' groups, all committed in improving patients' lives and advancing Europe leadership role in personalised services for integrated care.

Keywords:
Integrated care, end-users needs, personalised care, independent living solutions, patient empowerment, adverse events detection, real-time monitoring, medication management, reduced hospital admissions, flexible eHealth solution
Website:
http://www.ict4life.eu/
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
France, Hungary, Spain
Regions involved:
Comunidad De Madrid, Île De France, Baranya

Organisation

Organisation name:
HOPE - European Hospital and Healthcare Federation
Organisation address:
Avenue Marnix, 30 - 1000, Brussels (Belgium)
Kind of organisation:
NGOs

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 1.000 – 5.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
ICT4Life platform supports integrated care processes for Parkinson's and Alzheimer's diseases joining all actors involved in care: patient, caregivers (formal & informal) and professionals (health & social) supporting a better care coordination and integration between them through the use of the different devices provided (mobile apps, web and smartTV), which improves the continuity of care in chronic diseases.
It offers services to patient and caregivers to improve their Quality of Life and empowerment by supporting increased knowledge of the disease and the treatments, personalized training and reminders and alerts which targets a higher feeling of safety and control of patients and caregivers supporting patients to live longer and independently at home. It includes communication services between patients, caregivers and professionals, reducing isolation feelings from some people living alone and providing continuous support in case of adverse events. This contributes in turn to face emergency needs and, as a consequence, to decrease hospital stay duration and the hospital admission.
The ICT4Life platform incorporates home care sensorial services. Data collected from the sensors is a reliable source of information about the patient's health status in clinical

practice. Sensors monitoring allows early detection of risky situations, facilitating personalised treatment and improved better health outcomes for the patient.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Small-sized industry, Research centres, Academia, NGOs, International/European public authorities, Regional public authorities, Local public authorities, Advocacy organisations patients/users

Source of funding:

European funding

Contact details

Name:

Isabella Notarangelo

Email:

eco@hope.be

Psychological Support Program for the Elderly (PAPI) in Portuguese Programa de Apoio Psicológico ao Idoso

Based on logic of descentralization and contracting of services provided by retirement homes of Montemor-o-Velho (county of Coimbra) the Psychological Support Program for the old-age people (PAPI in Portuguese Programa de Apoio Psicológico ao Idoso) seeks to promote the bio-psycho-social balance of the elderly. This project provided services that will go from the assessment to intervention as well as prevention programs of rehabilitation of emotional and cognitive problems targeting an implementation of psychological support in old-age people. Also creating of an educational / training plan based on the perceived needs of these type of people for the technicians.

Keywords:
Multimorbid patients, Cognitive decline, Population Intervention Plans, Cognitive Stimulation, Preventive secondary Plan, Health saving costs.
Website:
http://apoiopsicologicoid.wixsite.com/papi
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Portugal
Regions involved:
Região de Coimbra

Organisation

Organisation name:
peroneo centro terapêutico lda.
Organisation address:
Rua Principal, Nº 453 Amieiro
3140-021 Montemor-o-Velho
Kind of organisation:
Private companies

Viability

Time for deployment:

More than three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Medium impact – e.g. shortly beyond the pilot project period

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Day care centres, Home care centres, Informal caregivers, Community

Source of funding:

Private funding

Contact details

Name:

monic4sous4@gmail.com

Email:

monic4sous4@gmail.com

FrailSurvey: a mobile phone app for self-assessment of the frailty status among community-dwelling older people

FrailSurvey is a mobile phone app for self-assessment of the frailty status among community-dwelling older people. This mobile app is free of charge, being available for IOS and Android operating systems.
The screening of frailty status was based on the Groningen Frailty Index. The app assesses diverse sides of the life of the elderly, namely their mobility, physical shape, vision, hearing, nutrition, as well as cognitive and psychosocial aspects. In the end, the older adults were classified as robust, pre-frail or frail. When the older adult is classified as pre-frail or frail some recommendations were available. The results obtained in terms of frailty status will be important for healthy ageing, as it can help lifestyles changes to prevent or revert they frail status.
This app collects data in an anonymous way and generates a database for research proposes.

Keywords:
Aheing, frailty, app, mhealth
Website:
Initiative status:
Completed

Background

Geographical scope:
National level
Countries involved:
Portugal
Regions involved:

Organisation

Organisation name:
University of Porto/ Porto4Ageing Reference Site
Organisation address:
Praça Gomes Teixeira
4099-002 Porto, Portugal
Kind of organisation:
Academia

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.

Time of impact:

Medium impact – e.g. shortly beyond the pilot project period

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Primary care centres, General practioners, Pharmacists

Source of funding:

Private funding

Contact details

Name:

Elísio Costa

Email:

emcosta@ff.up.pt

Happyair an m-health program for integrated care in chronic respiratory disease

We provide a service to HCPs and patient/care-givers which is enabled via a platform where patient data is collected via an App for mobile telephones or tablets which the patient or care-giver uses.Our educator/coach network is initially being led & managed by respiratory physiotherapists to ensure that physical activity is a key factor to the patients program, to improve health status.

A team of educators or coaches can monitor the patient information through this platform & in parallel ,via a contactcenter CRM service, follow-up patients or care-givers on their progress . They can share this information with collaborating healthcare professionals : doctors , specialists or other HCPs such as psychologists who offer holistic support, with patient consentment.

The program also enables the patient and/ or care- giver to access health education materials or workshops, to learn more about his/her disease management and learn how to self- track effectively using digital tools or devices with a specific program for their disease or needs.

Each person has their own daily healthcare plan and follows their own goals guided by their doctors' and coaches advice.

The relationship with the coach provides them with information on many items prevention, better understanding about their diagnosis, a care plan and deals with worries or concerns that arise. The service is hybrid: both online and offline where available in the patients own location where they can participate in group sessions or individually.

The educators role is to empower the patient with support and guidance in digital healthcare tools or other needs in their own environment.They are trained as tele-care educators specialised in active lifestyle in chronic-care patients. They help patients to navigate their digital literacy skills and work on motivation & behavioural change to improve adherence and outcomes.

The care support is online/offline according to network and local resources with collaboration from partners who want to provide better quality of life and solutions for an ageing population across their network or region.

Keywords:
integrated care, chronic disease management, digital health, m-health, Patient Empowerment, workforce change, integrated care pathways

Website:
http://happyair.org/

Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Europe
Regions involved:
Comunidad De Madrid

Organisation

Organisation name:
Fundación Lovexair
Organisation address:
Paseo de las Delicias, 30
Madrid 28045
Spain
Kind of organisation:
NGOs, Advocacy organisations patients/users

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running

Description of impact:
This model can be transferred out via trained educators in a 6 month period.The resources are all available and the IT partnering is being scaled up to meet larger number of users. The training programs for educators will be launched in October 2017.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Specialised physicians, Small-sized industry, Research centres, Academia, NGOs, Advocacy organisations patients/users, Advocacy organisations others, Physiotherapists
Source of funding:
Not-for-profit

Contact details

Name:
Shane Fitch
Email:
presidencia@lovexair.com

Integrated care and ICT to reduce frailty and chronic diseases in ageing women of the CARMEN cohort.

The aim is the reduction of frailty and chronic diseases with strong gender profile, mainly musculoskeletal (osteoporosis) and cognitive decline, through the implementation of healthy lifestyle. Our population is composed of the women entering the cohort Chronic Ailment Reduction after MENopause (CARMEN, 1400 community dwelling women from the urban area of Valencia). Women initiate a program of integrated care, where primary care nurses and social workers act together to perform screening and subsequent monitoring after implementation of a physical activity program. The team also includes specialists in women's health in the third level hospital. ICT is used to empower participants, whose adherence is stimulated through the use of a mobile phone-based virtual support group. A basic teaching course is given to facilitate use of technology. The tools used for frailty and cognitive decline screening are being shared with other A3 partners as a result of a collaborative work initiated in 2013 in order to strengthen synergy and harmonisation of databases. Further, the commitment is inserted within the Valencia reference site. Clinical and analytical data are kept in a database while serum and ADN samples are stored in biobank. A parallel basic research programme aims at exploring the effects of lifestyle on genomics of bone metabolism and frailty. The fact that the program is developed within the public health system provides conditions for scalability at national and international level.

Keywords:
Gender, frailty, Cognitive decline, quality of life, Mood, Physical activity, Osteoporosis, Musculoskeletal disease, ict, adherence
Website:
http://salusvitae.es/
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Comunidad Valenciana

Organisation

Organisation name:
University of Valencia- INCLIVA
Organisation address:
AV BLASCO IBÁÑEZ 17
46010 Valencia, Spain
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Research centres, Academia

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
During the progression we have not been able, for obvious reasons, to detect changes in final clinical events, which require a long-term
follow up and a huge number of participants. However, even with the still low numbers, we have detected improvement in psychological indicators (mood, social interaction) as well as biomedical features, including clinical traits like weight or waist circumference. Also a trend towards frailty reversal has been detected.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Research centres, Academia, NGOs, Regional public authorities, Local public authorities, Advocacy organisations others

Source of funding:

European funding

Contact details

Name:

Antonio Cano

Email:

ANTONIO.CANO@UV.ES

Lifestyle to improve frailty, mood, cognitive decline and quality of life in women surviving cancer or with diabetes

Survival of cancer and diabetes define two morbidities with growing prevalence and marked specificities. Gender profile affects specific areas, like breast cancer, which leaves women in a deteriorated health state and increased vulnerability. We aim at implementing healthy lifestyle, including nutrition and physical activity, to reduce the burden of frailty and of chronic diseases with strong gender profile, mainly musculoskeletal (osteoporosis) and cognitive decline, in women surviving cancer or suffering diabetes. Improvement of mood and quality of life are additional objectives. To reinforce scalability, the commitment in embedded into the CARMEN program, which provides integrated care at primary care level of the public health system. Nurses, who share with social workers first assessment and monitoring, initiate enrolment in the programme. Referral to primary care doctors or the third level specialist (gynaecologist) is done when required. Empowerment is strengthened by the use of an ICT-based program (mobile-based) and by the involvement of patients associations. Adherence in the long term and sustainability are promoted in that way. Collaborative work with other EIPAHA partners materialises in sharing of screening and monitoring tools. Further, the commitment is inserted within the Valencia reference site. Clinical and analytical data are kept in a database while serum and ADN samples are stored in bio-bank. A parallel basic and clinical research program is attached to the initiative.

Keywords:
Gender, frailty, Multi-Morbidity, Cancer survivor, Diabetes, Cognitive decline, quality of life, Mood, Physical activity, ict
Website:
http://salusvitae.es/
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Comunidad Valenciana

Organisation

Organisation name:

University of Valencia- INCLIVA

Organisation address:

AV BLASCO IBÁÑEZ 17, 46010 Valencia, Spain.

Kind of organisation:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Research centres, Academia, NGOs

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

During the progression we have not been able, for obvious reasons, to detect changes in final clinical events, which require a long-term follow up and a huge number of participants. However, even with the still low numbers, we have detected improvement in psychological indicators (mood, social interaction), general health indicators (waist circumference, weight, better functional performance in certain musculoskeletal parameters), and quality of life.

Transferability level:

Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Research centres, Academia, NGOs, Regional public authorities, Local public authorities, Advocacy organisations others

Source of funding:

European funding

Contact details

Name:

Antonio Cano

Email:

ANTONIO.CANO@UV.ES

Adapted Physical Activity Programmes (Programmi di Attività Fisica Adattata)

Adapted Physical Activity programs (APA) are group exercise programs, designed for individuals with chronic conditions, aimed at correcting sedentary life style and hereinafter at the prevention or mitigation of frailty and disability. There is a large body of published evidence indicating that a number of diseases, disabilities and premature deaths can be prevented by the adoption of healthy life styles, where physical activity is recognized to play a primary role. This has been demonstrated not only for healthy individuals, but also for individuals suffering from chronic conditions. The disabling effects of chronic diseases are worsened by the additive effect of sedentary life style, which causes new impairments, new functional limitations and more severe disability. There is sufficient evidence to conclude that this vicious circle can be corrected with an adequate program of exercise.

A key question from a policy perspective is how to translate the evidence on the beneficial effects of exercise into an effective large-scale network of services for persons with chronic conditions. The considerable financial pressure caused by the increasing prevalence of chronic diseases associated with an aging population has lead the Tuscany Regional Health System to launch in 2005 the APA programmes and to promote their diffusion throughout the entire Region.

Adapted Physical Activity was developed to provide a community-based, progressive, supervised group exercise for elderly, sedentary citizens as an alternative to over-subscribed clinic-based rehabilitation programmes. General practitioners (GPs) were the primary referral source. They were encouraged to refer all elderly patients with chronic musculo-skeletal complaints whom they deemed adequately medically stable to participate in exercise (Low disability classes). The Health Authority then began developing an APA programme for patients with chronic neurological deficits (High disability classes). These patients have significantly impaired function, and thus require a different programme of exercises, and smaller classes then those in the original programme. The Local Health Authority (LHA) staff coordinates patients assignment to local gymnasiums which have joined this initiative. General practitioners refer medically cleared patients for participation. APA participants attend classes two or three times a week in community gyms. LHAs train the gym instructors in protocols for the different chronic conditions and regularly observe APA classes to ensure treatment fidelity.

APA programmes are held during the day at “off hours” in the local gyms or pools. In locations where gyms were not available, suitable environments were identified in social clubs or parish premises. This strategy has enabled the LHAs to keep prices low, to get a large number of private operators involved (gyms or pools) and to obtain a wide geographical coverage of the service (thereby reducing travel distance and time). In addition

it has facilitated adherence and reduced social isolation by facilitating the interaction among participants.
People pay for themselves (2.20/2.50 € for one hour exercise session, i.e. approximately the cost of a cappuccino and a pastry) and must arrange their own transportation. The entire cost of the programme is covered by the participants, except coordination which is provided by LHAs. Since at the end of 2016 the participants were apprroximatively 30,000, we can extimate that the total private expenditure in 1 year is around 7 millions euros (gyms costs, insurance costs, private associations fees), plus about 250,000 euros for coordination activities by LHAs as promotion and monitoring.

Keywords:
Exercise, health, prevention, disability, frailty, active ageing, Communit based programmes, Age-friendly cities and communities, Public Private Partnership, Promotion of physical activity
Website:
http://open.toscana.it/web/toscana-accessibile/a.f.a.-attivita-fisica-adattata
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Toscana

Organisation

Organisation name:
Regione Toscana
Organisation address:
Via T. Alderotti 26/n, 50139 Firenze, Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Time invested in the initial phase of the initiative should be addressed towards the team making among GPs, LHAs' clinicians and exercise trainers in order to create a strong trust environment among all the actors of the programmes. That might take time and patience, but will be very rewarding in the long term. In addition, time should be invested to promote the initiative among senior citizens through a positive approach, using all the communication opportunities offered by the community. Finally, it is very important to allocate resources and time in the continuous monitoring of the compliance of all the partners to the agreed standards of the service.

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Day care centres, Informal caregivers, Private companies, Research centres, Academia, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses, Advocacy organisations others, Trade Unions

Source of funding:

Private funding

Contact details

Name:
Elisa Scopetani
Email:
elisa.scopetani@regione.toscana.it

ICT4Life - ICT4Life services for Life Improvement for Elderly

ICT4Life is a three-year project financed under Horizon2020 that kicked off in January 2016 with the aim of finding solutions to promote self-care and integrated care while using innovative technologies. These solutions flow into the ICT4Life platform, connecting patients affected by Parkinson's, Alzheimer's and other dementias, families, health professionals and care-givers through user-friendly tools. ICT4Life approach is based on scientific research on end-users as a basis for offering personalized models of care. The technologies monitor the patients in real-time in order to detect abnormal behaviors and to call for early intervention. This will prevent fall risk, social isolation, depression, poor well-being and inadequate medication management. ICT4Life supports the exploitation and the use of interactive services allowing patients, carers and professionals to easily communicate within each other and increasing patients' quality of life and independence at home.
This initiative brings together nine partners representing academia, industry and users' groups, all committed in improving patients' lives and advancing Europe's leadership role in personalised services for integrated care.
The partners of this well-balanced and multidisciplinary consortium are: Artica Telemedicina (Spain), Polytechnic University of Madrid (Spain), Madrid Parkinson Association (Spain), Netis Informatics Ltd. (Hungary), E-seniors (France), Centre for Research and Technology Hellas (Greece), Maastricht University (Netherlands), European Hospital and Healthcare Federation (Belgium) and the University of Pécs (Hungary).

Keywords:
Independent living solution, integrated care, Patient Empowerment, informal carers quality of life, eHealth, mhealth, self-care, real-time monitoring, Early intervention
Website:
http://www.ict4life.eu/
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
France, Hungary, Spain
Regions involved:

Organisation

Organisation name:

HOPE - European Hospital and Healthcare Federation

Organisation address:

Avenue Marnix, 30 - 1000 Brussels (BE)

Kind of organisation:

NGOs

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Private companies, Small-sized industry, Research centres, Academia, NGOs, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses, Advocacy organisations others

Source of funding:
European funding

Contact details

Name:
Isabella Notarangelo
Email:
eco@hope.be

Intelligent Carpet System for Gait and Balance Monitoring in Home Environments

Abstract—We report on the photonic variant of the previously introduced guided-path tomography (GPT), by demonstrating a system for footstep imaging using plastic optical fiber (POF) sensors. The 1 m × 2 m sensor head is manufactured by attaching 80 POF sensors on a standard commercial carpet underlay. The sensing principle relies on the sensitivity of POF to bending, quantified by measuring light transmission. The photonic GPT system, comprising the sensor head with processing hardware and software, covered by a mass-production general-purpose carpet top, successfully performs footstep imaging and correctly displays the position and footfall of a person walking on the carpet in real time. We also present the implementation of fast footprint center of mass calculations, suitable for recording gait and footfall. A split-screen movie, showing the frame-by-frame camera-captured action next to the reproduced footprints, can be downloaded at http://ieeexplore.ieee.org

Keywords:
Index Terms— Footstep imaging, gait, “intelligent carpet”, parallel center of mass algorithm (PCoMA), photonic guided- path tomography (PGPT), plastic optical fiber (POF).
Website:
http://www.imagimat.co.uk
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Europe, United Kingdom
Regions involved:

Organisation

Organisation name:
THe University of Manchester (EEEand CEAS with NMSW)
Organisation address:
Oxford Road
M13 9PL, Manchester, UK

Kind of organisation:
Nurses, Research centres, Academia

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
More than 5.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Impacts listed have not yet been observed since no patient tests have yet taken place.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Private companies, Micro-sized industry, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Academia, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians
Source of funding:
National funding

Contact details

Name:
Dr Patricia Scully and Prof Krikor Ozanyan
Email:
P.scully@manchester.ac.uk

The Forward project

Il Pensiero Scientifico Editore, with the scientific support of the Department of Epidemiology of the Regione Lazio, designed and started in 2016 the Forward Project. Its aim is to reflect and discuss what is going to become relevant in the near future within the health sector. Health care is changing due to the introduction of organizational improvements, technological innovations, and clinical and therapeutic advances.
The Forward Project is also a useful Institutional tool to disseminate independent information regarding clinical appropriateness, public health strategies, diagnostic and clinical decision-making and to discuss the forthcoming landscapes that will be emerging in the health field.
The Project is linked to Recenti Progressi in Medicina, a monthly academic scientific journal established in 1946 and indexed in major international bibliographic databases. The Editorial Board of the journal serves as scientific reference, supported by an Advisory Committee made up by prominent experts involved in the National and Regional Health System.
Forward pays a special attention to the communication aspects of content dissemination. First of all, opinion mining and sentiment analysis of the Italian health professionals is the preliminary step of the Project. Then, Forward offers video interviews, timelines, infographics integrating the traditional communication.

Keywords:
dissemination, health information, critical appraisal
Website:
http://forward.recentiprogressi.it/the-forward-project/
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Italy
Regions involved:

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:

Via Cristoforo Colombo 112, 00147 Rome, Italy

Kind of organisation:

Regional public authorities

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Private companies, Small-sized industry, Research centres, Academia, Regional public authorities, Local public authorities

Source of funding:

Private funding

Contact details

Name:

Antonio Addis

Email:

a.addis@deplazio.it

The Lombardy Workplace Health Promotion Network

The program "The Lombardy Workplace Health Promotion Network - has as main objective the promotion of organizational changes in the workplace in order to enable the working environments to the adoption of healthy lifestyles for the prevention of chronic diseases. Chronic diseases represent, in fact, both a health priority and a challenge with social and economic impact for the world of work in the field of management and rehabilitation of workers, also in relationship to the enhancement of human capital. Improving work organization and environment can effectively impact on "Active and Healthy Ageing", also creating conditions supporting and including older workers and those with chronic diseases or disabilities. The Lombardy WHP Network belongs to the European Network for Workplace Health Promotion ENWHP (http://www.enwhp.org/the-enwhp/members-nco.html).

Keywords:
Workplace Health Promotion, healthy lifestyles, prevention of chronic diseases, working environments, well-being of workers
Website:
http://www.promozionesalute.regione.lombardia.it
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lombardia

Organisation

Organisation name:
Lombardy Region
Organisation address:
Piazza Città di Lombardia, 1 - Milan, Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The length of time that should be invested to actively involve the local companies has to be carefully planned as it might take long. To guarantee the long term sustainability of the practice it is necessary to involve companies committed to collaborate with their workers to implement a continual improvement process aimed at promoting the health, safety and wellbeing of all workers and the sustainable development of the workplace.
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Private companies, Regional public authorities
Source of funding:
Private funding

Contact details

Name:
Liliana Coppola
Email:
liliana_coppola@regione.lombardia.it

Identification of frail elderly by HIS and GPs

In Lazio, a prognostic indicator applied to data available in HIS allows for the identification of frail population subgroups. The information accounts for socio demographic characteristics, hospitalisations, emergency room visits, drug consumption. Regarding the population at high risk of multiple hospitalisation, about 25% of 65+ year olds are classified as “intense” users of the health care system.

Keywords:
multimorbidity, frailty, Hospitalisation
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:
Via Cristoforo Colombo 112, 00147 Rome - Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
No evidence or no demonstrated impact
Description of impact:
Once the lists of patients at risk of multiple hospitalisations will be used to inform GPs, this is expected to reduce hospitalisations among these patients.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Regional public authorities
Source of funding:
Regional funding

Contact details

Name:
Paola Michelozzi
Email:
p.michelozzi@deplazio.it

Regional Plan for Prevention of Heat Related Health Effects in the Lazio Region

Heat wave related frailty is defined on the basis of predicted mortality, which accounts for patterns of frailty indicators, such as female gender, living alone, hospitalisation for diabetes, diseases of the central nervous system, psychiatric disorders and cerebrovascular diseases. The heat susceptibility indicator classifies at medium-high and high risk an average of 4% of the 65+ years old population. About half of these are included in active surveillance by general practitioners (GPs) aimed to prevent physical and functional decline and premature death during heat waves. Furthermore, on a sample of elderly residents in Lazio region, the University of Tor Vergata is undertaking a multidimensional evaluation of frailty.

Keywords:
frailty, heat, monitoring, heat wave warning system
Website:
http://www.deplazio.net/it/temi/151-piano-di-prevenzione-e-sistema-di-allarme-on...
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:
Via Cristoforo Colombo 112, 00147 Rome - Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Health benefits have been observed in terms of reductions in mortality of frail elderly patients during heat waves (see paper "Michelozzi P et al. Surveillance of summer mortality and preparedness to reduce the health impact of heat waves in Italy.Int J Environ Res Public Health. 2010 May;7(5):2256-73)
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, General practioners, Nursing homes, Informal caregivers, Regional public authorities, Local public authorities
Source of funding:
Regional funding

Contact details

Name:
Paola Michelozzi
Email:
p.michelozzi@deplazio.it

Identification of patients affected by chronic disease as target populations for specific health care interventions

Through a validated algorithm based on the regional health information systems relating to hospital diagnoses, drug consumption and co-payment exemptions, the resident population with COPD and diabetes is identified every year. For these patients adherence to evidence based guidelines is assessed, accounting for regular glycated haemoglobin measurements in diabetes and use of long-acting beta-agonists in COPD management. Yearly results allow to identify population subgroups at risk for non-adherence and to measure temporal and spatial differences. This information is then returned to healthcare managers and medical practitioners aiming at an improved adherence.

Keywords:
Diabetes, COPD, adherence, Guidelines, Monitoring and evaluation
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:
Via Cristoforo Colombo 112, 00147 Rome - Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Less than a year

Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
No knowledge about evidence. No evaluation or documentation of effect has been carried out
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Having lists of patients affected by a specific diseases helps care givers to issue the best care to their patients
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Specialised physicians, General practioners, Regional public authorities, Local public authorities
Source of funding:
Regional funding

Contact details

Name:
Danilo Fusco
Email:
d.fusco@deplazio.it

Diagnostic and care pathways

For selected chronic diseases with high impact on diagnostic and therapeutic case-management, evidence based recommendations have been defined which outline the most efficient and patient-friendly standardised case management in COPD and diabetes (and in the near future also heart failure and anticoagulant therapy). Another activity aiming at integration of care for chronic disease management are the so-called Houses of Health (Case della Salute), i.e. primary care facilities whose main objective is promoting the integration of essential levels of health and social services through the spatial proximity of services and operators in a user-friendly facility. The multidisciplinary facility combines diagnostic and lab activities with primary and specialist care. To date, these facilities focus on diabetes and COPD.

Keywords:
Chronic Disease, Diabetes, COPD, intergrated care
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:
Via Cristoforo Colombo 112, 00147 Rome - Italy
Kind of organisation:
Local public authorities

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Integration of diagnostics and treatments of chronic patients accounting for both, health and social care reduces waiting times, facilitates multidisciplinary care, improves quality of and adherence to treatment, offers closer monitoring of chronic patients over time.
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Primary care centres, Specialised physicians, General practioners
Source of funding:
Regional funding

Contact details

Name:
Nera Agabiti
Email:
n.agabiti@deplazio.it

Diagnostic and care pathways

For selected chronic diseases with high impact on diagnostic and therapeutic case-management, evidence based recommendations have been defined which outline the most efficient and patient-friendly standardised case management in COPD and diabetes (and in the near future also heart failure and anticoagulant therapy). Another activity aiming at integration of care for chronic disease management are the so-called Houses of Health (Case della Salute), i.e. primary care facilities whose main objective is promoting the integration of essential levels of health and social services through the spatial proximity of services and operators in a user-friendly facility. The multidisciplinary facility combines diagnostic and lab activities with primary and specialist care. To date, these facilities focus on diabetes and COPD.

Keywords:
Chronic Disease, Diabetes, COPD, intergrated care
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:
Via Cristoforo Colombo 112, 00147 Rome - Italy
Kind of organisation:
Local public authorities

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Integration of diagnostics and treatments of chronic patients accounting for both, health and social care reduces waiting times, facilitates multidisciplinary care, improves quality of and adherence to treatment, offers closer monitoring of chronic patients over time.
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Primary care centres, Specialised physicians, General practioners
Source of funding:
Regional funding

Contact details

Name:
Nera Agabiti
Email:
n.agabiti@deplazio.it

Regional Outcome Evaluation Program

The Regional Outcome Evaluation Program (P.Re.Val.E.) is a comparative evaluation of regional healthcare outcomes using outcome indicators, process indicators, volume indicators and ambulatory care sensitive conditions (ACSC) indicators. The aim is to identify potential critical organizational or clinical factors and monitor trends in health care quality over time. The program evaluates hospitals (health care production) and local health trusts (health care protection) and investigates the heterogeneity of access to healthcare across both geographical areas and hospitals. The results are returned to medical doctors and hospital managers through a dedicated website which offers also the opportunity to participate in a distance learning activity. Moreover, results are discussed in face-to-face meetings with interested stakeholders. Since 2013, the compensation of each chief executive officer of Lazio health structures has been determined on the basis of overall hospital or local health trust performance and depends on P.Re.Val.E. indicators.

Keywords:
evaluation, performance, Outcomes, process, volume, audit
Website:
http://95.110.213.190/prevale2016/index.php
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Department of Epidemiology, ASL Roma 1, Lazio Region
Organisation address:
Via Cristoforo Colombo 11200147 Rome - Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Evaluation of the performance has led to improvements in health care quality and has a positive impact on the health of the regional population. According to the indicators, this can reflect in lower mortality (e.g. after AMI), shorter hospital stay (e.g. cholecistectomy), better quality of life (e.g. timely hip fracture surgery, lower cesaerian section rates).
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Regional public authorities, Local public authorities
Source of funding:
Regional funding

Contact details

Name:
Danilo Fusco
Email:
d.fusco@deplazio.it

Happyair : an m-health integrated care model for patients with chronic respiratory disease.

HappyAir program offers a completely new service for patients with chronic respiratory disease, managing the condition more easily while reducing costs in healthcare systems & offering new workforce and care pathways to empower patients in disease-management whilst aggregting clinical data for research and new interventions to prevent and promote healthier and active lifestyles.

HappyAir innovations include:

- A novel platform to help patients manage their disease. Using an App, the platform combines a time-based healthcare strategy, a progress tracking system, medication and therapeutic treatment follow-up schedules. Its clinical validation and service model benefits will come from the trials currently running in Madrid in this first pilot program in patients with COPD stages iii/iv age 65+.
- Platform interactions with Internet of things [IoT] electronics related to COPD management. For the first time, HappyAir offers device integration e.g directly registering pulsioximeter data to a COPD-management App, or electronic inhaler's info recording and storing into the platform. Happyair App is also integrated with GoogleFit fully registering the respiratory patient's exercise program.
- Patient's guidance and supervision through a designated educator or coach, a qualified respiratory physiotherapist.
- Interoperability with other Platforms
- monitoring patients activity levels and adherence to their treatment in pharmacological and other therapies or interventions

HappyAir is the first program for lung disease monitoring that strongly integrates patient/healthcare provider management to the advantages of the IoT. Through the mobile App it is possible to interact with common devices used for COPD management (Second phase to include Blue tooth connected inhaler) - Bluetooth Pulsioximeter. HappyAir records patient's oxygen saturation and pulse data from these devices to help healthcare providers, ensuring a thorough follow-up of the patient and suggesting actions if needed. The data analysis described above also applies here.

Learning to manage the App and connected devices empowers patients, enhancing their skills at self-managing thus improving their quality of life and health status.

COPD predominantly affects people over 40. The HappyAir program has been specifically designed to tackle the needs of this age group since its inception taking into account all digital literacy barriers that exist in this user group.

17 years of experience with the respiratory community internationally in rare and chronic diseases, have given us a clear grasp on the needs of patients, care-givers and healthcare

professionals. HappyAir empowers respiratory patients and increases treatment adherence as they can clearly see the results of their own interventions.
The HappyAir App was developed by the partnership Lovexair(NGO)-Persei(SME). Persei has broad experience in developing healthcare software for Public-Private Healthcare providers. Lovexair´s research team in this endeavour include leading respiratory physiotherapists (educators), expert respiratory physicians at secondary and primary care level, University experts and an extensive network of related stakeholders.
HappyAir introduces the role of educators to motivate user´s engagement by triggering behavioural changes, providing education whilst guiding users through their own care-plan. Personal one-on-one support, helps to overcome the digital gap. Moreover, users' feedback from the clinical trial will be used to improve the App's interface. Persei & Lovexair team are constantly reviewing usability issues for the App and smooth integration with quality and reliable IoT devices.

Keywords:
workforce change, innovative co-financed service, adherence, Patient Empowerment, alternative networks, Chronic care, healthy ageing, Prevention and control, integrated care, Monitoring and evaluation
Website:
http://happyair.org/international/
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Spain
Regions involved:
Comunidad de Madrid

Organisation

Organisation name:
Fundación Lovexair
Organisation address:
Paseo de las Delicias, 30,
Madrid 28045, Spain

Kind of organisation:
NGOs, Advocacy organisations others

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
We are already begining to see a number of SROIs in the pilot model. The kind of impact includes: better care integration, less iolated, better quality of life, better health for example.
We want to test in informal settings to gauge better how to fine-tune the model as a cost-effective viable service whilst maintaining clinical validation to ensure that healthcare professionals, prescribers, also engage in the deployment stage and maintain their engagement with end-users via the filter of the coach figure. Our aim is for long term impact but the current work needed in digital healthcare interventions is preparing the market for change and the service providers (traditional) including healthcare profesionals. This work is essential in the next year to better support rapid deployment.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Pharmacists, Private companies, Small-sized industry, Large-sized industry, Research centres, Academia, NGOs, Advocacy organisations patients/users,

Respiratory Physiotherapists and Researchers/University lecturers in Physiotherapy, Scientific Society

Source of funding:

Not-for-profit

Contact details

Name:

Shane Fitch

Email:

presidencia@lovexair.com

Carealia

Carealia aims to bring affordable, cost- and time-effective ICT solutions to dementia care for the wider public. Specifically, the company builds smart monitoring systems to assist in the care of dementia in homes and nursing homes. Interconnected devices, such as wearable and ambient sensors, combined with intelligent algorithms and clinical knowledge, support doctors and nurses to accurately and reliably assess symptoms and behavioral patterns relevant to the disease, leading to effective interventions for improved care and quality of life. Carealia is a spin-off company of the Multimedia Knowledge and Social Media Analytics Laboratory (MKLab) of the Information Technologies Institute (ITI) and the Centre of Research and Technology Hellas (CERTH), specialized in the provision of intelligent systems for the assessment, remote monitoring and support of people with dementia and their caregivers. The company was founded in 2016 after CERTH's coordination of the Dem@Care (FP7 IP - www.demcare.eu) project during 2010-2015, in order to further exploit its findings. In detail, our vision is to disseminate affordable, time- and cost-effective eHealth solutions to the wider public at an international level. Our mission is to contribute to the timely diagnosis, assessment, maintenance and improvement of the quality of life of people with dementia, by deepening the understanding of how dementia affects their everyday life and behaviour. Carealia's experience originates from the participation of its founders to several EC-funded and national ICT and clinical research, through which valuables synergies with nursing homes, memory clinics and patient organizations in Europe have been forged. The interdisciplinary team is comprised of clinical psychologists, IT and market experts. Since its foundation in 2016, Carealia has established installations and partnerships in Greece and Sweden, reached the top ten finalists (out of more than a thousand) of the Hellenic Entrepreneurship Award the same year and been featured in multiple nation-wide events and media.

Keywords:
dementia, sensors, interventions, clinical decision support system
Website:
http://www.carealia.gr
Initiative status:
On-going

Background

Geographical scope:
European level

Countries involved:
Greece, Sweden
Regions involved:
Κεντρική Μακεδονία (Kentriki Makedonia)

Organisation

Organisation name:
Carealia
Organisation address:
6th Km Charilaou-Thermi, Thessaloniki, Greece
Kind of organisation:
Private companies

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 1.000 – 5.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Informal carers felt less stresses and more confident while saving money from having to hire sporadic home visit nurses.
Nursing homes upgrade their service value and save time and cost on staff doing sporadic visits for manual observation.
Individuals at home or nursing home feel constantly cared for, secure and included, while their mood and mental decline both improved due to the accurate interventions.
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Private companies, Micro-sized industry, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses

Source of funding:

Private funding

Contact details

Name:

Thanos Stavropoulos

Email:

thanos@carealia.gr

ALTOGETHER BETTER

Altogether Better is a national NHS network organisation with a diverse team of experienced managers, clinicians, community engagement specialists, and organisational development and change consultants, whose aim is to bring clinicians, patients and citizens together to deliver models of care based on the fundamental principles of coproduction. The changes which result have high impact, are cost effective, transformational and inherently sustainable.

Established in Yorkshire and Humber in 2008, Altogether Better has developed an evidenced based award-winning model that has engaged over 24,000 people who give their time as health champions in 18 CCG areas who have in turn reached thousands of others. Academic evaluation of the programme has demonstrated effectiveness in improving health outcomes, better use of health services and decreasing hospital admissions. An evidence review on older volunteers in health and well-being, produced by Leeds Metropolitan University, captures the impact that health champion work, and that of those in similar roles, has for older people. This includes older people who become health champions and older people in communities who are supported by champions. The findings suggest that older people engaging in lay public health roles are well placed to improve individual and community health and reduce health inequalities.

Building on this early work in community settings Altogether Better has developed a robustly evaluated evidenced based approach which brings citizens and GP Practices together which delivers:

- A vast range of new offers that promote wellbeing and resilience, prevent ill health and treat people who struggle to live well with long term conditions, isolation and loneliness (many of whom are older people)
- Reduction in consultation in primary and secondary care and a shift in the way patients use services – moving towards social rather than medical solutions
- Failure demand, one of the biggest costs in the NHS, is reduced
- A financially sustainable business model for General Practice
- Patients, carers and citizens becoming a valued part of an 'extended health and care team'
- Reduction in workload pressure
- Improvement in staff morale

Prototyping of the approach is about to begin in Residential Care Home settings.

Keywords:
citizen, primary care, new models, co-production, general practice, transformation, services, relationships, conversations, collaborative practices

Website:
http://www.altogetherbetter.org.uk
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
United Kingdom
Regions involved:
Barnet, Yorkshire and the Humber

Organisation

Organisation name:
Altogether Better
Organisation address:
SWYPFT
Fieldhead
Block 10, Room 29
Ouchthorpe Lane
Wakefield
WF1 3SP
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The impact observed covers all the areas listed above:

- Better health (societal)
- Better quality of life (societal)
- Less isolated people (societal)
- Better care integration (economic & societal)
- Less hospital re-admission (economic)
- Shorter stay in hospital (economic)
- Creation of jobs

It also reduces pressure in General Practice leading to a substantive Primary Care system (ie it is a new model of care that is sustainable). http://www.altogetherbetter.org.uk/film
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Nursing homes, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, People in the community
Source of funding:
Local funding

Contact details

Name:
Alyson Mcgregor
Email:
Alyson.McGregor@swyt.nhs.uk

Automated Audio Data Monitoring for a Social Robot in Ambient Assisted Living Environments

Human life expectancy has steadily grown over the last century, which has driven governments and institutions to increase the efforts on caring about the eldest segment of the population. Although this concern was initially addressed by building larger hospitals and retirement homes, these facilities have been rapidly overfilled and their associated maintenance costs are becoming far prohibitive. Therefore, modern trends attempt to take advantage of latest advances in technology and communications to remotely monitor those people with special needs at their own home, which boosts their life quality and has very few impact on their social lives. Nonetheless, this approach still requires a considerable amount of qualified medical personnel to track every patient at any time. The purpose of this paper is to present a social robot for assisted living
that tracks patients status by automatically identifying and analyzing the acoustic events happening in a house. Specifically, we have taken benefit of the amazing capabilities of a Raspberry Pi together with a Nao robot to collect data inside a house and send it in realtime to the medical center. Conducted experiments verify the feasibility of our approach and open new research directions in this domain.

Keywords:
assisted living, human robot interaction, social robots, remote therapy, audio recognition
Website:
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Spain
Regions involved:
Cataluña

Organisation

Organisation name:
FUNITEC - La Salle

Organisation address:
Sant Joan de La Salle, 42, 08022, Barcelona (Spain)
Kind of organisation:
Academia

Viability

Time for deployment:
No evidence or no record kept of prior preparation
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
No knowledge about evidence. No evaluation or documentation of effect has been carried out
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
No evidence or no demonstrated impact
Description of impact:
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Day care centres, Home care centres, Nursing homes, Private companies, Research centres, Academia
Source of funding:
Regional funding

Contact details

Name:
Rosa Maria Alsina
Email:
ralsina@salleurl.edu

Integrated health and social care/services in Policka region

General and specific objectives of the practice is to provide holistic set of support/care/services (health and social care) tailored to the needs of people with reduced self-sufficiency due to illness, disability or frailty and to support their carers so that they can stay at home or in their community as long as possible.
It includes close interdisciplinary cooperation within Association of all local/regional municipalities (AZASS) facilities and services (post-acute and long-term care hospital, primary care physicians/specialists, social rehabilitation and occupational therapy as well as home care, respite and residential services for elderly and housing) to assure person centred and continuous support to those in need in the region.
Main methods, processes and organisation.
The services are operated by purposely formed association of 27 municipalities (AZASS) to share decisions, strategy, property and services. The structure was designed to assure stability, subsidiarity, democracy and to face instability of political cycle. AZASS owns the hospital and all the services mentioned previously that have one executive leadership. Each municipality has proportioned vote according to number of citizens, but none can have a majority (so they need to look for common agreement). Executive board (5 mayors) manages and set rules for the director of the services. Supervisory board is formed by professionals (doctor, economist) and 3 mayors. Ad hoc commissions are formed to prepare strategic projects, so that experts and public can participate to create solutions for local problems. The director is negotiator in all those activities, suggest and recommends to mayors, but has to respect their final decision.
Key aspects that can be transferable:
Structured rules of cooperation on the development of AZASS shared by municipalities
Intense personal cooperation and communication with stakeholders and municipalities
Whole person approach to planning and provision of care/services including caregivers (carers) and their environment. Close ties to the region and its citizens (inhabitants)

Keywords:
Inderdisciplinarity, whole person approach, community based care, structured cooperation of municipalities, integrated care, sustainability of the system.
Website:
http://www.azass.cz
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Czech Republic
Regions involved:
Pardubicky kraj

Organisation

Organisation name:
Svazek obcí AZASS (Association of municipalities)
Organisation address:
Palackého náměstí 160, 57201 Polička
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, Home care centres, Nursing homes, Housing organisations, Local public authorities, Other, please specify

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Actually all the impact listed above were encountered.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Home care centres, Nursing homes, Informal caregivers, Housing organisations, NGOs, Local public authorities

Source of funding:

Regional funding

Contact details

Name:

Mgr. Ing. Libor Stráník (director)

Email:

l.stranik@tiscali.cz

Improved management of visits in Home Care

The practice includes Home Care services for patients within the region of Prague Capital. The Home Care Centre is a department of the Sisters of Mercy of St. Borromeo Hospital in Prague (Nemocnice Milosrdných sester sv. Karla Boromejského). The general objective is providing the medical care at the homes of patients. Specifically, it is focused on nursing care, i.e. treatment of wounds, application of infusion, injections, wound dressing, treatment of pain and others.
The nurses are visiting the patients according to the indication of medical doctor and in cooperation with him. Management of visits in Home Care (HC) is improved by ICT solution called IMACHECK. The First step of the innovation is implemented (identification of nurse visits); second step is under development in Autumn 2016 – distribution of scenarios for individualized home care and patient data collection (reporting). The ultimate goal is to improve services in homecare by digital processing of routine operations in homecare.
The transferable experience at current stage of the practice could be electronic evidence of visits at the patients and their time management.

Keywords:
home care, nursing care, electronic evidence of visits, time management of visits, Near-field communication (NFC), integration of data with hospital information system (HIS) .
Website:
http://www.nmskb.cz
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Czech Republic
Regions involved:
Hlavní město Praha

Organisation

Organisation name:
The Sisters of Mercy of St. Borromeo Hospital in Prague (Nemocnice Milosrdnych sester sv. Karla Boromejského)

Organisation address:
Vlašská 336 / 36, 118 33 Prague 1, Malá Strana, Czech Republic
Kind of organisation:
Hospitals

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The practice, besides improved accuracy in care processes and integration of relevant records, increased also sense of security of patients.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Nurses, Home care centres
Source of funding:
Not-for-profit

Contact details

Name:
Mgr. Šárka Šlégrová, Manager of Home Care
Email:
slegrova@nmskb.cz

Shoulder rehabilitation via distance technology

In our part of the country some people live far away from a physiotherapist, and may not have the ability to travel far.
In those cases we use distance technique, after for example shoulder surgery, in order to give equal rehabilitation to
every patient. We have used this method for some years. The patient is at home with a computer or a I-Pads and meet the PT at the hospital via distance technique. The PT and patient can see and talk to each other while exercising.
The communication programme is safe and the secrecy is maintained.

Keywords:
shoulder, rehabilitation, distance
Website:
http://media.nll.se
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Sweden
Regions involved:
Norrbottens län

Organisation

Organisation name:
The County COuncil of Norrbotten Orthopedic clinic, Sunderby sjukhus
Organisation adrdess:
NLL
Ortopedkliniken
Sunderby Sjukhus
971 80 Luleå
Kind of organisation:
Hospitals

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Better health and quality of life, increased sense of security with training with distance technology at
home and better care integration.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians
Source of funding:
Regional funding

Contact details

Name:
Ulla Klippmark, Christina Jakobsson
Email:
christina.m.jakobsson@nll.se

An effective palliative care process

We tried to get an overwiew of how the palliative patient´s way through the health and social care works. We did a review of the medical- and care journals of patients connected to our palliative team, to see what kind of problems the patient/relatives contacted health- or social care for and who they contacted in case of help needed. We regonized that it seems unclear for the patient and their relatives who they should contact in different kind of problems. There were many caregivers involved in various kind of careforms. They seemed not to have a primary health care contact. We had meetings with representatives of careunits involved and tried to find ways to improve the contacts for the patients, to sort out who is primary health care contact for the patient. Some new routines for primary care centers and hospital has to be made to get this work done.

Keywords:
Palliative care
Website:
http://www.nll.se
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Sweden
Regions involved:
Norrbottens län

Organisation

Organisation name:
The County Council of Norrbotten, Palliativa rådgivningsteamet Gällivare sjukhus
Organisation address:
Gällivare sjukhus
Källgatan 14
982 82 Gällivare
Kind of organisation:
Hospitals, Nurses

Viability

Time for deployment:
No evidence or no record kept of prior preparation
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
We have not yet seen any effects, as described above, but we expect to see an improved interaction from hospital care to home care, particularly regarding physician participation in home health care. We hope that this will lead to that those patients, who desire to be cared for at home, to a greater extent than today can stay at home for the rest of their lives.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Nurses, Home care centres
Source of funding:
Local funding

Contact details

Name:
Susanne Espling
Email:
susanne.espling@nll.se

The patient journey through emergency medical care

Our goal has been to reduce the transportations and provide better accessibility for patients to local hospitals. Everyone who seeks the hospital gets a call and a prioritizing where we determine the level of care according to an interview guide. Then, we take care of the sick patients directly, while others who are not acutely ill refer to other instances. This saves energy and time for the elderly. They may also meet familiar health professionals, without long waiting times. The references are made both at the hospital and from the ambulances in Piteå. Many times, the paramedics to meet the person's needs are done already in their homes by treating and safeguarding patients directly, without bringing them to the hospital. We work together with the patient through the use of person-centered care. We listen to the patient's story, forming a partnership with the elderly and documenting what we come up with together. Person-centered care means to respect and acknowledge the person's experiences and interpretation of health and illness and to promote health for this particular individual. We often interact with the elderly, health centers, home care, district nurses and with the patient in order to find the most convenient solution. The patient receives a folder where we write down what we agreed on and how all the vital parameters. Here, the elderly get information about where to call. The patient also receives the name of the health care professionals as they talked to. We see the patient as a capable person with resources and abilities. Introducing this method had reduced the need for emergency and intensive care and increased the patient safety.

Keywords:
Process working and collaboration
Website:
http://www.nll.se
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Sweden
Regions involved:
Norrbottens län

Organisation

Organisation name:
The County COuncil of Norrbotten
Organisation address:
The County Council of Norrbotten, IVAK Piteå hospital
Kind of organisation:
Hospitals

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
Emergency medical care are now used more resource efficient. The ambulances are tangible for the new missions with higher priority. The ambulances remain on each city to a greater extent. The Emergency Department at Piteå hospital are getting into fewer people, this leads to more time to the people who need emergency care. The patients avoid unnecessary transports. Better accessibility for patients to local hospitals. Increased patient safety by getting all staff to do the same in a standardized way of working. Better patients security through assessment and follow-up meetings. Fewer hospital visits. Fewer care contacts. Economic savings To find the patients deteriorates rapidly leads to economic gains, decreased cardiac arrest and shortened treatment times. Similarly, we see a win for patients where the paramedics can facilitate/support staff at homes for the elderly. Patients can remain in their normal environment. Person-cantered care, this means that the person will be seen as a resource and as an expert of themselves.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Home care centres, Nursing homes

Source of funding:

Local funding

Contact details

Name:

Anna Åström

Email:

Anna.c.astrom@nll.se

Distance spanning healthcare

Distance spanning healthcare is a practice stemming from the strategy for distance spanning healthcare where three prioritized areas for carrying out healthcare at distance are pointed out:

1. Acute assessment between rural healthcare centers and hospitals as well as between hospitals
2. Planned and routine visits/assessments between rural healthcare centers and hospitals as well as between
3. hospitals
4. Planned and routine visits/assessments between rural healthcare centers and healthcare centers along the cost (larger towns)

For area 1 and 2 pilot projects have been carried out and routines have been established and implementation is ongoing. Not however for number 3.
For the work there has been an assigned project manager, project group and steering group. Work has been focused and carried out in areas in most need of the solutions but also with a readiness/maturity to do the piloting. The specific objectives have been to create:

- New ways of working and new opportunities
- Method for continued development and implementation
- User and patient-participation
- Technical solutions and services
- Organization and regulations

The key aspects which can be transferred to the rest of the county and also to a national level and beyond would be the knowledge of infrastructure needed in place, which competences need to be present, the maturity and readiness to adopt technical solutions, digital literacy in both personnel and patient.

Keywords:
e-Health, integrated care, primary care, rural medicine
Website:
http://www.nll.se/publika/lg/verk/Kansli/Lst/2014/Bilagor/140527/L%C3%A4nsstrate…
Initiative status:
On-going

Background

Geographical scope:
Regional level

Countries involved:
Sweden
Regions involved:
Norrbottens län

Organisation

Organisation name:
The County Council of Norrbotten, Primary care
Organisation address:
Övertorneå hälsocentral
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Regional public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians
Source of funding:
Regional funding

Contact details

Name:
Mari Huhtanen
Email:
Mari.huhtanen@nll.se

Psychosis and schizofrenia care process

Patients with schizophrenia and/or psychosis can have varying disabilities of mental/somatic illness. This group of patients should be offered early interventions and professional treatment by a health care programs that support them in the rehabilitation process. Medical and psychosocial interventions should be provided by a symptoms and function-oriented approach. A clear and documented care plan must be drawn up and evaluated in collaborations with patients.

Keywords:
Participation. Cooperation. Equal treatment
Website:
http://www.nll.se
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Sweden
Regions involved:
Norrbottens län

Organisation

Organisation name:
The County Council of Norrbotten, Gällivare
Organisation address:
Gällivare sjukhus
Kind of organisation:
Hospitals

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.

Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
All suggested alternatives: Better health (societal), better quality of life (societal), less isolated people, (societal) Increased sense of security (societal), better care integration (economic and societal), less hospital re-admission (economic), shorter stay in hospital (economic), better health (societal), better quality of life (societal), less isolated people (societal), increased sense of security (societal), better care integration (economic and societal), less hospital re-admission (economic), shorter stay in hospital (economic), creation of jobs or SMES, or growth of local companies
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Home care centres
Source of funding:
Local funding

Contact details

Name:
Rose-Marie Larsson, Bertil Karlsson
Email:
Rose-marie.a.larsson@nll.se

My plan

The Project covers 5 hospitals, 33 primary Health care centres and the social service at 14 municipalities. It aims to empower the patient in both the discharge planning process and the planning process at home by increasing their influence on the process and enhance their access to their plan. This will be reached through development, test and implementation of new workflows, routines and new supportive technology that support a new upcoming law that regulate the planning process.

Keywords:
co-creation, equality, availability, safety
Website:
http://www.nll.se
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Sweden
Regions involved:

Organisation

Organisation name:
The County COuncil of Norrbotten
Organisation address:
Robertsviksgatan 7, Luleå
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.

Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
No evidence or no demonstrated impact
Description of impact:
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Home care centres, Nursing homes, Informal caregivers, Private companies, Academia, Regional public authorities, Local public authorities, Advocacy organisations patients/users
Source of funding:
European funding

Contact details

Name:
Sofi Nordmark
Email:
Sofi.nordmark@nll.se

Integrated care process for children with special needs

The overall aim of this PAINNE (Proceso de Atención Integrada a Niños y Niñas con Necesidades Especiales) is to implement an integrated model of care for children with special healthcare needs (CSHCN), using a quality improvement method to enhance the overall care and satisfaction of the children and families affected. This model promotes quality care towards children and their families in a way that is efficient and sustainable, with the goal of early detection and intervention in situations of risk, ultimately aiming to help these children reach their maximum potential and improve their overall quality of life. Multidisciplinary groups comprised of nearly 90 professionals from the healthcare, social services and education sectors in Bilbao worked together to create appropriate structures for care coordination, reach consensus regarding procedures to offer integrated care and tools to enhance early detection of situations of risk, define key indicators for quality improvement, and create a comprehensive directory of resources in these three sectors. These ideas were published in the Guía PAINNE 2013, and the screening tools agreed upon for the early detection of developmental delays and psychosocial risk factors were incorporated into the electronic medical record (EMR) for routine use in well child visits in the pediatric primary care centers in Bilbao. Currently, more than 200 professionals in the healthcare, social services, education and third sectors are revising the guide in order to publish an updated version in 2016 and are implementing the model throughout Vizcaya.

Keywords:
Children with special healthcare needs, care coordination, Early intervention, prevention of childhood deficits, health and social care
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Spain
Regions involved:
País Vasco

Organisation

Organisation name:
OSI Bilbao-Basurto
Organisation address:
Avenida de Montevideo, 18 - 48013 Bilbao, Bizkaia
Basque Country, Spain
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
As mentioned previously, qualitative and quantitative data has been collected to determine the impact of this model. Care coordination/ integration has been enhanced quantitatively between pediatrics and social services, with 93-95% of referrals being accepted for early intervention services. Additionally, the age of referral for autism from pediatrics to mental health has decreased from 3.8 years to 3 years with the incorporation of systematic use of assessment tools for development in primary care. Primary care teams are better identifying families with psychosocial risk factors, during prenatal, newborn and well-child visits, which allows greater coordination between primary care and social services and/ or mental health, and the earlier provision of services. Much data supports the effects of early intervention, with an increase of return of investment, better quality of life for children and families, better integration into all aspects of society, and decreased need for specialty and additional services in the healthcare, social services and educational sectors. Qualitative data from surveys and informal interviews with professionals from the three sectors and

third sector shows that this model has had a positive impact, is well accepted, is viewed as useful, and all providers note enhanced communication and coordination amongst the sectors. Focus groups with families have also shown positive perceptions of care with enhanced coordination, and family survey questionnaires that are currently being developed will provide greater insight into the direct impact on families.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Third sector and families

Source of funding:

Regional funding

Contact details

Name:

Jon Txarramendieta Suarez

Email:

jtxarramendieta@kronikgune.org

Care plan for the elderly

This project, aimed at people over 70 years, pretends to prevent or delay the loss of function through preventive interventions and health promotion activities along with control of geriatric syndromes and associated comorbidity.
The main objective is to have a homogeneous system of multidimensional assessment and action, in people aged 70 or older, based on current recommendations, oriented to prevention, functionality and adapted to the reality of primary care, allowing classification in typologies of elder people.
This classification will provide us with a better understanding of the health situation of people of health quotas assigned in primary care and can thus establish appropriate interventions in each case and plan activities in an organized way for the different typologies of older people. Also through the Taxonomy NANDA-NOC-NIC will give us the possibility to individualize care plans which will allow better monitoring.
The transferable key issues are the following:

- Have a program for elderly evaluation
- Have a classification model by typologies
- Associate typologies based on functionality according to NANDA Diagnoses
- Have a registration system for monitoring the elderly
- Have information to get indicators on health and social situation of the elderly.

Keywords:
multidimensional assessment in elderly, fragility, Integrated care in the elderly, functionality, continuity of care in elderly
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
País Vasco

Organisation

Organisation name:

Primary and secondary healthcare subdirectorate

Organisation address:

C/ Alava 45; 01006 Vitoria-Gasteiz, Araba

Basque Country, Spain

Kind of organisation:

Regional public authorities

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

As explained above, we have obtained very favorable results in indicators of the following areas:

- Clinical preventive (general, specific and medication) rating
- Funcional rating
- Mental rating
- Social and family and caregiver Rating

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Primary care centres, General practioners, Nurses

Source of funding:

Regional funding

Contact details

Name:

Jon Txarramendieta Suarez

Email:

jtxarramendieta@kronikgune.org

Telemonitoring COPD patients with frequent hospitalizations.

COPD is a leading cause of morbidity and mortality worldwide with two important impact points; one is the use of healthcare resources that the disease implies; and the other, the effect of the disease in the patient. Hospitalization has been identified from years as the main factor of cost in this disease. At the same time exacerbation, especially hospitalization, has potential severe consequences in the COPD patient as lost of pulmonary function and quality of life and increase in mortality risk.

The project has the following objectives:

1. Determine the rate of readmission for exacerbation in a cohort of patients with COPD with readmissions to the hospital, comparing with themselves in the previous 2 years and during the same period of intervention, with respect to an external control group.
2. Determine the frequency of this cohort of patients with COPD who are readmitted to hospital emergency departments compared to a control group.
3. Evaluate the quality of life related to health during follow-up period compared to a control group.
4. Evaluate the degree of satisfaction of patients in both cohorts.
5. Establish medical costs arising from the implementation of this program about a group treated by conventional care and respect to the costs prior to the inclusion of this program.

The inclusion criteria were being hospital admitted at least twice in the previous year or at least three times in the 2 previous years. The cohorts were follow-up for 2 years. Several clinical measurements like pulmonary function, exercise capacity, health related quality of life, limitation in daily life activities and anxiety and depression were recorded in both cohorts. Telemonitoring and an organized education program were only and applied in the intervention cohort.

Finally, the key aspects that can be transferable are the education program and the program of telemonitoting and control of the patients.

Keywords:

COPD, Severe exacerbations (hospitalizations), Telemonitoring

Website:

Initiative status:

Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
País Vasco

Organisation

Organisation name:
Integrated Care Organisation Barrualde-Galdakao
Organisation address:
Barrio Labeaga, s/n 48960 Usansolo, Bizkaia
Basque Country, Spain
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:

- Results in the use of health resources: Lower rate of hospitalizations Reduced use of hospital emergencies. Lower average stay if hospitalized. Lower rate of readmissions.
- Health results in the patient with respect to the control group Stability, therefore lower drop of the quality of life, exercise capacity and limitations in daily life

Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Informal caregivers, Housing organisations, Regional public authorities
Source of funding:
Regional funding

Contact details

Name:
Jon Txarramendieta Suarez
Email:
jtxarramendieta@kronikgune.org

Advance Care Planning in an Integrated Care Organisation

Every human being is recognized with his or her right to make decisions regarding medical treatment, even when his/her level of competence is compromised by adverse health conditions. Advanced Care Planning (ACP) guarantees patients' right both to make decisions as well as to have those decisions respected when time comes.

The general goal of this program is to promote ACP, mainly for chronic patients. The program states two specific goals: 1) adjusting end of life care to meet patients' preferences, and 2) improving decision making processes.

The program defines three stages:

1. Diagnostic stage, aiming at identifying the population that could benefit from the program,
2. Therapeutic stage, aiming at developing the intervention (after providing training opportunities for involved health professionals),
3. Evaluative stage, aiming at assessing both the impact of the program and the program itself.

The core intervention at the heart of the program consists on two individual semiestructurated interviews with the patient and one or two significant others. Previous to these meetings patients invited to participate receive a document that intends to elicit reflections about health, care, quality of life and end of life. The interviews are initially conducted by the program coordinator along with patient's GP and Community Nurse. The program is intended to help clinicians become capable of conducting the interviews themselves.

The first meeting aims mainly at introducing the subject (Advanced Directives) and inviting the patient to reflect on his/her preferences regarding care. The second interview focuses on discussing the specific issues related to the patient him/herself and according to his/her clinical characteristics and situation. Transferring the program to other contexts would require adjustments mainly related to cultural issues.

Keywords:
Advanced care planning, Shared decisions, Chronic care, End of life care, Autonomy
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level

Countries involved:
Spain
Regions involved:
País Vasco

Organisation

Organisation name:
Integrated care Organisation Araba
Organisation address:
C/ Jose Atxotegi, s/n - 01009 Vitoria-Gasteiz, Araba
Basque Country, Spain
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The program has not yet been formally evaluated. Nonetheless, listening to participating patients, families, GPs and Community Nurses has helped us understand how invitations to reflect and discuss values and preferences regarding treatment and care have been of much use both for all of them who now seem to share a common view of what kind of options the patient would choose for him/her when time comes. Interviews inviting to reflect and discuss have been somehow systematically introduced into some Community Care Teams' (GP+Community Nurse) agendas, and approaches to chronic care. Healthcare professionals

working at secondary/tertiary levels (mainly hospitals) now start to be familiar with the program and benefit from accessing the information regarding preferences accessible through the electronic health record .

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Regional public authorities, Local public authorities, Advocacy organisations patients/users

Source of funding:

Regional funding

Contact details

Name:

Jon Txarramendieta Suarez

Email:

jtxarramendieta@kronikgune.org

Malnutrition in the elderly and hospital stay

According to the literature malnutrition affects 60% of the people admitted in nursing homes, 40% of hospitalized, and about 5% of the general population. Malnutrition slows recovery, increases the average length of stay and increases the cost (up to 50%) of early readmission rates, increases susceptibility to infection and increases mortality.
We note that in our clinical practice, there is no systematic nutritional assessment of elderly patients, being an entity unrecognized and untreated, that can be prevented and limited.
It is a preventable public health problem cost.
Likewise, the systematic introduction of the nutritional assessment at hospital admission and adequate dietary prescription are related to the evolution of the disease, taking into account occurrence of complications (bedsores, infections and bone fractures), mortality, days of stay and readmissions.
We want to know the prevalence of malnutrition in elderly patients admitted to the network of public hospitals in the Basque Country and its clinical consequences, in order to promote a strategic line that affects all levels of care (primary care and geriatric residences).
This strategy aims to address the nutritional status of our elderly patients through a multidisciplinary, comprehensive and efficient way.

Keywords:
Malnutrition, Elderly, Hospital stay, Multidisciplinary approach, Nutritional assessment
Website:
Initiative status:
Completed

Background

Geographical scope:
Local level
Countries involved:
Spain
Regions involved:
País Vasco

Organisation

Organisation name:
Santa Marina Hospital

Organisation address:
Carretera de Santa Marina no 41, 48004 Bilbao, Bizkaia,
Basque Country, Spain
Kind of organisation:
Hospitals

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The results achieved during the pilot project support the assumptions made by the team: • Pricipal hypothesis: In the elderly, a good nutritional status before the hospital admission decreases the average stay. • SEcondary hypothesis: 1: Malnourished patients have a higher risk of complications during their hospital stay. 2: Malnourished patients have a higher mortality rate. 3: The number of malnourished patients with readmissions is higher than those with good nutritional status.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Large-sized industry, Regional public authorities

Source of funding:

Local funding

Contact details

Name:

Jon Txarramendieta Suarez

Email:

jtxarramendieta@kronikgune.org

Transversal approach of the pain from a pain unit

The aim of this practice is to solve problems in both the healthcare se(drug prescription is unified, the clinical course of patients is monitored) and social care settings (avoids the movement of patients with functional limitation, consultations with caregivers are provided, wider agenda to treat patientsthat do not have a specific appointment).
The main goal of the practice is to improve the care of patients with pain, coordinating the conventional personal assistance with various forms of non in-person care, which allows to improve the delays of waiting lists, avoids impediments to the arrival of patients to the Pain Units and duplication of simultaneous treatments. To this end, it has designed a Functional Plan for pain treatment by transversal and continuous health-care agreements between primary care, specialized care and the Pain unit. The specific objectives of the practice include an average delay in first consultation lower than 30 days, more time for face—to-face consultations for infiltrations and reduce to zero the referrals documented in paper.
In addition, the Unified Electronic Health Record (HER) is incorporated, along with the development of non face-to-face care pathways, with very positive results measured through quantitative and qualitative methods. Thus, the time available for personal assistance has been increased, and training and the collaboration between professionals of different levels of care have been improved.
Finally, it is necessary to emphasize that the EHR is a key facilitator. It allows sharing all patient information between all professionalsand with the patient. It also allows instant electronic consultation and prescription, avoiding duplications and errors of treatment. Its use, along with the development of a non face-to-face care pathways are transferable key aspects. Thanks tour practice the time available for personal assistance has been increased, and education and collaboration with clinicians in health centers and specialized consultations have been improved.

Keywords:
Pain, Non face-to-face care, Unified Electronic Health Record, Unified electronic prescription
Website:
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain

Regions involved:
País Vasco

Organisation

Organisation name:
Integrated care Organisation Araba
Organisation address:
C/ Jose Atxotegi, s/n - 01009 Vitoria-Gasteiz, Araba
Basque Country, Spain
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Decreased delays, expedite care, avoid unnecessary movement, improving teaching with case studies in primary care.
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres

Source of funding:
Regional funding

Contact details

Name:
Jon Txarramendieta Suarez
Email:
jtxarramendieta@kronikgune.org

Design and implementation of interventions aimed at improving the safety of prescription.

The practice includes management of polypharmacy in multimorbid elderly or fragile people. The main objective is to improve the adequacy and safety in prescribing the Integrated Care Organisation Donostialdea. The specific objectives are: to know the prevalence of inappropriate prescribing (PPI) and security issues of medicines, designing interventions aimed at improving safety in prescribing and assess their impact.
It is a planned strategy of progressive implementation. The components are:

- Training aimed at medical and nursing professionals with the following modules: general training in polypharmacy and prudent use of medication, medication reconciliation, review of mediation (tools and case studies), medication review in specific areas related to each project to be implemented (excessive polypharmacy, renal failure, STOPP-START criteria, osteoporosis, security alerts, etc.).
- Methodology: training "cascade" interactive. The promoter group, led from Primary Care Pharmacy and of multidisciplinary composition, prepares materials and provides "training of trainers" (a reference-forming in each primary care unit).
- Consensus between primary-care and specialist-care
- Identification of multimorbid patients through the tool "Osakidetza Business Intelligence (OBI)"
- Medication Review by the primary care physician
- Evaluation and feed back to professionals
- transferable key aspects: training methodology, automation of consultations, local consensus process, methodology medication review, evaluation.

Keywords:
Polypharmacy, Drug-Related Side Effects and Adverse Reactions, Inappropriate prescription, implementation, Medication reconciliation
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Spain

Regions involved:
País Vasco

Organisation

Organisation name:
Integrated Care Organisation Donostialdea
Organisation address:
Begiristain Doktorea Pasealekua, 117, 20080 Donostia, Gipuzkoa
Basque Country, Spain
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Assessments that have been made are short-term. We have preliminary data indicating that the practice is sustainable (question 30). It has substantially improved the potentially inappropriate prescriptions but its impact on hospital admissions is unknown. However, throughout 2016 and also at work on osteoporosis have reached agreements with the 7 hospital services.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Nursing homes, Research centres, Regional public authorities

Source of funding:

Regional funding

Contact details

Name:

Jon Txarramendieta Suarez

Email:

jtxarramendieta@kronikgune.org

Telemonitoring, Teleassistance and Teleconsultation Project for patients with Heart Failure and Chronic Pulmonary Disease

Telescopico aims to create a telemonitoring system, teleconsultation and remote assistance for patients with chronic conditions, in particular with chronic heart failure and COPD, at risk of clinical instability. The system ensures a continuous link between specialist (in hospital) and general practitioners, allowing for monitoring of clinical and instrumental parameters of the patients. The project, through the adoption of the system, aims to validate telemedicine models in the integrated management between territory and hospital about diagnosis and treatment for heart failure, COPD, improve territorial management of these patients, intercept phases of instability before reach criticality, reduce the rate re-hospitalization.
Through Telescopico Project we aim to:

- Reduce the steps of destabilization of Heart Failure patients with chronic Diseases
- Reduce the re-hospitalization
- Optimize the therapy
- To promote the integrated management of Hospital and Territory
- Train specialized nursing figures
- Evaluate the satisfaction Practitioners and patients of this type of management
- Evaluate costs and benefits

The primary end point is to verify the possible use of technological telemedicine devices within integrated management models between hospital and territory of cardio-pulmonary chronic diseases in order to improve its management and to facilitate the integration between specialists and practitioners.
Secondary end points are:

- Reduce the number of hospitalizations for Heart Failure and for COPD in area of interest
- Reduce days of hospitalization for SC and COPD

Keywords:
telemedicine, de-hospitalization, management of chronicity, innovative technological instruments, Integration.
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Italy
Regions involved:
Puglia

Organisation

Organisation name:
ASL BARI
Organisation address:
ASL Bari, Lungomare Starita 6, 70123 Bari (BA)
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Local public authorities, Other, please specify

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
We notice a reduction in hospital admissions, a higher patient monitoring,a reduction of the waiting lists. Stronger relationship between practitioners and patients.
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, General practioners, Nurses, Local public authorities

Source of funding:

European funding

Contact details

Name:

Doctor Pasquale CALDAROLA

Email:

PASCALD@LIBERO.IT

Telemonitoring, teleconsultation and telecare project aimed to patients with Heart Failure, Chronic obstructive Pulmonary Disease and Diabetes

TeleHomeCare Project is proposed as a technological support already structured the activities of home care with the main objective to affect favorably on the reduction of re-hospitalization rate and improving the quality of care at the patient's home, also validating new telemedicine models applied for diagnostic and therapeutic pathways for the management of chronicity. Patients, opportunely selected, are followed by their family doctors with by telemonitoring using the innovative technological instruments H@H Hospital at Home, able to detect the main clinical and instrumental parameters in addition to the therapeutic administration, based on oxygen and bronco-aspiration.
The telemedicine project are to implement a new type of monitoring of the patients who suffering of chronic diseases, based on continuous collaboration and patient monitoring, by different professionals and different users. TeleHomeCare includes the following main objectives:

- Reduce the number of patients with heart disease, Chronic Diseases and Diabetes in the process of instability;
- Reduce hospitalization and re-hospitalization;
- Activate protected de-hospitalization;
- Optimize the therapy and diagnosis according to international guidelines;
- To promote the integrated management of Hospital and Territory;
- Evaluate the satisfaction of the doctor, caregiver and patient;

Primary end point:
Check the possible use of technological devices for telemedicine within integrated management models between hospital and territory about chronic diseases with high social impact, in order to improve its management and to facilitate the integration between specialists and doctors.
Secondary end point:

- Reduce the number of admissions;
- Reducing hospital stays;
- Activate protected resignation.

Keywords:
telemonitoring, teletherapy, de-hospitalization, management of chronicity, innovative technological instruments.
Website:

Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Italy
Regions involved:

Organisation

Organisation name:
ASL Brindisi
Organisation address:
ASL Brindisi, Via Napoli 8, 72100 Brindisi (BR)
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Local public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Home care centres, Informal caregivers, Private companies, Small-sized industry, Local public authorities

Source of funding:

European funding

Contact details

Name:

Doctor Francesco GALASSO

Email:

francesco.galasso15@tin.it

A telemedicine-based intervention study involving real-time and anywhere transmission of blood glucose data to a Decision Supported Software-assisted server with web-based analysis of data and medical feedback on metabolic control

The practice aims to validate the clinical efficacy of a telemedicine- and web-based system platform for self-monitoring of blood glucose (SMBG) data transmission and analysis of metabolic control, assessed by measuring changes inHbA1c, in insulin-treated diabetic patients. The system platform involves (i.) systematic (real-time and anywhere) transmission of SMBG data to a decision supported software (DSS)-assisted server, (ii.) web-based analysis of data, and (iii.) feedback on patients and medical staff to implement metabolic control. Additional aims include assessments of patients' adherence to perform SMBG, analysis of the specific and overall quality of glucose control, identification of situations predictive of hypoglycemic and/or hyperglycemic episodes, and detection of episodes of hypoglycemia and sustained hyperglycemia.
It is to be expected that use of the telemedicine- and web-bases system platform will result in improved metabolic control as compared with standard of care, as shown by a greater decrease in HbA1c from baseline. In addition, it will potentially result in better quality of glucose monitoring and control (e.g., appropriateness of SMBG testing, glucose excursions, indexes of glucose variability) and frequency and severity of hypoglycemic episodes. Also, quality of life should be improved in the telemedicine group. Thus, patients and physicians will be provided with a tool that allows to verify the appropriateness of SMBG in relation to the diabetes status, and this will be also relevant to "payers" (false glucose reporting and data collection will be avoided, patient/physician interaction will be optimized while limiting the number of medical visits).

Keywords:
diabetes mellitus, self-monitoring of blood glucose, insulin therapy, digital trasmission, decision supported software.
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level

Countries involved:
Italy
Regions involved:
Puglia

Organisation

Organisation name:
Azienda Ospedaliero-Universitaria Policlinico Consorziale di Bari Universitò degli Studi di Bari Aldo Moro
Organisation address:
Piazza Giulio Cesare, 11
Bari 70124
Italy
Kind of organisation:
Hospitals, Research centres

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
We have recently developed a telemedicine system [Glucoonline®, 2011], which consists of a smartphone-connected glucometer, a software-implemented smartphone for real-time and anywhere blood glucose data collection and transmission to a remote server, and a Decision Supported Software (DSS)-assisted server capable of performing data collection and analysis, and providing feed-back to the patient and the medical staff according to pre-defined specific algorithms. A pilot study showing the feasibility of using this system in 10

individuals with type 1 diabetes treated with a multiple daily injection (MDI) regimen over a 3-month period has been already carried out [Giorgino F, data on file].
A clinical trial using this system is running (Clinicaltrials #NCT01804803) to assess its efficacy in insulin-treated individuals with type 1 or type 2 diabetes mellitus. Interim analyses have been carried out, which show satisfatory outcomes in terms of improved metabolic control, assessed by measuring changes inHbA1c, improved patients' adherence to perform SMBG according to current guidelines, improved specific and overall quality of glucose control, and detection of episodes of hypoglycemia and states of sustained hyperglycemia.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Private companies, Large-sized industry, Research centres, Academia, National public authorities , WHO, Regional public authorities, Advocacy organisations patients/users

Source of funding:

Private funding

Contact details

Name:

Francesco Giorgino, M.D., Ph.D. Professor of Endocrinology Chairman, Department of Emergency and Organ Transplantation Head, Section of Internal Medicine, Endocrinology, Andrology and Metabolic Diseases Director, Postgraduate School in Endocrinology and

Email:

francesco.giorgino@uniba.it

MARIO: Managing active and healthy aging with use of caring service robots

MARIO addresses the difficult challenges of loneliness, isolation and dementia in older persons through innovative and multi-faceted inventions delivered by service robots. The effects of these conditions are severe and life-limiting. They burden individuals and societal support systems. Human intervention is costly but the severity can be prevented and/or mitigated by simple changes in self-perception and brain stimulation mediated by robots. From this unique combination, clear advances are made in the use of semantic data analytics, personal interaction, and unique applications tailored to better connect older persons to their care providers, community, own social circle and also to their personal interests. Each objective is developed with a focus on loneliness, isolation and dementia. The impact centres on deep progress toward EU scientific and market leadership in service robots and a user driven solution for this major societal challenge. The competitive advantage is the ability to treat tough challenges appropriately. In addition, a clear path has been developed on how to bring MARIO solutions to the end users through market deployment.

Keywords:
Assistive Robots, Comprehensive Geriatric Assessment, People with Dementia, Reduction of Isolation and Loneliness, Healthy Aging
Website:
http://www.mario-project.eu
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Europe
Regions involved:
Deutschland, France, Italia, United Kingdom, Ελλαδα (Ellada)

Organisation

Organisation name:
IRCCS Casa Sollievo della Sofferenza

Organisation address:
Viale Cappuccini snc, 71013 San Giovannni Rotondo (FG)
Kind of organisation:
Hospitals

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
More than 5.000 EUR per targeted citizen / patient
Evidence of practice:
No knowledge about evidence. No evaluation or documentation of effect has been carried out
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Since the trial period hasnot yet started we're not able to report the impact generated with the introduction of MARIO robot in the clinical setting
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Specialised physicians, Nurses, Nursing homes, Informal caregivers, Small-sized industry, Research centres, Academia, Local public authorities, Advocacy organisations patients/users
Source of funding:
European funding

Contact details

Name:
Francesco Giuliani
Email:
f.giuliani@operapadrepio.it

Integrated telemedicine platform for predictive medicine, telemonitoring and empowerment of patient affected by Chronic Kidney Diseases (CKD)

Chronic kidney disease (CKD) has an high socio-economic impact, as it affects 10% of the world general population(700 M people). The Carhes Study reports an italianCKD prevalence of 7.1% in the general populationaged 35-79 years (2.2 million of italians)thatconsumes about 2.5-4 % (around 5 billion euros) of the National Healthcare System's budget for each year. To be precise, the italian government is spending 1.8-2.0%of its gross national product invested in health to guarantee the healthcare system toitalian people affected by stage I-IVof CKD (GFR between 90-15 ml/min) and the same amount (1.8-2.0% of GNP) to treat 200.000 patients with a GFR less than 15 ml/min (about 150.000) or already on dialysis (about 50.000).

CKD is a silent disease that should be early identified by general practicioners (GPs) for an early referral to nephrologists to avoid its progression towards end stage kidney disease. The clinical characteristics of CKD patients have changed in recent years (aging and complexity), resulting in an increased burden of care for the healthcare facilities and the need for a more extensive involvement of families and social services. In this context, our practice aims to create a new technological system, based on a new "digital" healthcare model, involving cooperation among different territorial care entities. Specifically, our practice aims to prevent CKD in general population, to early identify patients affected by CKD, to increase de-hospitalization of patients with overt CKD starting dialysis, to improve quality of life and to reduce the healthcare costs.

CKD integrated-care (Smart Health 2.0 project)is aplatform with ane-learning environment,with edu-games for the empowermentof the general population (Help-Large) and patients affected by CKD with their caregiver, a business intelligence tool on board (ULYSSES) for the early identification of CKD patients through the analysis of clinical pathology data, a sofa (DIADOM), inspired by home living design and fully equipped with medical devices connected toa telemonitoringsystem (TELCARE) able to create an audio-video connection between patients, nurses and nephrologists.

In addition, Smart Health 2.0 project has trained Care and Case managers, Nurses and Physicians with specific expertise on the use of Ulysses, Help-Large and telemonitoring/teledialysis system, those will be the new professionals required for the creation of virtuous paths between hospital and territory.

Keywords:
Nephrology, teledialysis Care and Case manager, e-Health, m-Health Empowerment, Predictive medicine

Website:
http://www.smarthealthpuglia.it
Initiative status:
Completed

Background

Geographical scope:
National level
Countries involved:
Italy
Regions involved:
Sicilia, Emilia-Romagna, Lombardia, Piemonte, Calabria, Campania, Puglia

Organisation

Organisation name:
Nephrology, Dialysis and Transplantation Unit –University of Bari- Bari Polyclinic–
Organisation address:
GiulioCesare square, 11, 70124 Bari (Italy)
Kind of organisation:
Hospitals, Specialised physicians, Research centres, Academia

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period

Description of impact:
We verified an average time-to-impact of two weeks, through psychological interviews and questionnaires on psychological state, self-perceived quality of life and satisfaction with the service, throughout the experimental period.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Private companies, Micro-sized industry, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Academia, National public authorities , WHO, Regional public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses
Source of funding:
National funding

Contact details

Name:
Prof. Loreto Gesualdo
Email:
loreto.gesualdo@uniba.it

Primary and secondary prevention and early diagnosis of cognitive decline through the instruction, home telemonitoring, and weekly feedback on lifestyle in elderly subjects at risk of cognitive decline (SMARTAGING). Early diagnosis of Alzheimer's disease

Increase in life expectancy brought to a raise of the pathological aging and dementia (especially Alzheimer's disease, AD), leading to a low life quality, limited autonomy, and higher costs for assistance. A scientific question is: can lifestyle modify the risk of cognitive decline in elderly? Although some risk factors cannot be changed (aging, genetic predisposition, chronic kidney disease and chemotherapy due to blood cancer), they interact with other environmental factors modifiable by lifestyle. We have developed ICT solutions for the prevention and early diagnosis of dementing disorders in two national projects called "SMART HEALTH 2.0" and "OPLON", granted by the Italian Government (MIUR). The first, SMARTAGING (developed in the SMART HEALTH 2.0, enriched in OPLON) grounded upon the Italian Telecom platform ("Nuvola Italian Home Doctor") and some Telbios servers, exploits the concepts of preventive medicine providing: 1) instructions for healthy lifestyle; 2) telemonitoring of daily activities, training of cognitive functions; 3) telemonitoring of physiological parameters; 4) automatic feedback about subject's response. A successful "proof of concept" of feasibility, usability, and satisfaction was reached in clinical experiments performed in 20 Apulian elderly subjects (ten survived to a blood cancer) over 3-6 months.
The second, MINDBRAIN (grounded upon the "DECIDE" platform; www.eu-decide.eu) exploits the use of MRI and EEG biomarkers for an early diagnosis of AD. A successful "proof of concept" of its diagnostic validity was reached in clinical experiments performed in about 100 Apulian elderly subjects with cognitive impairment. New confirmatory experiments of are in progress in chronic kidney disease subjects.

Keywords:
Cognitive Decline, ICT, Healthy aging, Prevention, Chronic Diseases
Website:
http://www.smarthealth2.com/eng/
Initiative status:
On-going

Background

Geographical scope:
National level

Countries involved:
Italy
Regions involved:
Emilia-Romagna, Lombardia, Piemonte, Puglia

Organisation

Organisation name:
Azienda Ospedaliero-Universitaria Policlinico Consorziale di Bari Department of Emergency and Organ Transplantation – University of Bari
Organisation address:
GiulioCesare square, 11, 70124 Bari (Italy)
Kind of organisation:
Hospitals, Research centres, Academia

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
As mentioned before, SMARTAGING and MINDBRAIN were modules of the projects SMART HEALTH 2.0 AND OPLON, granted from MIUR. These modules included “proof of concept” experiments in the clinical practice involving Operative Units in Apulia. The experiments were completed in SMART HEALTH 2.0 while they are in progress in OPLON. The results of SMARTAGING were successful and are reported in the formal documentation of these projects (deliverables). They were also disseminated in several national and international Conferences and events, in line with the project dissemination plan.
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Private companies, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Academia, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses

Source of funding:

National funding

Contact details

Name:

Prof. Loreto Gesualdo Prof. Claudio Babiloni

Email:

claudio.babiloni@uniroma1.it

REMOTE MONITORING IN HEART FAILURE OUTPATIENT

Apply the Information Communication Technology (ICT) in medicine means to respond promptly to the diagnostic needs of patients regardless of where they are. Many companies are investing in and developing markets that address remote management of chronic diseases, health and wellness. Remote monitoring (RM) is a new and different way of organizing the health care. The aim of our project is evaluate the possible usefulness of the information provided by implantable cardiac defibrillator (ICD) trough RM in a population of HF outpatient at high risk of events. This System is based on primary nursing: Technician or Nurse expert checks the website and makes a first filter on the transmission of patients. Transmissions that report abnormal data, arrhythmic episodes important, critical events are brought to the attention of the physician. In case of relevant event nurse or physician call patients to modify drug therapy or to schedule another follow-up. On basis of our findings, RM by ICD seems to be useful tool for a better management of technical failures and clinical complications occurring in HF outpatient, thus strengthening the hypothesis of a routinely use of RM in this clinical setting.
Second experience: we partnered with Puglia Region, CNR and Capurso City to "ProgettoIppocrate", whose data are still in progress, which was intended to evaluate a potential correlation between climatic variations and the risk of disease cardiovascular onset in people with high cardiovascular risk through use of a wearable "Weheart", device capable of monitoring the biometric data of patients.

Keywords:
remote monitoring, icd, heart failure, healthcare, progetto ippocrate
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Puglia

Organisation

Organisation name:

U.O. Cardiologia Universitaria – Azienda Ospedaliero Universitaria Consorziale Policlinico Bari

Organisation address:

Giulio Cesare Square, 11 – 70124 - Bari

Kind of organisation:

Hospitals

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Remote monitoring (RM) is proposed as a tool for changing the management of HF patients with an implanted device, aiming to improve patient outcome. Our challenge is improve quality of care and of life of HF outpatient with a reduction of in-office visits without compromising patient safety. Moreover RM have a favourable profile in terms of costs, from the perspective of both the healthcare system and that of the patient, as already demonstrated in "MORE–CARE" trial. This may be a valid reason for implementing this model of health care organization.

http://onlinelibrary.wiley.com/doi/10.1002/ejhf.626/epdf

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals

Source of funding:

Local funding

Contact details

Name:

Prof. Favale Stefano – Dott. Santobuono Vincenzo Ezio

Email:

stefano.favale@uniba.it

Radiofrequency-induced thermal ablation of liver tumors

- Increasing life expectancy, reducing the rate of hospitalization, cost savings;
- Minimally invasive treatment of liver tumors (including metastasis) to improve the quality of life and survival;
- Radiofrequency-induced thermoablation/thermotherapy involves introducing a needle electrode into the cancer liver metastasis. Placing the probe is monitored through ultrasound. The procedure involves a radiologist, a nurse, a specialist and an anaesthesiologist. One or two treatment sessions are usually needed and are performed under short-term anesthesia. The treatment is generally well-tolerated;
- Replacement of surgical procedures with minimally invasive percutaneous techniques.
-

Keywords:
Liver tumor treatment minimally invasive, radiofrequency thermoablation/thermotherapy, cost saving health, increasing life expectancy.
Website:
http://www.irccsdebellis.it
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Puglia

Organisation

Organisation name:
IRCCS "S. De Bellis" gastroenterological hospital
Organisation address:
Via Turi, 27 70013 Castellana Grotte BARI (ITALY)
Kind of organisation:
Hospitals

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

Between 1.000 – 5.000 EUR per targeted citizen / patient

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.

Time of impact:

Medium impact – e.g. shortly beyond the pilot project period

Description of impact:

Transferability level:

Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:

Hospitals, Specialised physicians, Nurses, Day care centres, Large-sized industry, Research centres, National public authorities , WHO, Regional public authorities, Advocacy organisations patients/users

Source of funding:

Regional funding

Contact details

Name:

Francesco GABRIELE

Email:

francesco.gabriele@irccsdebellis.it

BURNOUT PREVENTION THROUGH THE EMOTIONAL EDUCATION: AN INTERVENTION PROGRAMME

Burnout has been conceptualized as a psychological syndrome that takes place in response to chronic interpersonal job stressors', however some people are affected more than others, showing major consequences. Socioemotional skills would help to better understand why certain subjects are more susceptible to the negative consequences of stress than others. This practice addresses a socioemotional educational program with nursing assistants in nursing home settings for burnout prevention.

Method:

According to its objectives, the socioemotional program developed comprises twelve sessions organized in four modules: a) to recognize my emotions, b) to understand own and others' emotions, c) to deal with emotions I don't like and maximize positive emotions, and d) to put in practice what I learned through teamwork.

To analyze the efficacy of the program a pre-test and post-test methodology with control group was carried out. The sample was randomly assigned to groups and was blind to the aim of the study. The study was approved by the Matia/Hurkoa/Gerozerlan Healthcare Ethics Committee and all participants signed the informed consent before their participation.

All participants, 208 nursing assistants were recruited from ten nursing homes for older adults managed by different providers in the Basque Country (northern Spain). They were evaluated before and after the intervention with the same assessment tool.

Results:

No statistical differences were found in any of the assessed variables between control and experimental groups before the treatment. After the educational program, the experimental group compared to the control group improved the ability to manage emotional complex situations ($Z=-2,29$, $p=0,02$) as well as the perception regarding their perceived health ($Z=-2,23$, $p=0,02$). Finally, the experimental group showed after the treatment lower levels of emotional exhaustion ($t(100)=4,11$, $p=0,00$), personal distress ($t(54)=2,09$, $p=0,04$) and alexithymia ($t(54)=2,08$, $p=0,04$) as well as better emotional management ($t(97)=-3,24$, $p=0,00$),.

Conclusions:

Our results suggest that training nursing assistants in emotional competences as emotional recognition, understanding and repair, positively influence their emotional wellbeing and constitutes a useful tool to prevent the work stress adverse effects. As people know how to manage complex emotional situations and how to decrypt the hidden messages behind these emotional demands, they may feel less emotionally exhausted at work. This would increase workers satisfaction and accomplishment at work, and as a result of the workers'

wellness, caring for the older people at nursing homes would improve These results are of great importance taking into account de social, health and economic impact of the Burnout in the European society, and its high prevalence among health professionals working with older people. It is well known that European population is aging, the population aged 65 and over being expected to reach the 28% by 2060. Accordingly, the healthcare workforce is also growing quickly and is expected to continue doing so in the years to come. Thus, the need to prevent burnout among nursing assistants in older care settings becomes highly relevant both to preserve the health of the workers and to provide good quality care to the older people.

Keywords:
burnout, emotional skills, prevention, nursing assistants, older adult care
Website:
http://www.matiainstituto.net/es/proyectos/estudio-e-intervencion-sobre-el-burno…
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Gipuzkoa

Organisation

Organisation name:
Matia Instituto Gerontológico
Organisation address:
Camino de los Pinos 27, bajo, 20018 Donostia-San Sebatián (Spain)
Kind of organisation:
Research centres

Viability

Time for deployment:
Less than a year

Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
No evidence or no demonstrated impact
Description of impact:
Unfortunately we don't have evidence about the program's impact after the study and over time due to a lack of funding for it. However, we think that the program and its results are promising and would be great to be have the chance to prove the temporal stability of our results.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Nurses, Nursing homes, Regional public authorities
Source of funding:
Regional funding

Contact details

Name:
Erkuden Aldaz Arroyo
Email:
erkuden.aldaz@matiainstituto.net

Safe Therapeutic Economic Pharmaceutical Selection

This initiative delivers a clinician driven procurement process that ensures that they have a comprehensive input into the process.The process is predicated on the basis of safety and quality driving health gain and economy. It is evidenced based and also takes account of risk assessment of products It also enables the needs of specific patient groups to be taken into account especially older people and ensuring that recommendations in this population are based on evidence relating to that age group ie patient centred.

Keywords:
clinician driven procurement, quality, safety, cost effective, patient focussed
Website:
http://www.themoic.com
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
United Kingdom
Regions involved:
Northern Ireland

Organisation

Organisation name:
Medicines Optimisation Innovation Centre for Northern Ireland
Organisation address:
Antrim Area Hospital
45 Bush Road
Antrim, BT41 2RL, Northern Ireland
Kind of organisation:
Hospitals, Research centres, Regional public authorities

Viability

Time for deployment:
Between one year and three years

Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
The system has increased the efficiency of the pharmaceutical procurement process and helped reduce hospital product costs as well as increased formulary support and compliance in community settings with a subsequent economic benefit This occurs shortly after completion of any specific product area.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Specialised physicians, General practioners, Pharmacists, Nurses, Private companies, Academia, Regional public authorities, Advocacy organisations patients/users
Source of funding:
Regional funding

Contact details

Name:
Professor Mike Scott
Email:
drmichael.scott@northerntrust.hscni.net

Andalusian Telecare Service

The Andalusian Telecare Service is a continued social personal, people-oriented service that provide any help or monitoring 24 hours a day, 365 days a year, supported by the Information and communication Technology whose purpose is to improve the quality of life of citizens, encouraging greater autonomy, independence and integration in their family and social environment.

This service prevents and gives immediate response to situations of loneliness and social isolation, emergency or insecurity, providing support to the elderly, dependent people and disabled people as well as their carers.

The main services are:

1. Installation and maintanance of Telecare devices in home of the users by specialized personnel.
2. Immediate attention
3. Attention to health emergencies and other health care demands.
   3.1. Urgent and emergent Healthcare
   3.2. Notices to the Primary Health Center
   3.3. Health advice.
   3.4. Medical appointments.
4. Attention to other emergencies situations.
5. Conversation and company situations of loneliness and isolation.
   5.1. Periodic follow-ups to know the status of the beneficiary.
   5.2. Personal follow-ups.
   5.3. Greetings.
   5.4. Remainder of specific activities, such as medical appointments and medication.
   5.5. Regular personal data update.
   5.6. Detection of risk situations.
6. Diffusion Campaigns
7. Care for caregivers.
8. Telephone management other services
9. Attendance Care

Keywords:

Andalusian Telecare Service. Isolation. Independence. Quality of life. Communication Technologies.

Website:

http://www.juntadeandalucia.es/agenciadeserviciossocialesydependencia

Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Andalucía

Organisation

Organisation name:
Andalusian Social Services and Dependency Agency, ASSDA
Organisation address:
Avenida de Hytasa 14, 41071, Sevilla, Spain
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been

considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Informal caregivers, Private companies, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Regional public authorities

Source of funding:

Regional funding

Contact details

Name:

Mercedes García Sáez

Email:

coord.accionexterior.cips@juntadeandalucia.es

Electronic Frailty Index

Yorkshire & Humber Academic Health Science Network's Healthy Ageing programme is a coordinated programme of evidence-based improvement interventions focusing on supporting primary care teams and frontline care home staff to keep people well for longer. We have developed, validated and implemented an electronic frailty index (eFI) that uses routine GP data to enable evidence-based, proactive models of integrated care for older people with frailty.

The Electronic Frailty Index (eFI) has been developed as a collaborative partnership between the University of Leeds, TPP (a UK company who provide the SystmOne primary care electronic health record used by one third of the UKs General Practitioners), Bradford Teaching Hospitals NHS Foundation Trust, Bradford University and Birmingham University. We followed international guidelines to develop and validate the eFI using routinely collected UK primary care electronic health record (EHR) data from over 900,000 older people in two large primary care databases. The eFI comprises of 36 'deficits' (clinical signs, symptoms, diseases and disabilities), which are constructed using around 2,000 routinely available codes related to a patient's diagnosis. The eFI enables the automatic calculation of a frailty score that can be used to identify older people with mild, moderate and severe frailty, without the need for a resource-intensive clinical assessment. A higher eFI score identifies older people at increased risk of care home admission, hospitalisation, and mortality (Clegg Age Ageing 2016). The eFI has been implemented in the leading UK primary care EHR systems which means it is available to GPs across the UK. Importantly, the eFI has been developed using coding systems that are widely available in other countries, enabling future international implementation

Implementation of the eFI into routine primary care practice is a major advance in the care of older people with frailty. A frailty collaborative has been developed as part of the Yorkshire & Humber Academic Health Science Network Improvement Academy (http://www.improvementacademy.org/improving-quality/healthy-ageing.html), which is supporting the development and evaluation of new models of primary care for people with frailty. The eFI is being used by GPs and CCGs across the country to develop better, more proactive care pathways for older people with frailty. Examples include:

- Development of integrated community frailty services for older people
- Identification of older people with frailty for medication reviews
- Identification of older people with frailty for proactive falls prevention

Keywords:
frailty assessment, primary care, active and healthy ageing, deficits, patient records

Website:
http://www.improvementacademy.org/improving-quality/healthy-ageing.html
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
United Kingdom
Regions involved:

Organisation

Organisation name:
Academic Unit of Elderly Care & Rehabilitation, University of Leeds
Organisation address:
Bradford Institute of Health Research
Temple Bank House,
Bradford Royal Infirmary,
Duckworth Lane,
Bradford, BD9 6RJ
Kind of organisation:
Research centres, Academia

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Medium impact – e.g. shortly beyond the pilot project period

Description of impact:

Future plans

The eFI will be developed further within the GP electronic health record systems (for example, through templates and/or protocols aligned to the eFI report) to support and optimise clinical utilisation of the eFI within primary care. Work is underway within the Healthy Ageing Collaborative to implement medication reviews for all older people with frailty using a STOPP protocol developed for SystmOne, based on the original Gallagher et al et al (2008) STOPP/START criteria. Additional projects aim to design a self-care intervention for older people with mild frailty which utilises 'A Practical Guide to Healthy Ageing' and is suitable for groups of older people at risk of mild frailty. Data extraction from ResearchOne will inform the understanding of: primary care utilisation relative to frailty severity; the relationship between frailty severity and improvements in end-of-life care planning for older people with frailty; and whether the use of eFI has improved the recognition and diagnosis of frailty (via the proxy indicator of increased Frailty Read Code prevalence).

The value added by the eFI will be demonstrated through the health economic analysis of three discrete case studies/projects undertaken as part of the Healthy Ageing Collaborative, in partnership with York Health Economics Consortium. It is hoped the cost consequence analyses will provide insight as to which interventions work for people with frailty and warrant being scaled up alongside further development of the eFI. The outputs of this improvement programme will be disseminated across partner organisations within the region and nationally.

See national and international frailty guidelines:

- Fit for Frailty (UK) British Geriatric society - http://www.bgs.org.uk/campaigns/fff/fff_full.pdf
- Frailty consensus: a call to action, published by John Morley in JAMDA 2014/15 - http://www.ncbi.nlm.nih.gov/pubmed/23764209

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Private companies, Small-sized industry, Medium-sized industry, Research centres, Academia, NGOs, National public authorities , WHO, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses

Source of funding:

Regional funding

Contact details

Name:

Andrew Clegg

Email:

andrew.clegg@bthft.nhs.uk

Living it Up

LiU is an award-winning online digital self-management service which empowers people, aged 50 and over, to use technology to manage their health and wellbeing, and be better connected to their communities.
LiU has been co-designed and co-produced by a range of partners in the public, statutory, voluntary and private sectors.
LiU's person-centred platform supports the management of the high-costs of caring for an ageing demographic and a growing population living with long term conditions, through a series of prevention and early intervention initiatives.

Keywords:
Digital platform, self-managemet, co-production
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
United Kingdom
Regions involved:
SCOTLAND, Eastern Scotland, North Eastern Scotland, South Western Scotland

Organisation

Organisation name:
Scottish Centre for Telehealth and Telecare, NHS 24
Organisation address:
NHS24
Caledonia House
140 Fifty Pitches Rd
Cardonald, Glasgow, G51 4EB
Kind of organisation:
National public authorities

Viability

Time for deployment:

More than three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Up to May 2015, Living it Up (LiU) was an innovation project funded over 3 years by the Scottish Government and Innovate UK (previously the Technology Strategy Board) as part of the UK wide dallas programme. Following the completion of the dallas innovation phase, LiU was funded by the Scottish Government over 2015/16 to consolidate its assets and begin to develop a service offering to deliver real benefits to the people of Scotland. The 2015-16 phase has been entitled 'Service Development Phase 1' (SD1). This phase included a specific evaluation of LiU, which was undertaken by Impact Generation Ltd, to evidence any return on investment from LiU and any impact on health & wellbeing outcomes. The new business case focusing on Service Development Phase 2 (SD2) is currently being developed.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Primary care centres, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Medium-sized industry, Large-sized industry, National public authorities , WHO, Regional public authorities, Local public authorities

Source of funding:

National funding

Contact details

Name:
Russell Scott
Email:
russel.scott@nhs24.scot.nhs.uk

Teleswallowing

Teleswallowing links speech and language therapy clinicians with patients resident within nursing homes to provide eating and drinking assessment in a timely way to avoid deterioration and admission to hospital.

Keywords:
dysphagia, eating and drinking, speech and language therapy, Health technology Assessment
Website:
http://www.teleswallowing.com
Initiative status:
Completed

Background

Geographical scope:
European level
Countries involved:
Europe
Regions involved:
United Kingdom

Organisation

Organisation name:
Teleswallowing Ltd
Organisation address:
60 Forest Gate, Blackpool, Lancashire, UK, FY3 9AP
Kind of organisation:
Private companies

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, Nurses, Home care centres, Nursing homes, Academia
Source of funding:
National funding

Contact details

Name:
Veronica Southern
Email:
veronica.southern@hotmail.co.uk

RAPid Community COGnitive screening programme

Our target area, Cork County (South Lee) with a total population of c 180,000, has approximately 20,000 adults over 65 years. 8% of these, 1,600, are expected to have evidence of dementia although the true prevalence remains unclear. This project is developing screening instruments using information technology (IT) software for use in a community wide screening initiative for MCI and dementia. RAPCOG is coordinated by the centre for gerontology and rehabilitation (CGR) in University College Cork as part of the Collaboration on Ageing (COLLAGE), Irelands two star reference site for active and healthy ageing under the EIP on AHA. Parallel work, by the CGR, has already informed the initiative. The Optimal Dementia Care in Acute Care settings, ODCACS (see other link) found a high prevalence of dementia and delirium (40%) in older people admitted to six acute hospitals in Cork. A point prevalence study of delirium in Cork University Hospital also revealed a point prevalence of acute confusion i.e. delirium in approx. 20% of adult inpatients. The CGR is also participating in the FP7 funded project NILVAD, See NILVAD.eu and the pre-frailty study PERSSILAA, See Perssilaa.com (including patients with MCI) expertise obtained from this project is being used in RAPCOGs development. Everyone in our target area (South Lee) will be invited to screen friends or family members, without known cognitive deficits, using the QMC. Copies of the QMC, will be posted or emailed via a link, in a staggered fashion, to all households in our target area over a one year period. Subjects screening positive will be asked to attend their primary care physician (GP) for assessment using the Qmci. All older adults screening positive for cognitive impairment by their primary care physician will be reviewed in the Cork memory clinic in St Finbarrs. Copies of the QMC will be made available in all HSE (Irish department of health) offices and GP surgeries. Those patients or family members and caregivers with access to email/computer access will provided with a link to an electronic version. Members of the public will be invited to attend workshops/lectures on how to score the QMC in conjunction with a local health promotion initiative. Individuals over 65 with concerns will be advised to re-screen annually. In the long-term we will analyse the impact of RAPCOG by comparing rates of institutionalisation and hospitalisation seen in the CARTS (community assessment of risk treatment) programme before and after introduction of the programme. The CGR has developed expertise in assessing older persons ability to use IT [12, 13] and have trialed the use of brain training and other IT approaches as therapeutic modalities in MCI. The validation and publication of the Qmci in English is complete and the Qmci Iphone and Ipad App, launched on the Apple App Store in 2012, is available but requires translation and adaption for use in other countries. Different language versions of the Qmci will be validated with a view to using this tool in other European centres. The Qmci is validated in Dutch as part of preparation for the PERSSILAA study (another example of good practice and already on the repository), where a Dutch version is

used as a cognitive screen with Dutch patients. GPs in Cork have received training in the Qmci and inter-rater reliability is complete. The QMC has recently been validated in the Cork memory clinic against the SMMSE and is being prepared for publication. The QMC will be converted into an application and local funding is available to complete this. Screening is expected to be complete by summer 2017. Validation of the programme will be complete by 2018.

Keywords:
dementia, mild cognitive impairment, information technology, screening, community
Website:
http://www.ucc.ie/en/charge-ucc/rapcog/
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Ireland
Regions involved:
South-West (IE)

Organisation

Organisation name:
Collaboration on Ageing
Organisation address:
C/o Prof DW Molloy,
Centre for Gerontology & Rehabilitation, University College Cork,
St Finbarrs Hospital,
Douglas road
Cork City,
Ireland
Kind of organisation:
Hospitals

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Informal caregivers, Small-sized industry

Source of funding:

Local funding

Contact details

Name:

Rónán O'Caoimh

Email:

rocaoimh@hotmail.com

TELEMEDICINE FOR REAL LIFE INTEGRATED CARE IN CHRONIC PATIENTS

The Service consists of a structured telemedicine program differentiated for the types of chronic disease involved. From year 2006 up to now chronic patients (chronic obstructive pulmonary disease and chronic respiratory insufficiency, chronic heart failure, amyotrophic lateral sclerosis, post-stroke and post-cardiac surgery) discharged from our Istitute after a period of in-hospital rehabilitation were admitted to our program. The length of the program differed among diseases. The Telemedicine service consists of a structured physician-directed and nurse-managed telephone support and telemonitoring. . An educated and dedicated health team is involved, including specialists, nurses, physiotherapist and technical personnel. A nurse-tutor has the key role in the service, connecting all the hospital and home personnel by telephone. The intervention consists of four principle components: 1. pre-discharge education sessions on the disease and its therapy, 2. regularly scheduled telephone coaching, 3. home telemonitoring in reale time of different parameters (weight, blood pressure, heart rate, saturation, etc.) and assessment of scales to help patients to detect worsening symptoms, 4. A specialist second opinion for nurse or patient' GP if necessary. The devices supplied for remote telemonitoring depend to the principle problems of the patients. Where rehabilitation sessions are present, a videoconference solution is provided.

Keywords:
chronic patient, home care, Disease management, telemedicine, e-Health
Website:
http://www.fsm.it/uo.php
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lombardia

Organisation

Organisation name:
Salvatore Maugeri Foundation
Organisation address:
Via Salvatore Maugeri, 27100 Pavia, Italy
Kind of organisation:
Hospitals

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Specialised physicians, Nurses, Small-sized industry, National public authorities , WHO, Regional public authorities, Advocacy organisations patients/users
Source of funding:
Regional funding

Contact details

Name:
Simonetta Scalvini
Email:
simonetta.scalvini@fsm.it

EURO MEDITERRANEAN REGISTRY OF OSTEOPOROSIS

The Euro Mediterranean Bio-Medical Scientific Institute (ISBEM, Brindisi, Italy) has launched a pilot project for the disease management of osteoporosis, which is aimed at the prevention of fragility fractures through the early identification of people at higher risk through the use of phalangeal QUS and the collection of clinical risk factors in the R.O.I.S. registry (Ionian and Salento Osteoporosis Registry) which represents the first section of the EMEROS (Euro Mediterranean Registry of Osteoporosis), acknowledged as official commitment by the European Commission Action Group on Active and Health Ageing. The registry has started in 2009 thanks to a strong cooperation between ISBEM researchers and physicians from the Local Health Authorities ASL Brindisi, ASL Taranto and ASL Lecce (limited to the hospital of Gallipoli, Division of Orthopedics and Traumatology). This first section of the registry is of particular interest because Salento sub-region represents the “oldest” area of Apulia and Italy.

Keywords:
Osteoporosis; Fracture Prevention; Adherence to treatment;
Website:
http://www.isbem.it
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Albania, Greece, Italy, Portugal, Spain, Egypt, Turkey
Regions involved:

Organisation

Organisation name:
ISBEM- Euro Mediterranean Scientific Biomedical Institute
Organisation address:
Via Reali di Bulgaria - 72023 Mesagne (Br) ITALY
Kind of organisation:
Research centres

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
We have a great number of subjects, about 4.000, enrolled and monitored for at least three years that demonstrates that people diagnosed with osteoporosis receive an antifracture therapy. In many cases, the therapy is provided after the enrolment in the registry. A specific action in the project is focused on “active monitoring” of the treated patients, with telephone calls for assessing their compliance to the treatment. Thanks to the monitoring activities implemented in the osteoporosis registry, we are allowed to compare fracture rates occurred in osteoporotic and osteopenic patients or in compliant vs. not compliant patients after the recruitment in the project. In addition we can search for association between osteoporosis and other conditions (i.e. diabetes).
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Specialised physicians, Research centres, Academia, Regional public authorities, Local public authorities
Source of funding:
Crowd funding

Contact details

Name:
Prisco Piscitelli
Email:
priscofreedom@hotmail.com

Andalusian eHealth Strategy & System (DIRAYA)

The Andalusian Public Healthcare System has adopted corporate information systems, accessible to all health professionals, as a strategy to cater for citizens' mobility and the participation of many multidisciplinary teams of professionals involved in healthcare processes. The AeHS (Diraya) helps health professionals in their daily work, integrating all health information for each patient in one single record. Reduction of administrative tasks has contributed to its use. Of particular interest is the e-prescription module, as well as the e-lab and the x-ray ones. Patients also benefit from the AeHS, thanks to the use of the centralised appointment systems, the use of electronic prescription (Receta XXI), avoiding unnecessary visits to the health centre just to ask for repeated medication (of special interest for long term conditions), as well as personal access to their healthcare information through ClicSalud. Different health apps are being connected to the system.

Keywords:
eHealth Strategy, single eHR, ePresciption, online patients' access
Website:
http://www.juntadeandalucia.es/servicioandaluzdesalud/principal/documentosacc.as...
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Andalucía

Organisation

Organisation name:
Regional Ministry of Health of Andalusia
Organisation address:
Avenida de la Innovación, Edificio Arena 1 – 41071 Seville (Spain)
www.juntadeandalucia.es/salud/sites/csalud/portal/index.jsp

Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Regional public authorities

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Some of the most significant benefits include:

- Reduction of more than 15% in GP visits for patients who have their first prescription using Receta XXI for an episode of care.
- Sustained cumulative cash savings from generic prescribing of some €100 million
- Reduction of non-attendances in outpatient specialised care of 10%
- Application of determined protocols and standards throughout the region
- More efficient employment of health professionals along all healthcare services
- Reduced support costs of a centralised database replacing many local databases
- More efficient appointments with Salud Responde, the regional call centre.

Examples of impact:

- Increase usage and user satisfaction of AeHS
- 100% coverage of mobile intensive care units for training in mobile health applications
- Data from 2014:
  - 157 M e-prescription
  - 40.5 M PHC visits
  - M outpatients visits
  - 79% of all discharge reports

- 3.3 M emergency care visits
- 55.6 M e-lab tests
- 9.2 M xRay images
- 103 M appointmets
- 212.954 patients' access to eHR

The economic impact of the AeHS:

- e-prescription saving of € 3,1 million (elimination of printing cost and 3,2 data management);
- Decrease of hospital admissions (from an average stay of 7,5 days in 2008 to 7,16 in 2012)
- Decrease of consultations in family medicine (-16,11% from 2007 to 2012)

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Private companies, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Academia, Regional public authorities

Source of funding:

Regional funding

Contact details

Name:

Ana Carriazo

Email:

anam.carriazo@juntadeandalucia.es

KS ACTIVE INSOLE - DR FUSCO METHOD

The Ks is a leading and highly original in orthopedics. It possesses key competences both in the areas of health, in the orthopedic / Physiatric and in the body's metabolic balance, both in the study of the application materials, both in the design and manufacture of diagnostic equipment and rehabilitation. All aimed at improving the quality of life of people. At the same time the Ks creates value through innovation, growth and continuous experimentation. The proprioceptive plantar stimulation method to neuro bio mechanical action plantar guarantees a recovery and an even distribution of muscle tone and elasticity to the entire body's fascial static chain. The goal is to reduce the risk of fall and improve balance and postural habits.

Keywords:
insoil - balance - posturology - risk of falls reduction
Website:
http://www.ksig.it
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Italy
Regions involved:
CENTRO (IT), Firenze, Campania

Organisation

Organisation name:
Centro ricerche KS International Group srl
Organisation address:
Via Ammiraglio Bianco
83013 Mercogliano (AV)
Italy
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
We have identified the time of impact on the basis of our on field experience treating about 50,000 people in 10 years
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Specialised physicians, General practioners, Informal caregivers, Private companies, Advocacy organisations patients/users, gImnasium
Source of funding:
Private funding

Contact details

Name:
dott Fusco Maria Antonietta
Email:
info@ksig.it

The “Walking Groups” Programme

The "walking groups" are groups of people who regularly meet to walk together. Initially led by health professionals, they have gradually become self-sustaining through walking leaders identified among specifically-trained volunteers. The Programme is open to all the community but is specifically designed for people with chronic diseases (diabetes, hypertension, psychological/mental diseases). It supports the participation of patients to contrast and delay disabilities caused by chronic and mental diseases. The program pursuits two goals: the first is strictly related to the health of the participants; the second one to the wellbeing and social dimensions.

Keywords:
Promotion of physical activity, cross-sectorial collaboration, healthy behaviours, communityprevention programmes
Website:
http://www.promozionesalute.regione.lombardia.it
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lombardia

Organisation

Organisation name:
Regione Lombardia - D.G. Welfare
Organisation address:
Piazza Città di Lombardia 1, 20124 Milano Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The length of time that should be invested to actively involve the local stakeholders, in particular municipalities, has to be carefully planned as it might take long. The first three months after the activation of the practice should be dedicated to the involvement of the health professionals that at the beginning will practically guide the different walking groups. Once the practice is implemented and ongoing, time should be dedicated to its periodic evaluation and assessment and to the consequent implementation of corrective action if needed.
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Local public authorities, Health Protection Agencies, General Practitioners, citizens including the voluntary sector
Source of funding:
Regional funding

Contact details

Name:
Liliana Coppola
Email:
liliana_coppola@regione.lombardia.it

The "Walk to school" Programme

The Health promoting schools - Lombardy Network (SPS) has collaborated to promote Pedibus that consists in the organization of safe pedestrian pathways from home to school. Children go to school on foot, accompanied by adult volunteers and along a predetermined route with stops. The program is aimed at promoting physical activity, wellness and environment respect. Three targets chased: daily regular physical activity; fostered relationships and friendships between children and all the adults involved in the program; reduced car traffic and air pollution.

Keywords:
adoption of healthy behaviours, phisical activity, healthy environments, community strategies, preventive action
Website:
http://www.promozionesalute.regione.lombardia.it
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:
Lombardia

Organisation

Organisation name:
Regione Lombardia - D.G. Welfare
Organisation address:
Piazza Città di Lombardia 1, 20124 MILANO, Italy
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Between one year and three years

Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The length of time that should be invested to actively involve the local stakeholders, in particular municipalities and schools, has to be carefully planned as it might take long. To guarantee the long term sustainability of the practice is necessary to involve motivated adult volunteers to “drive” the walking bus (Pedibus).
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Local public authorities,Primary Schools, local health care authorities, adult volunteers
Source of funding:
Regional funding

Contact details

Name:
Liliana Coppola
Email:
liliana_coppola@regione.lombardia.it

Population Risk Stratification: Deployment of Stratification Methods in the Basque Country

Within the Basque Country healthcare system, a customized version of the Adjusted Clinical Groups (ACG) Predictive Model is used for risk stratification (RS). The aim of the risk stratification is mainly case finding; RS is deployed to stratify the entire population of the Basque Country being by next year' healthcare cost. Then population is classified in four groups according to the presence or not of a chronic disease, with a special focus on the 95th percentile of chronic population. To stratify by use of healthcare resources allows identifying and selecting target populations that may benefit from specific programs of action. The RS model is based on diagnoses, socio-demographic data, pharmacy data, prior health care utilization, and socio-economic data. Currently work is being carried out to develop mechanisms to perform a periodic evaluation and optimization of the RS model, and to improve the tool enabling data collection in a more regular basis.

Keywords:
appraisal, health risk, delivery of health care, integrated, chronic diseases, risk adjustment, feasibility studies

Website:

Initiative status:
On-going

Background

Geographical scope:
Regional level

Countries involved:
Spain

Regions involved:
País Vasco

Organisation

Organisation name:
Basque Ministry of Health

Organisation address:
C/Donostia-San Sebastian, 1. Vitoria-Gasteiz. 01010. Araba

Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, National public authorities, Regional public authorities, Local public authorities, Other, please specify

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The best practices and lessons learnt from the implementation and deployment of a RS in the Basque Country are supposed to serve as examples for the development of programs for managing multi-morbidity among complex frail older citizens, and to help policy makers and stakeholder to design, plan, deploy and validate RS in other regions.
A high-quality operational plan establishing the agenda and the strategic goals and objectives for the years to come is needed. Having trained people qualified in RS is necessary. The clinicians' commitment is a sine qua non requirement. If we can assure the commitment of innovators and early adopters, the remaining organizations will follow in their steps. The communication, not only of RS, but also of what it is aiming for, is a key element of its feasibility. If the clinicians do not see the point of RS, it would be really difficult to implement. Since the clinical group consists of different profiles, it is vital to have a multidisciplinary team leading the RS deployment: each and every one of the professional profiles involved is important. Besides, having appropriate ICT has been identified as crucial. Care intervention includes case finding and selecting the target population allows one to focus efforts on the people that can make the best of the programmes designed for chronic patients. A process of continuous improvement that, on the one hand, includes the quality assessment and improvement process and, on the other hand, the pathway definition and implementation, always helps to produce feasible interventions.

Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Regional public authorities, Integrated Health Care Organizations
Source of funding:
Regional funding

Contact details

Name:
Dolores Verdoy
Email:
dverdoy@kronikgune.org

Digital Home

Digital Home was promoted by Consellería de Sanidade through its healthcare service provider (SERGAS) involved a PPI contract gained by a Joint venture formed between two ICT companies. Telemedicine is one of the clearest proposals to successfully solve the needs of improvement of chronic patients care and at the same time improve the sustainability of the system.

Under the Digital Home Assistance concept is encapsulated products and innovative services to improve the citizens quality of life in the home as well as in other social environments in general, which materialise through the implantation of intelligent information devices and systems which support the communication of health information orientated around the prevention and promotion of health, the vigilance and monitoring of pathology (especial the chronic type) or which constitute an access channel to the Health Services used by patients or citizens themselves.

The implantation of these services constitute the primary steps in the transformation of the care model towards a new paradigm which look to improve the efficiency of the current processes and the quality of the services delivered to the patients, pursuing the implication of these services so that they contribute to the management of their health, converting them into an agent of the Health system and, in the medium term, into experts managers of their illnesses.

Hogar Digital Platform was created to empower patients affected by various chronic diseases. Patients can send and receive health information to/from clinicians. The platform allows the development of a care and self-care and treatment agenda, prescribe diets, offer recommendations for exercise, and it can include a variety of multimedia content like videos, presentations, etc. to support the patient and/or caregiver.

Hogar Digital also includes seamless integration with a sensor network to monitor some basic patient features and it represents a powerful tool to establish a double communication between patient and clinicians. The system works effectively with patients that introduce their health data, symptoms and diets in the Platform.

Moreover, it is needed to highlight that all this information is integrated in the Galician Electronic medical record.

The implantation of these services constitutes the primary steps in the transformation of the care model towards a new paradigm which will look to improve the efficiency of the current processes and the quality of the services delivered to the patients, pursuing the implication of these services so that they contribute to the management of their health, converting them into an agent of the Health system and, in the medium term, into experts managers of their illnesses. The benefits obtained with this new model include:

- Minimize the number and the duration of hospital admissions of chronically ill patients, by establishing a better control of the monitoring parameters, early detection of possible alterations that require modification in the pathological treatment.
- Optimally re-using the time of Health professionals by reducing the number of follow-up consultations generated by the high number of chronically ill patients.
- Establishing collaborative environments that generate medical knowledge and making this available to the health professionals quickly and accurately.

One of the existing challenges is making the system useful for a population without knowledge of IT or disabilities. Besides, Hogar Digital is likely to be connected in the future to social media and third party medical apps providing a powerful tool for patients and clinicians, as it has the capability to be connected to EMR systems. Despite the current powerful and relevant features, the system should be completed with more advanced tools and methods for assessing adherence, detection of the defaulting patient, analysis of the factors that determine the failure or implementation of strategies directed to the patient or caregiver. It also lacks of "smart algorithms" to provide reactive information (like alerts of inappropriate adherence by patients, of absence of enough exercise, etc) to patients and clinicians.

Keywords:
telemedicine, chronic patients, empowerment
Website:
http://www.sergas.es
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Galicia

Organisation

Organisation name:
Consellería de Sanidade de Galicia (The Galician Health Ministry)

Organisation address:
Consellería Sanidade
Xunta de Galicia
Edificio Administrativo San Lázaro, sn
15707 Santiago de Compostela
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 1.000 – 5.000 EUR per targeted citizen / patient
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
The data accumulated via questionnaire show that our patients are very satisfied with telemonitoring proccess. Moreover, a significant percentage agrees that through their telemonitoring equipment has improved their accesibility to the health system (better interaction with professionales, accessibility of information, etc.) and believe that telemonitoring has saved time and avoided innecessary trips to visit their Gps or other healthcare proffesional.
Professionals also have been surveyed, and a large majority agrees that telemonitoring is an important aspect of future initiatives to improve the delivery of care, believes that patients are benefiting from this program and telemonitoring in general improves adhesion of patients. In addition, two thirds of the professionals surveyed said that the focus of this program will bring long-term benefits and is in the right direction of the organization.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been

considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Private companies, Regional public authorities

Source of funding:

Other, please specify

Contact details

Name:

Susana Fernández Nocelo

Email:

susana.fernandez.nocelo@sergas.es

Appsam - professional and social support in dementia, part of the CareSam R & D network

AppSam aims to promote innovation, learning and development of skills in the field of elderly care through the exchange of knowledge between countries with different welfare logics. It focuses on dementia care and applied digital technology. The AppSam is a part of the CareSam R & D network. The project AppSam departs from the Swedish-Danish CareSam project (2011-13) which defined a number of areas, showing significant needs to achieve sustainable development: a) technological innovation in the field of elderly care, b) qualifying the future education and learning aiming at work in elderly care sector, and c) development of skills in practice with a special focus on dementia. These three areas are supposed to be explored in the seed funding.

The overall aim of the AppSam seed project is to develop a common understanding of what needs there are within dementia care in countries with different welfare logics and to create collaborative added value. Through workshops a common understanding of how to create participation, meaningfulness and well-being is developed. The workshops will lead to a set of concepts that mirrors what can be done togheter in the different regions. The concepts will act as mediation between partners as well as input to the future project. The workshops will also elaborate what competences there are in the network and what additional resources are needed in AppSam.

In conclusion the overall aims of AppSam seed project are: 1) to extend the established CareSam Network with two new partner countries: Poland and Lithuania, 2) to develop IoT-concepts in the area of elderly care that can contribute to improve quality of life for elderly, relatives, and support health professionals, 3) to explore how participation, interaction and communication can be facilitated through digital technology to meet regional challenges of the elderly focusing on technology, learning and skills in dementia care 4) to prepare an application for Horizon2020 through the extended network based on the findings from the project.

Keywords:
collaboration, dementia care, International, welfare
Website:
http://blogg.mah.se/appsam
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Denmark, Lithuania, Poland, Sweden
Regions involved:

Organisation

Organisation name:
Malmö University
Organisation address:
Malmo University/Dept of Social Work
Nordenskiöldsgatan 8
SE-205 06 Malmo
Kind of organisation:
Academia

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Private companies, Academia, NGOs, Local public authorities

Source of funding:

National funding

Contact details

Name:

Jonas Christensen

Email:

jonas.christensen@mah.se

Baseline Assessment of Frailty application

The Baseline Assessment of Frailty (BAF) app is a computer app that allows to fill the BAF questionnaire. The questionnaire will initially be developed on the open source application platform "limesurvey", distributed under the GNU GPL license, installed on our server and by a mySQL database, developed specifically to achieve questionnaires and online surveys. It is possible to use for individual assessment and get an immediate answer, or to store and export data for analysis of a group of questionnaires.The set up of a mobile app that works even in offline mode to facilitate data collection in areas not served by the Internet, is under development in order to allow the storage of data when the infrastructure allow it . This is a first level questionnaire to assess the frailty status, made up by two questionnaires already validated: the Risk Instrument for Screening in the Community and the short version of the Functional Geriatric Evaluation (SFGE)

Keywords:
frailty assessment, community-dwelling elderly
Website:
http://survey.longlivetheelderly.org/index.php/survey/index/sid/891659/newtest/Y…
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Italy
Regions involved:
Lazio

Organisation

Organisation name:
Biomedicine and Prevention Dept, University of Rome "Tor Vergata"
Organisation address:
Via Montpellier 1, 00173 - Rome, Italy
Kind of organisation:
Academia

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

The impact of the assessment of frailty included in a running services has been evaluated in the framework of the Long Live the Elderly program in Rome. The indication to the service stemming from the assessment allow to give priority in the intervention to the frail individuals and this resulted in a reduced hospitalization and institutionalization rate that can be observed even at four/five years from the assessment (http://file.scirp.org/pdf/AAR_2015111315241899.pdf).

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Primary care centres, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Informal caregivers, Research centres, Academia, NGOs, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities

Source of funding:

Local funding

Contact details

Name:
Giuseppe Liotta
Email:
giuseppe.liotta@uniroma2.it

primerCOG - Platform for stimulation and cognitive training

primerCOG is a Web-based platform with a solid scientific background, suited to the healthy ageing of seniors and to their needs for stimulation, maintenance, monitoring and rehabilitation with respect to a number of neurodegenerative pathologies that affect the elderly. It targets two user profiles: the healthy profile (cognitively healthy older adults) and the mild profile (individuals with a medical diagnosis of neurodegenerative disease, e.g. mild cognitive impairment and Alzheimer's disease) and offers a series of activities targeted at occupational health that are geared to cognitive training of the memory, attention, executive functions, language and visual-spatial ability.

Keywords:
cognitive training, healthy ageing of seniors, stimulation, maintenance, monitoring, rehabilitation, mild cognitive impairment, Alzheimer's disease
Website:
http://primercog.pt/
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Portugal
Regions involved:
Região de Coimbra

Organisation

Organisation name:
MediaPrimer, Lda.
Organisation address:
Rua Sanches da Gama, 160
3030-021 Coimbra, Portugal
http://www.mediaprimer.pt/
Tel. +351 239 703232 /3
Kind of organisation:
Private companies, Small-sized industry

Viability

Time for deployment:

Between one year and three years

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:

Low impact – e.g. impact has been seen only while a pilot project was running

Description of impact:

During the pilot study of primerCOG's functional validation, it was clear the big positive involvement of all users with primerCOG's activities and positive evolution of the motivation and engagement.

Participants presented behaviors that indicate motivation, such as:

- Attention and interest in the explanation of tasks;
- Carefully reading of the information and the instructions of the activities;
- Selection and click with the computer mouse in the suggested tasks;
- Interest in analyzing their own performance;
- Critical thinking about performed tasks. It became notorious with all suggestions of improvements made;
- Positive assessment of activities whose maximum level of performance was hit.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, Day care centres, Home care centres, Informal caregivers, Housing organisations, Private companies, Research centres, Academia, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities

Source of funding:
National funding

Contact details

Name:
José Carlos Teixeira (Prof. Dr.)
Email:
teixeira@mediaprimer.pt

A new and effective targeted prevention programme

We promote health awareness by providing tools that can be used in all contexts stages:

- start by building public awareness
- entertaining individuals and screening them according to their risk profiles
- changing behaviour to manage individual risk
- providing individuals with useful tools that can be used in general contexts

Keywords:
e-Health, public-events, cardiovasular risks, prevention strategies, public information, public campaigns
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Austria
Regions involved:

Organisation

Organisation name:
Institute of Hypertension, Agency Spiritone
Organisation address:
Medical and Scientific management:
Univ.-Prof. Dr Dieter Magometschnigg
Director of the Institute for Hypertension magometschnigg@bluthochdruck.at
Tel: +43 1/408 45 11 – 12
Kinderspitalgasse 10/15
1090 Wien
Austria

nfotainment: creation and organisation:
Agency Spiritone

Managing Director: Johannes Thonhauser o
ffice@spiritone.at
Tel: +43 676/ 48 080 41
Jedlersdorfer Straße 349/DG
1210 Wien
Austria

Kind of organisation:
Primary care centres, Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
Over the past 12 years, starting in 2004, we have developed a targeted prevention programme for cities, regions and entire countries to reach people who are not aware of their hypertension and, furthermore, to increase treatment success to 80%.
Since 2006, we have tested our programme at large yearly events supported by the public and by industry.
The use of our programme at these events has been filmed and the results have been presented at press conferences.
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Pharmacists, Private companies, Small-sized industry, Research centres, NGOs, Regional public authorities, Local public authorities

Source of funding:
Regional funding

Contact details

Name:
Univ.-Prof. Dr. Dieter Magometschnigg
Email:
dieter@magometschnigg.eu

OuluHealth Labs

OuluHealth Labs, the innovation environment of OuluHealth, is an important part of the ecosystem and provides a unique, integrated health test and development environment – including professionals' feedback – for every phase of an R&D process. To summarise, OuluHealth Labs offers a user-centric innovation platform for the products and solutions that are in the development phase. Structured collaboration methods between healthcare professionals and companies ensure the effective utilisation of resources. Feedback from the healthcare professionals in the development phase ensures that solutions become more user-centric. OuluHealth Labs currently consist of three public driven test bed facilities; OYS TestLab, Oulu CityLab and Oamk SimLab.

OYS TestLab, operated by Oulu University Hospital (OUS), is a test environment for specialised healthcare products and services. In close collaboration with the industry, OUS also uses the laboratory to develop its processes and to model and simulate building projects for the Future Hospital Programme.

Oamk SimLab, operated by the Oulu University of Applied Sciences, is a versatile simulation and studio environment, which is used as a learning environment for health and social professional education. SimLab can be used as a testing and development environment in the product innovation of health technology and welfare services, featuring considerable student involvement. Oamk SimLab covers bioanalytics, nursing and emergency nursing, optometry, oral healthcare, radiography and radiation therapy as well as rehabilitation. Oamk SimLab includes also UsabilityLab which supports usability testing of health technology devices and software. Oamk SimLab is located at the OuluHealth campus, in the University of Applied sciences premises.

Oulu CityLab, operated by the city of Oulu, is a test environment where the end users are at customers' and patients' homes and in all social and healthcare services. The City of Oulu opened a technology healthcare centre in 2008. In addition to usual patient care, this healthcare centre contributes to the development of city's technology-enhanced processes and provides companies with a basic healthcare environment for product testing and development. Oulu CityLab testing operations extends to cover other social and health services in the city as well, including home care.

38 use cases have been already started since October 2015.Six of the are already completed.Through collaboration with testbeds in Sweden, Norway, Denmark and Japan, it is possible to test new products also in international contexts.

Keywords:

Integrated health test and development environment, a user-centric innovation platform for the products and solutions, test bed facilities

Website:
http://ouluhealth.fi/labs/
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Denmark, Norway, Sweden
Regions involved:
Suomi / Finland

Organisation

Organisation name:
City of Oulu / OuluHealth
Organisation address:
City of Oulu / Oulun kaupunki
PL 1
90015 Oulun kaupunki
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Research centres, Academia, Regional public authorities, Local public authorities

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Home care centres, Nursing homes, Informal caregivers, Private companies, Micro-sized industry, Small-sized industry, Medium-sized industry, Large-sized industry, Research centres, Academia, NGOs, Regional public authorities, Local public authorities
Source of funding:
Other, please specify

Contact details

Name:
Noora Jansson, Director, OuluHealth Ecosystem Strategy, BusinessOulu/ City of Oulu
Email:
noora.jannson@businessoulu.com

MASK (Mobile Airways Sentinel Network)

MASK (Mobile Airways Sentinel Network) is a new development of the ARIA (Allergic Rhinitis and its Impact on Asthma) initiative. It works closely with POLLAR (Impact of Air POLLution on Asthma and Rhinitis, EIT Health), and collaborates with professional and patient organizations in the field of allergy and airway diseases. MASK proposes real-life care pathways (ICPs) centred around the patient with rhinitis and/or asthma multimorbidity.

Keywords:
ARIA, AIRWAYS ICPs, Care pathways, MASK, mhealth, Rhinitis, DG Santé
Website:
https://www.mask-air.com/
Initiative status:
On-going

Background

Geographical scope:
International level
Countries involved:
Europe, Belgium, Denmark, France, Germany, Greece, Italy, Lithuania, Netherlands, Norway, Poland, Portugal, Spain, Sweden, Turkey, Mexico, Australia, Argentina, Brazil
Regions involved:
BELGIQUE-BELGIË, Extra-Regio NUTS 2, Extra-Regio NUTS 3, Danmark, Extra-Regio Nuts 1, South East (England)

Organisation

Organisation name:
MACVIA-France
Organisation address:
MACVIA-France (contre les Maladies Chroniques pour un VIeillissent Actif en France. Fighting chronic diseases for active and healthy ageing in France), Fondation Partenariale FMC VIA-LR, Université Montpellier, Boulevard Henri IV, 34000- Montpellier, France, +33-611-42-88-47
Kind of organisation:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, Informal caregivers, Housing organisations, Private companies, Micro-sized industry, Small-sized industry, Medium-sized

industry, Research centres, Academia, NGOs, International/European public authorities, National public authorities, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Informal caregivers, Private companies, Micro-sized industry, Small-sized industry, Medium-sized industry, Research centres, Academia, NGOs, International/European public authorities, National public authorities , WHO, Regional public authorities, Local public authorities, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses, Advocacy organisations, citizens, patients with allergic rhinitis and/ or severe asthma y
Source of funding:
Private funding

Contact details

Name:
Jean Bousquet
Email:
jean.bousquet@orange.fr

Matia Person Centered Care Practices Monitorization

The aim of the present document is to briefly describe the background, method and aims of a good practice that is being developed (2016-2017) in the Matia Foundation through the Matia Institute.

Background: The Matia Foundation is a more than 100 years old historic foundation in San Sebastian, Basque Country, which aim Is provide care and support to the older and disable people. Matia has several residential care centres, daycare settings, hospitals and social services. Since 2011 Matia foundation is involved in improving the Care Model in order to adjust the characteristics of their centres to the older users' needs: physical architecture, organization and practices in the professional environment. Matia Institute, as the research spinoff of Matia Foundation, is committed to advance in the knowledge on the continuity of care at the residential care centres. Matia is also committed to transfer the knowledge acquired and to produce guidelines for care improvement and person centred care model development. Consequently, the itinerary of implementation and consolidation of Matia Person Centered Care Model (Matia PCCM) has to pay special attention to the development of training and support to professional caregivers and obtaining evidence of such actions in the acquisition and maintenance of residents' treatment and care. To this aim Matia is developing several qualitative procedures for gathering information at the centres and monitoring the implementation of Matia PCCM as well as adapting existing instruments such as PCAT and PDC. This procedure will be developed in closed collaboration between the healthcare centres of Matia Foundation and the research department of Matia Institute to improve the quality of life of the Matia services users.

Aim: The aim of the practice is to achieve objective indicators of implementation of good practices based on the person centred care model.

Method: The method involves recording selected timeslots of the day in 7 Matia residential settings through the region. Initially 1 hour and 30 minutes at lunchtime will be recorded in each centre 1 day a month during 8 months. These will provide a longitudinal sample of how the staff behaviour is changing through time regarding good and bad practices according to the model. The recordings will be analysed by means of recording and mapping the professional behaviours through a category system developed at hoc.

Results expected: We hope to develop an adequate category system based in establishing functional categories of the behaviour that make possible to gather qualitative and quantitative measures of behavioural staff change. Furthermore, we hope to record several observable good practices behaviours that, previously given permission of the nurse, let us improve our formative programme by means of showing real examples of best practices within our foundation.

Keywords:
Person Centred Care, Behaviour recording, Observational Analysis, Good practices
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:

Organisation

Organisation name:
Matia Institute
Organisation address:
Hospital Bermingham,
Camino de los pinos 27, bajo.
San Sebastián
CP: 20018
Guipúzcoa
Kind of organisation:
Hospitals, Primary care centres, Nurses, Day care centres, Nursing homes, Research centres

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
No knowledge about evidence. No evaluation or documentation of effect has been carried out
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Transferability level:
Transferability has not been considered. The innovative practice has been developed on local/regional/national level and transferability has not been considered in a systematic way

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Nurses, Day care centres, Home care centres, Nursing homes
Source of funding:
Private funding

Contact details

Name:
Alvaro García Soler
Email:
alvaro.garcia@matiainstituto.net

ALOHA, the Active and Healthy Ageing Academy

The purpose of ALOHA is to address a large part of the targeted population as fast as possible, using the digital communication channel in order to inform, educate and engage this population. The integration of both the healthcare professionals and the citizens/ seniors/patients at the heart of the project is to avoid any asymmetry of information between these two target populations to ensure trust and efficiency in the decision-making process.
The internet is a rich source of information on health but reliability of these sources is often questioned. The aim of ALOHA is to become a referent source in health promotion of effective diseases preventative interventions in the seniors for a healthy ageing.
The core of ALOHA is the creation of a state-of-the-art expert-based new (web) portal to inform, educate and engage lay public and healthcare professionals on prevention means (which include but are not limited to: vaccination, nutritional intervention and physical activity) and will provide tools for personal recommendation to empower the users making good preventive choice.

Keywords:
prevention, Immunosenescence, Education, Healthy ageing, Reliable information, Infectious diseases, Public Health policy, Caregivers, e-learning, Health promotion
Website:
http://www.aloha-academy.eu
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
France
Regions involved:

Organisation

Organisation name:
Gerontopole Autonomie Longevite des Pays de la Loire
Organisation address:
Maison Regionale Autonomie Longevite,

Gerontopole Autonomie Longevite des Pays de la Loire
8 rue Arthur III,
44200 Nantes,
France
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
Low impact – e.g. impact has been seen only while a pilot project was running
Description of impact:
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Specialised physicians, General practioners, Nurses, Home care centres, Nursing homes, Informal caregivers, Advocacy organisations patients/users, Advocacy organisations physicians, Advocacy organisations nurses, Advocacy organisations, students, lay public, gerontologists
Source of funding:
Private funding

Contact details

Name:
Kevin Galery
Email:
kevin.galery@gerontopole-paysdelaloire.fr

eHealth in wound care - from conception to implementation

The European Wound Management Association published this domain specific document aiming to provide wound care clinicians as well as relevant health care authorities with a rapid and structured overview of the key issues related to use and implementation of eHealth applications (telemedicine and telehealth) within wound care. This includes:

- An overview of terminology and available literature
- Guidance on the methodology for evaluation of eHealth solutions
- An introduction to and discussion of the potential benefits of eHealth technologies in wound care, and the possible barriers to their implementation
- Recommendations for ensuring a good implementation process and supporting involvement of wound care professionals in safeguarding that eHealth solutions meet the needs of the patients.

Keywords:
wounds, eHealth, telemedicine, telehealth, implementation
Website:
http://ewma.org/what-we-do/ewma-project-portfolio/list-of-completed-ewma-project…
Initiative status:
Completed

Background

Geographical scope:
European level
Countries involved:
Europe
Regions involved:

Organisation

Organisation name:
European Wound Management Association
Organisation address:
EWMA Secretariat
Nordre Fasanvej 113
DK-2000 Frederiksberg
Denmark
www.ewma.org

Kind of organisation:
NGOs

Viability

Time for deployment:
No evidence or no record kept of prior preparation
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.
Time of impact:
No evidence or no demonstrated impact
Description of impact:
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Home care centres, Nursing homes, Private companies, Research centres, NGOs, International/European public authorities
Source of funding:
European funding

Contact details

Name:
Julie Bjerregaard
Email:
jb@ewma.org

Gastrological approach to malnutrition

The Action Group A3 Food & Nutrition in the EIP-AHA has developed a common, integrated vision on the nutritional approach to frailty, taking into account also the impact of social integration and psychosocial behavior of the elderly. According to this vision, the gastrological approach should be the primary approach to prevent or treat undernutrition in non-frail, pre-frail or frail elderly in all healthcare settings.
The focus on the gastrological approach is to carry out personalized interventions that take advantage of validated screening, assessment and monitoring tools, recognizing a coherent set of work packages all aimed at improving food intake in elderly persons. These work packages consist of interprofessional collaborating gastro-teams managing selective taste control and optimized meal contexts.
A digital Modular Gastrological Platform (MGP) is built to facilitate these interprofessional efforts. MGP focusses on supporting workflows in the Primary and Secondary Care Level. The aim of the open and extensible platform is to add business and social value by providing evidence-based tools to optimize existing and new workflows, without increasing the workload, by empowering patients and care givers in their respective roles. MGP is built around the concept of transmural care and has been designed to be patient-centered.
The gastrological approach has been implemented in different Belgian contexts of care for elderly people. According to the practice based evidence from these small scale implementations, upscaling the gastrological approach supported by the MGP, might lead to more elderly people satisfied with taste and choice of meals. As such, the integrated use of the gastrological approach and the MGP might have the potential to contribute significantly to the EC goal to increase the average healthy lifespan in the EU by two years by 2020 in a more accessible way.

Keywords:
screening, Monitoring, taste steering, Food
Website:
http://www.centerforgastrology.com
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Belgium, Netherlands

Regions involved:
Prov. Antwerpen, Prov. West-Vlaanderen

Organisation

Organisation name:
Center for Gastrology
Organisation address:
Vismarkt 10c
3000 Leuven - Belgium
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Nurses, Nursing homes, Private companies, Large-sized industry, Research centres, Academia, ICT providers, Hotelschools, Training centers,

Source of funding:
Private funding

Contact details

Name:
Edwig Goossens
Email:
edwig.goossens@centerforgastrology.com

Gastrological approach to malnutrition

The Action Group A3 Food & Nutrition in the EIP-AHA has developed a common, integrated vision on the nutritional approach to frailty, taking into account also the impact of social integration and psychosocial behavior of the elderly. According to this vision, the gastrological approach should be the primary approach to prevent or treat undernutrition in non-frail, pre-frail or frail elderly in all healthcare settings.
The focus on the gastrological approach is to carry out personalized interventions that take advantage of validated screening, assessment and monitoring tools, recognizing a coherent set of work packages all aimed at improving food intake in elderly persons. These work packages consist of interprofessional collaborating gastro-teams managing selective taste control and optimized meal contexts.
A digital Modular Gastrological Platform (MGP) is built to facilitate these interprofessional efforts. MGP focusses on supporting workflows in the Primary and Secondary Care Level. The aim of the open and extensible platform is to add business and social value by providing evidence-based tools to optimize existing and new workflows, without increasing the workload, by empowering patients and care givers in their respective roles. MGP is built around the concept of transmural care and has been designed to be patient-centered.
The gastrological approach has been implemented in different Belgian contexts of care for elderly people. According to the practice based evidence from these small scale implementations, upscaling the gastrological approach supported by the MGP, might lead to more elderly people satisfied with taste and choice of meals. As such, the integrated use of the gastrological approach and the MGP might have the potential to contribute significantly to the EC goal to increase the average healthy lifespan in the EU by two years by 2020 in a more accessible way.

Keywords:
screening, Monitoring, taste steering, Food
Website:
http://www.centerforgastrology.com
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Belgium, Netherlands

Regions involved:
Prov. Antwerpen, Prov. West-Vlaanderen

Organisation

Organisation name:
Center for Gastrology
Organisation address:
Vismarkt 10c
3000 Leuven - Belgium
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:
Hospitals, Primary care centres, Nurses, Nursing homes, Private companies, Large-sized industry, Research centres, Academia, ICT providers, Hotelschools, Training centers,

Source of funding:
Private funding

Contact details

Name:
Edwig Goossens
Email:
edwig.goossens@centerforgastrology.com

Electronic medical record System, IANUS, improves regional health care in Galicia

IANUS, the Galician Electronic Medical Histoy, provides a powerful and effective tool for managing clinical information, having a single model of access to information through a web application. It is about a single shared medical history, giving integrated care to patients when the integration of care processes and the continuity of care between primary and specialized care in any SERGAS centre is improved, minimizing testing and allowing shared management of the same. The information is available in an integrated, simple way, which avoids the separation of information which can be generated from any patient at any level of health care and being completely accessible to authorized healthcare professionals, also including the image that healthcare provides. This then improves patient safety, allowing for better diagnosis and for tailored and individualized treatments.

Through IANUS, electronic prescriptions and dispensations of all medication throughout all of the Galician Public Health System is guaranteed. All the community pharmacies are connected to IANUS for dispensations This is a major benefit for the population and mainly for the elderly population, which allows for a unique and extraordinary comprehensive amount of information on pharmacotherapy resource consumption, adherence to treatment, drug interactions and even an additional element to stratify the population. In addition, IANUS bears the supply and the pharmacotherapeutic care to over 8,000 patients in nursing homes, which is done from the hospital pharmacy service. Moreover, IANUS allows effective and efficient management of the patient care program for poly-pharmacy patients of Galicia. Currently 100% of health centres and hospitals of Galicia and a 100% of pharmacies are connected.

Nevertheless, the IANUS system is not a tool designed for the exclusive use by medical personnel. Some 2 700 000 citizens of Galicia can also access basic information about their own medical records via the internet, using their personal national identification number. These changes are particularly beneficial for people with chronic illnesses. It is estimated that IANUS has reduced visits to the Emergency Rooms (ER) of hospitals by 4 %, cut consultations at the primary care level by 10 % and meant that the number of patients waiting for an appointment has been reduced by 19 %. The introduction of an electronic prescription service has resulted in 2 500 000 fewer visits each year by patients to their General Practitioner (GP).

Keywords:
electronic medical records, EHR

Website:
http://ec.europa.eu/regional_policy/en/projects/spain/electronic-medical-record-…

Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Galicia

Organisation

Organisation name:
The Galician Health Ministry (Consellería de Sanidade)
Organisation address:
Edificio Administrativo San Lázaro sn
15707 Santiago de Compostela
A Coruña-Spain
Kind of organisation:
Regional public authorities

Viability

Time for deployment:
More than three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Pharmacists, Nurses, Day care centres, Home care centres, Nursing homes, Regional public authorities

Source of funding:

European funding

Contact details

Name:

Susana Fernandez Nocelo

Email:

susana.fernandez.nocelo@sergas.es

Euskadi Lagunkoia (Age-Friendly Basque Country)

Euskadi Lagunkoia is a cross-cutting initiative engaging citizens, public and private sectors to create enabling environments for older people. Launched by the Ministry for Employment and Social Policies with Matia Institute, it works with 40 towns and cities to develop a network of age-friendly communities and facilitate the exchange of good practices, combat ageism; enable autonomy and support Healthy Ageing in all policies. Euskadi Lagunkoia is a proactive strategy to make living spaces more age-friendly, without physical obstacles and barriers.

Goals:

- Tapping the potential of seniors in villages and cities as welfare generators.
- Promote community participation processes.
- Create a Network of friendly initiatives.
- Facilitate changes in the environments to improve quality of life.

Keywords:

Age-friendly cities and communities, empowerment, citizen participation, elderly

Website:

http://euskadilagunkoia.net/es/

Initiative status:

On-going

Background

Geographical scope:

Regional level

Countries involved:

Spain

Regions involved:

País Vasco

Organisation

Organisation name:

Ministry for Employment and Social Policies with Matia Institute*

Organisation address:

Matia Institute
C/ Orense 6 Planta 13 Puerta 1A
28020 Madrid, Spain

Kind of organisation:
Research centres

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:
Small-sized industry, Research centres, NGOs, Regional public authorities, Local public authorities, Elderly associations
Source of funding:
Regional funding

Contact details

Name:
Elena del Barrio
Email:
elena.barrio@matiainstituto.net

Dementia Counseling Centres Network

The Athens Association of Alzheimer's Disease and Related Disorders in collaboration with the Association for Regional Development and Mental Health (EPAPSY), CMT prooptiki and selected Municipalities in Greece developed 13 Counseling Centres for promoting dementia prevention and non-pharmacological interventions in the local community, 9 based in Athens and 4 in Cyclades. The project was funded under the program "We are all citizens" by EEA and Norway grants. Bodossaki foundation is the National funds operator for Greece. Dementia Consultation Centres aims to implementing a socially innovative model of dementia health care services provision.

In total, 1991 people have visited the Dementia Consultation Centres, number that exceeds in a percentage of 153% the initial users estimation (1300 users in total). The services that were provided during the lifetime of the project included:

- Neuropsychological screening and neurological examination: 1868 screening tests were conducted by trained psychologists of the impelementation team and 592 neurological assessments at the Dementia Consultaiton Centres in Athens
- Cognitive Stimulation groups of people with Mild Cognitive Impairment and normal Cognition: 14 groups of cognitive stimulation have been organised, further analysed into 361 sessions and 198 participants in total
- Carers psychoeducational support: 132 individual sessions have been organised, with the participation of 105 carers and 23 group sessions with the participation of 43 carers.

In parallel, 92 care professionals have participated in training sessions about dementia topics and the Dementia Consulation Centres Model. Furthermore, almost half of them have participated on the job training in order to faciliate the sustainability of the Centres after the end of the project. Additionally, 236 care professionals from all over Greece have registered to the eLearning course developed in the framework of the project.

During the lifetime of the project, 207 networking and dissemination actions organised in an effort to communicate the aims of the programme.

Keywords:

prevention, Early Diagnosis, carer's support, dementia services, community network

Website:

http://dementia-community.gr

Initiative status:

On-going

Background

Geographical scope:
National level
Countries involved:
Greece
Regions involved:
Αττική (Attiki), Άνδρος, Θήρα, Κέα, Μήλος, Μύκονος, Νάξος, Πάρος, Σύρος, Τήνος (Andros, Thira, Kea, Milos, Mykonos, Naxos, Paros, Syros, Tinos)

Organisation

Organisation name:
Athens Association of Alzheimer's Disease and Related Disorders
Organisation address:
Markou Mousourou 89, Athens, Greece
Kind of organisation:
NGOs

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Transferability level:
The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:

Primary care centres, Day care centres, Informal caregivers, NGOs, National public authorities , WHO, Regional public authorities, Local public authorities, Other, please specify

Source of funding:

European funding

Contact details

Name:

Paraskevi Sakka, Areti Efthymiou

Email:

kentroalz@otenet.gr

Improving of the health with the help of normobaric hypoxic therapy with hyperoxic and hypercapnic effect

Our main innovative medical technology registered under the name: "Improving of the health with the help of normobaric hypoxic therapy with hyperoxic and hypercapnic impact".This medical technology designed for prevention, treatment and rehabilitation of a wide range of people (up to 95%), to continue the healthy aging, to improve work capacity and endurance of the people, and so etc. In the future, it may take priority place in the scheme of healthy lifestyles, including recovery with no medication, but using organism's reserves. Currently methodical recommendations offer this medical technology to managers of public health, medical generalists, physicians, balneologists, fitness and spa industry, sports physicians and environmental medicine. This is a new non medical technology, in which new life processes have woken towards their normalization, stimulation of hidden reserves of the organism, causing the body goes to a new and better level of health. For this technology we have developed special gas medical equipment "Elbrus" based on our inventions .They have all kinds of scientific, technical and medical tests in the sanatoriums of the Ministry of Health, academic institutions, the National Academy of Sciences, National Medical Academy of Sciences.
Projects may be different, but almost all of them are based on 8 our patents for inventions and guidelines "Improving of the health with the help of normobaric hypoxic therapy with hyperoxic and hypercapnic impact".

Keywords:
Improving of the health normobaric hypoxic therapy hyperoxic and hypercapnic impact
Website:
http://elbrus.zt.ukrtel.net
Initiative status:
Completed

Background

Geographical scope:
National level
Countries involved:
Ukraine
Regions involved:

Organisation

Organisation name:

The medical improving centre "Elbrus"

Organisation address:

143, B.Tena Str., Zhitomir, 10001, Ukraine;
Tel: +38(0412)362215; tel mob.: +3(097)7662288;
elbrus0@ukr.net

Kind of organisation:

Small-sized industry

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:

Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice

Maturity level:

The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

The mechanism of realization of a method consists in daily 30...40 minute breath the different maintenance of oxygen and other components. Breath is made in cyclic-fractioning a mode. The basic mode of intermittent normobaric hypoxic therapy begins with the appointment of step adaptation

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Specialised physicians, General practioners, Nurses, Day care centres, Nursing homes, Micro-sized industry, Small-sized industry, Medium-sized industry, Large-sized industry, Advocacy organisations patients/users, Advocacy organisations physicians

Source of funding:

European funding

Contact details

Name:

General Director Leonid Bogatyrchuk

Email:

elbrus0@ukr.net

Study of Risk Stratification Tools in use in Europe - Analysis of the feasibility of introducing stratification tools in healthcare (ASSEHS)

Action Area 4 is one of the 9 Action Areas of B3 Action Group Action Plan and is focused on the study of Risk Stratification Tools in use in Europe. To do this, the Action Area 4 has developed a Work Plan to generate knowledge in this field. One of the outcomes of this Work Plan is this deliverable which contains a database with relevant information about risk stratification in several fields: design and definition of the tool, feasibility of implementation and impact on health services.

Keywords:
Health services, risk stratification
Website:
Initiative status:
Completed

Background

Geographical scope:
International level
Countries involved:
Europe, North America, South America
Regions involved:

Organisation

Organisation name:
Kronikgune
Organisation address:
For more information, contact Esteban de Manuel, General Director at
Kronikgune
Torre del BEC
(Bilbao Exhibition Centre)
Ronda de Azkue, 1
48902 Barakaldo (Bizkaia)
Kind of organisation:
Research centres

Viability

Time for deployment:

No evidence or no record kept of prior preparation

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Research centres, Academia

Source of funding:

European funding

Contact details

Name:

Dr. Esteban Manuel Keenoy, Director, Kronikgune

Email:

edemanuel@kronikgune.org

A Maturity Model for Adoption of Integrated Care within Regional Healthcare Systems (B3 Action Group)

B3 members have worked together to develop practical tools that support service local service delivery. One of them concentrated on Maturity models focusing on three key areas: organisational models, change management and the development and adoption of eHealth programmes and teleservices to support integrated care and service innovation, were developed. These models were subsequently converged into one comprehensive model - the B3 Maturity Model. This model covers a broad range of areas relevant for implementing integrated care and functions as a self-assessment tool that provides objective measurement and guides regions how to improve their capacity to deploy services.

Keywords:
eHealth, teleservices, organisational models, change management, Integrated care, service innovation
Website:
http://www.healthpolicyandtechnology.org/issue/S2211-8837(15)X0005-0
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Czech Republic, Denmark, Greece, Italy, United Kingdom, Spain, Sweden
Regions involved:
Olomoucký kraj, Sydjylland, Cataluña, Galicia, Puglia, Skåne län, SCOTLAND, Αττική (Attiki)

Organisation

Organisation name:
B3 Action Group
Organisation address:
For more information contact B3 Action Group Coordinator NHS24
Kind of organisation:
Hospitals, Primary care centres, Large-sized industry, Research centres, Academia, Regional public authorities, Local public authorities

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

Apparent evidence. Evidence is based on qualitative success stories

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

The innovative practice has been transferred in other locations or regions or national scale in the same country

Initiative

Stakeholders concerned:

Hospitals, Primary care centres, Nurses, Day care centres, Nursing homes, Large-sized industry, Academia, Regional public authorities, Local public authorities

Source of funding:

Regional funding

Contact details

Name:

B3 Action Group Coordinator

Email:

donna.henderson1@nhs.net

Refer-to-Pharmacy

Refer-to-Pharmacy allows bedside referral of patients to their community pharmacist for either a post-discharge medicines adherence consultation (New Medicine Service, Medicines Use Review), or to update a patient's medication record with changes made in hospital to improve safety. Pharmacies are also informed on hospital admission of their care home or blister pack patients so they can pause dispensing to reduce wasted medicines. Refer-to-Pharmacy is an electronic tool that facilitates rapid referral by the hospital pharmacy team; it is integrated with Trust IT systems so patient demography instantly populates the referral and their electronic discharge letter is automatically attached at discharge.

Keywords:
Refer-to-Pharmacy, referral, hospital pharmacy, community pharmacy, transfer of care
Website:
http://www.elht.nhs.uk/refer
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
United Kingdom
Regions involved:
East Lancashire

Organisation

Organisation name:
East Lancashire Hospitals NHS Trust
Organisation address:
Pharmacy department,
Royal Blackburn Hospital,
Haslingden Road,
Blackburn, Lancashire, BB2 3HH, UK
Kind of organisation:
Hospitals

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

No knowledge about evidence. No evaluation or documentation of effect has been carried out

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Medium impact – e.g. shortly beyond the pilot project period

Description of impact:

Readmissions rates are reported by the hospital as a matter of course. The effect of hospital to community referral was assessed from January 2016 (2 months after go-live of Refer-to-Pharmacy to allow sufficient time to train staff and embed behaviour). A reduction was seen quite quickly. As mentioned above the rate dropped by 1.5% which equated to 70 less people readmitted to hospital in the first four months of 2016 (compared to the same period of 2015).

More detailed reporting tools are being developed

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, General practioners, Pharmacists, Private companies, Academia, National public authorities , WHO, Advocacy organisations others, Academic Health Science Network

Source of funding:

Local funding

Contact details

Name:
Alistair Gray
Email:
alistair.gray@elht.nhs.uk

Telehealth service for patients after AMI and on anticoagulation treatment

The practice introduces remote monitoring of elderly patients who are hospitalized for acute infarct of myocardium (AMI) in cases of newly diagnosed (or until then unknown diagnosis of) diabetes using telehealth services and patients on anticoagulation treatment. The patients are telemonitored for AMI relapse, unstable angina pectoris and need of further interventional or chirurgic revascularization.
This good practice was initiated by experienced cardiologists who recognized need for improvement of care for mostly senior patients hospitalized for acute myocardial infarction (AMI) and other cardiacs. The purpose of the practice is support patients at home, early detect frequent comorbidity (diabetes) and respond to unwanted development of INR of patients in anticoagulation regime. Political support is sought on several levels, including regional government, national healthcare management authorities and also medical societies. The practice reflects regional conditions that are characterized by low usage of ICT in healthcare of patients in the CR and lack of reimbursement and other pre-requisites that would otherwise allow smoother operation of such services. The practice then must have been economically optimized. Experience from participation in relevant EU projects (CIP, such us United4Health) is capitalized in the updated practice. The practice is financed through projects undertaken by the NTMC within Structural funds, national funds and from resources of project partners. The investment is approximately 50 000 Euro and still increases with the number of concurrently monitored patients, which is under control.
This good practice is updated practice (no. 2) of the same healthcare provider that was evaluated in first half of 2013 in the context of EIP on AHA Reference Sites call in that year

Keywords:
Myocardial infarction, Diabetes, INR - International Reference Ratio, coagulation, telehealth, telemonitoring, quality of care, quality of life, comorbidity, Drugs
Website:
http://www.ntmc.cz
Initiative status:
On-going

Background

Geographical scope:
Regional level

Countries involved:
Czech Republic
Regions involved:
Olomoucky kraj

Organisation

Organisation name:
University Hospital Olomouc - Czech National eHealth Center
Organisation address:
I.P:Pavlova 185/6, 779 00 Olomouc, Czech Republic
Kind of organisation:
Hospitals, Research centres, Academia

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.
Time of impact:
Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began
Description of impact:
The impact of the intervention was in increased quality of care of the patients, namely due early intervention thanks to the practice that reduced deterioration of the patient's condition. It enables to initiate treatment of comorbidities and properly adjust drugs in anticoagulation treatment avoiding adverse development of disease at cardiacs. Quality of life of the patients was increased, which was confirmed also by their response during interviews. Patients are also more empowered, know more essential information about their disease and have lowered barriers to communicate with their carer.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been

considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Specialised physicians, Nurses, Research centres, National public authorities , WHO, Regional public authorities

Source of funding:

National funding

Contact details

Name:

Zdenek Gütter, PhD ; Miloš Táborský, M.D., Ph.D, FESC, MBA

Email:

gutter@ntmc.cz

Telehealth service for patients with advanced heart failure

The practice introduces specific remote monitoring of patients with Congestive heart failure, structural damage of myocardium and left chamber dysfunction through the deployment of telehealth services and enhances relevant medical protocols. This new practice is to detect as many patients with the given diagnoses as possible, deploy telehealth services for monitoring and improved treatment of these patients. Appropriate care protocols will be enhanced and standardized, based on evaluation of results of telemonitoring in practice. The telehealth service consist of telemonitoring with clinical protocol that is in line with protocol used in an large EU project Unite4Health (www.united4health.eu) that focused on assessing the impact of innovative healthcare services in real conditions in 14 regions of Europe. This clinical protocol is extended by several ICT based features that are enabled by service portal. These features increase technical reliability of distant communication between patient (gateway) and healthcare personnel (nurse, cardiologist with access to telehealth portal), provide fast drug ordering tool and enable bidirectional communication with the patient.
This practice is updated innovation that has been originally developed in 2012 and was also evaluated in the context of EIP on AHA Reference sites call in 2013.

Keywords:
Chronic heart failure, telemonitoring, telehealth, Nurses, cardiologists, rehospitalisation, quality of care, Drugs
Website:
http://www.ntmc.cz
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Czech Republic
Regions involved:
Olomoucky kraj

Organisation

Organisation name:

University Hospital Olomouc - Czech National eHealth Center

Organisation address:

I.P.Pavlova 185/6, 779 00 Olomouc, Czech Republic

Kind of organisation:

Hospitals, Research centres, Academia

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

Between 1.000 – 5.000 EUR per targeted citizen / patient

Evidence of practice:

Documented evidence. Evidence is based on systematic qualitative and quantitative studies

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

The impact of the intervention was in increased quality of care of the patients, namely due early intervention thanks to the practice that reduced deterioration of the patients condition. Reduction of rehospitalisation is approx. 40%. The patients better adhere to medication and have better access to prescribed drugs. Quality of life of the patients was increased, which was confirmed also by their response in questionnaires. Patients are also more empowered, know more essential information about their disease and have lowered barriers to communicate with their carer.

Transferability level:

The innovative practice has been transferred within the same country.

Initiative

Stakeholders concerned:

Hospitals, Specialised physicians, Research centres, National public authorities , WHO, Medical society - Cardiology

Source of funding:

National funding

Contact details

Name:

Zdenek Gütter, PhD ; Miloš Táborský, M.D., Ph.D, FESC, MBA

Email:

gutter@ntmc.cz

Tele-monitoring of patients with AMI and in anticoagulation regime

This good practice is updated practice (no. 2) of the same healthcare provider that was evaluated in first half of 2013 in the context of EIP on AHA Reference Sites call in that year.

Keywords:
Enhanced care of cardiacs, using ICT tools, economic design, Acute Myocardial Infarction (AMI), Diabetes, anticoagulation regime, International Normalised Ratio (INR)
Website:
http://www.ntmc.cz
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Czech Republic
Regions involved:
Olomoucky kraj

Organisation

Organisation name:
University Hospital Olomouc - Czech National eHealth Center
Organisation address:
University Hospital Olomouc,
NTMC
I.P. Pavlova 6, 775 20 Olomouc, Czech Republic
Kind of organisation:
Hospitals

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:

Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice

Maturity level:

There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use

Time of impact:

Medium impact – e.g. shortly beyond the pilot project period

Description of impact:

Implementation of telemedicine in care of chronically ill patients has impact in better compliance of patients, lower cost of treatment of patients due to early detection of adverse development of the disease or co morbidity that typically prevent transition of the patient's condition to worse status, which would require more cost from public health funds. Medical personnel is also capable to deal with slightly more patients in given time as most of traditional visits of outpatient department is routine and does not result in any change of medication or procedures. Patients are more interested in their health status and easily follow the instructions given to them. Some of the routine trips of patients to the outpatient department could be avoided.

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Specialised physicians, Nurses, Advocacy organisations physicians

Source of funding:

National funding

Contact details

Name:

Zdenek Gütter, PhD ; Miloš Táborský, M.D., Ph.D, FESC, MBA

Email:

gutter@ntmc.cz

Tele-monitoring of patients with AMI and in anticoagulation regime

This good practice is updated practice (no. 2) of the same healthcare provider that was evaluated in first half of 2013 in the context of EIP on AHA Reference Sites call in that year.

Keywords:
Enhanced care of cardiacs, using ICT tools, economic design, Acute Myocardial Infarction (AMI), Diabetes, anticoagulation regime, International Normalised Ratio (INR)
Website:
http://www.ntmc.cz
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Czech Republic
Regions involved:
Olomoucky kraj

Organisation

Organisation name:
University Hospital Olomouc - Czech National eHealth Center
Organisation address:
University Hospital Olomouc,
NTMC
I.P. Pavlova 6, 775 20 Olomouc, Czech Republic
Kind of organisation:
Hospitals

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient

Evidence of practice:
Agreed evidence. Evidence is based on an agreed established monitoring system/process before and after implementation of the good practice
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Implementation of telemedicine in care of chronically ill patients has impact in better compliance of patients, lower cost of treatment of patients due to early detection of adverse development of the disease or co morbidity that typically prevent transition of the patient's condition to worse status, which would require more cost from public health funds. Medical personnel is also capable to deal with slightly more patients in given time as most of traditional visits of outpatient department is routine and does not result in any change of medication or procedures. Patients are more interested in their health status and easily follow the instructions given to them. Some of the routine trips of patients to the outpatient department could be avoided.
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Specialised physicians, Nurses, Advocacy organisations physicians
Source of funding:
National funding

Contact details

Name:
Zdenek Gütter, PhD ; Miloš Táborský, M.D., Ph.D, FESC, MBA
Email:
gutter@ntmc.cz

PERsonalised ICT Supported Service for Independent Living and Active Ageing

PERSSILAA, a FP7 funded European project, develops and validates a new service model, to screen for and prevent frailty in community dwelling older adults, integrating nutrition, physical and cognitive function. PERSSILAA develops remote service modules for screening, monitoring and training. Screening - easy to use tools to get an overall picture of a person's health status. Monitoring – unobtrusive monitoring of everyday functioning. Training - remotely available health promotion programs. PERSSILAA innovates the way our care services are organized from fragmented reactive disease management into preventive personalized services offered through local community services, supported by a proactive team of caregivers and health professionals and integrated into existing healthcare services. PERSSILAA realizes a technical service infrastructure to support these multiple services and users in an efficient, reliable, easy to use way and therefore works on gamification, interoperability and clinical decision support. PERSSILAA builds on activities within the European Innovation Partnership on Active and Healthy Aging and on results of various earlier European projects. In the project, there is continuous end- user involvement and evaluation with 350 older adults in real implementation environments in Enschede (the Netherlands) and Campania region (Italy) to ensure increasing system efficiency and easy end-user acceptance. Outcomes focus on daily activities, quality of life and risk of hospitalization. PERSSILAA builds business models for sustainable implementation and develops recommendations for European guidelines.

Keywords:
screening, Monitoring, Training, e-health, Physical functioning, Nutrition, Cognitive decline, Frailty prevention
Website:
https://perssilaa.com/
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Italy, Netherlands

Regions involved:
Campania, Twente

Organisation

Organisation name:
Federico II Univerity Hospital
Organisation address:
via Sergio Pansini 5, 80131, Naples, Italy
Kind of organisation:
Hospitals, Research centres, Academia

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Documented evidence. Evidence is based on systematic qualitative and quantitative studies
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
We have been assessing the dimension of frailty by different tools at enrollment, according to the first and second screenings. Subsequently we have been carrying out the evaluation periodically according to the study design and we are now collecting the first evidences about the impact of: Health and ICT Literacy, Physical training, Cognitive training, Nutritional intervention.
From December 2014, until now:

- 175 older adults completed the first and second screening questionnaires, and, including also objective physical, cognitive, nutritional and health status assessment tests,
- 120 hours of lessons were implemented;
- 3 Cycles of 6 meetings each have been set up with the following main topics: Health literacy, Food safety, Disease prevention.

Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Informal caregivers, Private companies, Research centres, Academia, Local public authorities
Source of funding:
European funding

Contact details

Name:
Maddalena Illario
Email:
illario@unina.it

Home Care for Early and Protected Hospital Discharge (Assistenza Domiciliare per Dimissioni Protette)

Chronic multimorbid patients often have access to hospital for the reacutization of one condition, but once in the hospital, often the discharge is delaied by the exacerbation of the other conditions. The longer the stay, the more the conditions exacerbate. FOr this reason, early discharge represent an important target in the management of hospitalized patient. To favor this strategy, ADD protection has developed an ICT based home monitoring provided as a service by a private company of home care, that allow the hospital staff to follow the patient at home, like it was still in the hospital. The data collected at the place of the patient are made available to the staff of the hospital through a web based platform, that feeds the hospital eHR of the patient

Keywords:
home care; internal medicine; hospital, early discharge; telemonitoring; service
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Italy
Regions involved:
Campania

Organisation

Organisation name:
University of Salerno, Department of Medicine and Surgery, Scuola Medica Salernitana
Organisation address:
Campus di Baronissi, Via Salvator Allende snc, 84081, Baronissi, Italy
Kind of organisation:
Academia

Viability

Time for deployment:
Less than a year
Investment per citizen / service user / patient:
Between 100 – 1.000 EUR per targeted citizen / patient
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use
Time of impact:
No evidence or no demonstrated impact
Description of impact:
We have not yet demonstrated an impact. We expect by the preliminary analysis that it will 1) reduce the length of stay in hospital for patients. 2) allow a better quality of life during home hospitalization 3) reduction in hospital costs; 4) creation of a new business model based on home care services provided by SMEs
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Home care centres, Private companies, Academia
Source of funding:
Regional funding

Contact details

Name:
Guido Iaccarino
Email:
giaccarino@unisa.it

Fall risk assessment in domestic and hospital environments

This project focuses on the inference of fall risk with consumer products like Kinect, smartphones or environment sensors like motion sensors and ibeacons. We do this in domestic environments and in hospital environments. The research concerns the determination of the accuracy, robustness and acceptance of technology in these realistic environments.

Keywords:
fall risk, sensors
Website:
http://digitallifecentre.nl/projecten/bravo
Initiative status:
Planned

Background

Geographical scope:
Regional level
Countries involved:
Netherlands
Regions involved:
Groot-Amsterdam

Organisation

Organisation name:
Amsterdam University of Applied Science
Organisation address:
Digital Life Centre
Theo Thijssen Huis
Kamers 04A27/04A29
Wibautstraat 2-4
1091 GM Amsterdam
Kind of organisation:
Research centres, Academia

Viability

Time for deployment:

Less than a year

Investment per citizen / service user / patient:

No available calculation.

Evidence of practice:

No knowledge about evidence. No evaluation or documentation of effect has been carried out

Maturity level:

Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.

Time of impact:

Long term and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began

Description of impact:

Transferability level:

Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:

Hospitals, Home care centres, Private companies, Small-sized industry, Medium-sized industry, Research centres, Academia, Regional public authorities

Source of funding:

National funding

Contact details

Name:

Prof. Ben Kröse

Email:

b.j.a.krose@hva.nl

Health Campus

Health Campus is a not for profit organization that focuses its energies and its resources primarily on two major objectives: • specialist visits and inspections in order to prevent and detect risks to the health of citizens • dissemination of a culture of prevention that encourages changes in lifestyle in order to obtain a person's overall well-being (through education, information and communication issues related to prevention and wellness concept linked to lifestyles healthy). The Health Campus provides for the establishment of a true " Field Clinic" dedicated to the prevention, in which interested citizens can be visited, may receive ultrasounds and x-rays (mammography in particular for the prevention of breast cancer) and informed about the health risks and good practices to be implemented to facilitate the appearance of disease. The Campus can be set up during large events or at the request of public and / or individuals wishing to promote a culture of prevention and to offer citizens the opportunity to control their own health. The Association's activities are carried out exclusively voluntary and are based on the conclusion of agreements and partnerships with public and private in order to reach the largest possible number of citizens and realize concretely the principle of subsidiarity which sees the voluntary sector in the front line to guarantee services and assistance to the community.

Keywords:
active and healthy ageing
Website:
http://www.campussalute.it
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Italy
Regions involved:
Lazio, Valle d'Aosta/Vallée d'Aoste, Campania

Organisation

Organisation name:
Health Campus (Campus Salute Onlus)

Organisation address:
Via Martucci 48, 80131 Napoli (Italy)
Kind of organisation:
Other, please specify

Viability

Time for deployment:
Between one year and three years
Investment per citizen / service user / patient:
No available calculation.
Evidence of practice:
Apparent evidence. Evidence is based on qualitative success stories
Maturity level:
The practice is “on the market” and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.
Time of impact:
Medium impact – e.g. shortly beyond the pilot project period
Description of impact:
Transferability level:
Ready for transfer, but the innovative practice has not been transferred yet. The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has not been transferred yet.

Initiative

Stakeholders concerned:
Hospitals, Pharmacists, Nurses, Private companies, NGOs, Local public authorities
Source of funding:
Private funding

Contact details

Name:
Annamaria Colao
Email:
info@campussalute.it

Multidimensional integrated services to support independent living at home for people with chronic conditions

Keywords:
Innovation, action, applied, technology
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
France
Regions involved:
Isère

Organisation

Organisation name:
Isere County Council
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Sarah Hustache-Attiyoub
Email:
Sarah.hustache-attiyoub@cg38.fr

Action method to integrate support services and care in the area of independence: Developing protocols and tools for information sharing

Keywords:
Website:
Initiative status:
Completed

Background

Geographical scope:
Countries involved:
France
Regions involved:
Isère

Organisation

Organisation name:
National Solidarity Fund for Independence (CNSA)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Regional funding

Contact details

Name:
Sarah Hustache-Attiyoub
Email:
Sarah.hustache-attiyoub@cg38.fr

Multiprofessional medication evaluation

Keywords:

Policy

Website:

http://www.fimea.fi/kehittaminen/moniammatillinen_verkosto

Initiative status:

Completed

Background

Geographical scope:

Regional level

Countries involved:

Finland

Regions involved:

Etelä-Savo

Organisation

Organisation name:

Eastern Savonia Central Hospital

Organisation address:

Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Contact details

Name:
Hannele Häkkinen
Email:
hannele.hakkinen@aflra.fi

Riistavuori: all-around service centre for older people

Keywords:
Other
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Finland
Regions involved:
Helsinki-Uusimaa

Organisation

Organisation name:
City of Helsinki
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Hannele Häkkinen
Email:
hannele.hakkinen@aflra.fi

My Home Fits / The Home Test

Keywords:
Physical adaptations, Technology
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Netherlands
Regions involved:
Nederland

Organisation

Organisation name:
GeneratieThuis
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Josephine Dries
Email:
josephine@generatiethuis.nl

Long-term care: developing information centres and a new concept

Over the next three years a network of information centres of long-term care will be created in every bigger town in the Vysočina region. The information centres will gather all information about the providers of both social and health services and other services and proactively provide solutions for the needs of older people. The dedicated centres involve collaboratives with academic institutions to facilitate the flow of evidence for good practice. Information centres consisting of professionals have been created that will gather information about providers of health and social care, and disseminate this to service users helping them with their health and social care needs. Providers of care liaise closely with professionals at the contact centres to enhance co-operation and optimal flow of information and support the care needs of the client group. An academic group provides information about best practice to the new network through the assessment of new findings. Service users and their families will be contacted via internet, health care, professional consulting offices, departments of social affairs in municipalities, employment services in the Czech Republic, welfare officers and providers of social services. The Vysočina region, the Ministry of Labour and Social Affairs, the Polytechnic College of JIhlava as well as associations of social services providers and trade unions of employers are part of the project.

Keywords:
Innovation, action, applied, policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Czech Republic
Regions involved:
Kraj Vysočina

Organisation

Organisation name:
Vysočina Region

Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
National funding

Contact details

Name:
Jiří Horecký
Email:
prezident@apsscr.cz

A new centre for social services to provide integrated health and social care

Keywords:
Website:
Initiative status:
Completed

Background

Geographical scope:
Local level
Countries involved:
Czech Republic
Regions involved:
Hlavní město Praha

Organisation

Organisation name:
Prague Centre for Social Services (Centrum sociálních služeb, Praha 2)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Jiří Horecký
Email:
prezident@apsscr.cz

Patient Safety and Clinical Pharmacy

Communication problems in medicine use can often lead to unintented intakes of double doses, or problems with the restart of medicinal treatments. The initiative has a preventative focus as it addresses and prevents unsafe medication practice. The initiative is developed in the local hospital AZ Sint Maarten in Mechelen, and more specifically the hospital pharmacy. To improve communication flows about medicinal information and follow-up of patients medicinal treatments between the hospital and the participating nursing home WZC Hof van Egmont a new communication procedure was developed. The procedure includes the following: If a resident of the nursinghome Hof van Egmont is taken into hospital AZ Sint Maarten, the clinical pharmacist will check the 'medicinal profile' of the patient/resident and do a close follow-up during the residents stay in the hospital. The medicinal profile will be carefully checked on possible drug-drug interactions, actual times of intake of medication, possible errors due to formularium-switches. When the patient/resident gets discharged from the hospital, a complete and transparent discharge-letter is provided. The aim is a fast and instant briefing of carepersonnel in the nursinghome. One week after dischargement from the hospital, the pharmacist contacts the caregiver of the resident for a further follow-up of the medicinal treatment.

Keywords:
Communication, Monitoring
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Belgium
Regions involved:
Arr. Mechelen

Organisation

Organisation name:
St Maarten Hospital Mechelen and WZC Hof van Egmont nursing home
Organisation address:

Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
National funding

Contact details

Name:
Wendy Absillis
Email:
wendy.absillis@ocmwmechelen.be

Healthy@Home

The Public social welfare organisation of Mechelen in cooperation with the Local Health Platform of Mechelen (LOGO vzw) build up a demonstration house “Healthy@Home” to showcase “(un)healthy living”. The demonstration house was designed with low-threshold practical information about healthy and energy efficient living. Information also focuses on fall prevention for older people confronted with body-instability or balance problems because of health problems. Service users are led through the house room by room in an interactive way, accompanied by the ‘healthy@home-guide’. Different rooms address different problems : humidity and fungus, cigarette smoke, vermin and pests, air freshening, garbage storage, etc. Participants are also asked to bring in their own suggestions and solutions about unhealthy conditions. Together with the ‘healthy@home-guide’ they a list of easy, affordable and instantly applicable guidelines was completed. The project mainly focused on underprivileged groups, but a lot of professionals in the social housing sector and social welfare sector also visited the demonstration house.

Keywords:

Website:
Initiative status:
Planned

Background

Geographical scope:
Local level
Countries involved:
Belgium
Regions involved:
Arr. Mechelen

Organisation

Organisation name:
Public Social welfare Organisation of Mechelen (Social Huis Mechelin) and the Municipality of Mechelen
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Wendy Absillis

Email:

wendy.absillis@ocmwmechelen.be

Series of lectures and seminars for elderly people about the importance of promoting psycho-emotional health and opportunities for different age groups and family members of different generations, health day for senior citizens

Celebrating the International Day of Senior Citizens on October 1, Kuldīga District Museum welcomes all seniors to visit the museum free of charge. Kuldīga Town Council organizes a health day for senior citizens offering different activities and visits to different specialists

Keywords:
Innovation, action, applied, Communication, Physical adaptations, Technology, Knowledge transfer
Website:
Initiative status:
Completed

Background

Geographical scope:
Local level
Countries involved:
Latvia
Regions involved:
Latvija

Organisation

Organisation name:
Kuldiga Municipal Agency “The Social Service”
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Ineta Eņģele

Email:

ineta.engele@kuldiga.lv

Senior Citizen's Board- The board acts in an advisory capacity to help the city council to deal with the issues related to improvement of the quality of life for senior citizens.

Keywords:
Policy, Physical adaptations, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Latvia
Regions involved:
Latvija

Organisation

Organisation name:
Kuldiga Municipal Agency “The Social Service”
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Ineta Eņģele

Email:

ineta.engele@kuldiga.lv

Latvian Samaritan Society-alternative services regarding home care in rural districts

Keywords:
Innovation, action, applied, Physical adaptations, Technology
Website:
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Latvia
Regions involved:
Latvija

Organisation

Organisation name:
Kuldiga Municipal Agency “The Social Service”
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Regional funding

Contact details

Name:
Ineta Eņģele
Email:
ineta.engele@kuldiga.lv

HELPS - Housing and homecare for the Elderly and vulnerable people and Local Partnership Strategies in Central European cities

Keywords:

Website:

Initiative status:

Completed

Background

Geographical scope:

European level

Countries involved:

Italy

Regions involved:

Trieste

Organisation

Organisation name:

Regione Autonoma Friuli Venezia Giulia

Organisation address:

Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

European funding

Contact details

Name:
Stefania Romano
Email:
stefania.romano@welfare.fvg.it

Ageing Well in Wales

Ageing Well in Wales is a national Programme hosted by the Older People's Commissioner for Wales. It brings together individuals and communities with public, private and voluntary sectors to develop and promote practical and innovative ways to make Wales a good place to grow older for everyone. The Ageing Well Programme is actively supported by Welsh Government and key national organisations. It has a rapidly growing network of members encompassing diverse organisations and interests across Wales. Strong links are also maintained with partners across Europe, reflecting Wales being awarded the highest three star Reference Site status as part of the European Partnership on Active and Healthy Ageing (EIP-AHA). The Programme has five objectives: - to make Wales a nation of age-friendly communities. - to make Wales a nation of dementia-supportive communities. - to reduce the number of falls. - to reduce loneliness and unwanted isolation. - to increase learning and employment opportunities.

Keywords:
Other
Website: www.ageingwellinwales.com

Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
United Kingdom
Regions involved:
Wales

Organisation

Organisation name:
Older People's Commissioner for Wales
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

National funding

Contact details

Name:

Steve Huxton

Email:

steve.huxton@olderpeoplewales.com

Smart House Living Lab

The Smart House Living Lab objective is to research and develop in the Ambient Intelligence and Ambient (Active) Assisted Living context of technology and services to prevent, care and promote the health and welfare of people, support social inclusion and independent living of fragile and dependent groups, in all stages of the value chain: training, experimental research, technological development and technology transfer. The Smart House Living Lab is the main infrastructure for ICT R&D&I experiments and demonstrations. Since 2008 (3rd wave) SHLL is part of the European Network of Living Labs (ENoLL). Since 2014 SHLL is also part of the Laboratories and Infrastructures network of Madrid Region that aims at improving and facilitating the services provision offered by the research infrastructure and laboratories of the Madrid region.

Keywords:
Innovation, action, applied, Monitoring, Sensoring, Physical adaptations, Technology, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Spain
Regions involved:
Madrid

Organisation

Organisation name:
Life Supporting Technologies - Universidad Politecnica de Madrid
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:

Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
European funding

Contact details

Name:
Maria Fernanda Cabrera
Email:
mf.cabrera@upm.es

Card Junta 65 - transport discounts and others benefits

The Junta 65 Card is a free document that is at the disposal of people over 65 years old provided by the Regional Ministry of Equality and Social Policies of the Government of Andalusia, through the Agency of Social Services and Dependency of Andalusia. It is an ITC tool, provided with chip and magnetic stripe, about the services for elderly people, with no more formality. It was created in 2001 and it's used for a period of 5 years. Its renovation is also free. With this card elderly people can enjoy of services and benefits in a very quickly and easy way: discounts, grants, access to programmes, etc. Between these services the cardholders have a discount of a 50% in the public interurban transports of general and permanent use, with origin and destination inside the Andalusia Region, that are provided by the companies that have signed an agreement with the Agency of Social Services and Dependency of Andalusia. Other services provided by the Junta 65 Card are in relation with the Tele-assistance Service in Andalusia, discounts in optical goods and hearing aids, legal advice service, dinning service, etc.

Keywords:
Technology
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
Andalucía

Organisation

Organisation name:
The Agency of Social Services and Dependency of Andalusia. Public Agency that belongs to the Regional Ministry of Equality and Social Policies (Government of Andalusia)
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Regional funding

Contact details

Name:

Ana Carriazo

Email:

coord.accionexterior.csbs@juntadeandalucia.es

Dementia Ambient Care: Multi-Sensing Monitoring for Intelligent Remote Management and Decision Support

Dem@Care aspires to contribute to the timely diagnosis, assessment, maintenance and promotion of self-independence of people with dementia, by deepening the understanding of how the disease affects their everyday life and behaviour It implements a multi-parametric closed-loop remote management solution that affords adaptive feedback to the person with dementia, while at the same time including clinicians into the remote follow-up, enabling them to maintain a comprehensive view of the health status and progress of the affected person. The system includes: a loop for people with dementia and their informal caregivers to monitor and assess their cognitive and behavioural status by integrating a multiplicity of wearable and in-situ sensors, enable time evolving context-sensitive profiling to support reactive and proactive care, and afford personalised and adaptive feedback. a loop for dementia clinicians to provide objective observations regarding the health progression of the person with dementia and medication effectiveness, warn about trends closely related to dementia (e.g. apathy), and support preventive care decision making and adjustment of treatment recommendations.

Keywords:
Innovation, action, applied, Monitoring, Sensoring, Technology
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Greece
Regions involved:
Θεσσαλονίκη (Thessaloniki)

Organisation

Organisation name:
CERTH
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

European funding

Contact details

Name:

Ioannis Kompatsiaris

Email:

ikom@iti.gr

Participatory Seniors' Walkability Assessment Tool

SeGAPe 65+ - Seniors' Group Assessment of Pedestrian Environment - is a participatory instrument to evaluate and rate the quality of streets for walking from the viewpoint of older adults. The tool provides a practical, systematic method to conduct a structured and quantified assessment of walkability conditions and improvement opportunities in a given area/neighbourhood, directly engaging older citizens in the planning process of age-friendly urban public spaces. A SeGAPe65+ Application Guide, including the tool, other materials and detailed instructions (Portuguese version only), is available online (www.ienvelhecimento.ul.pt/182), to support autonomous use by interested researchers, local authorities, or other local organizations and groups. Based on the methodology of Community Street Reviews (Abley et al., 2010, www.nzta.govt.nz), SeGAPe65+ was adapted to the older population in Portugal and pilot-tested in 2013 and 2014 in two cities (Odivelas and Lisbon), as part of the project AUPE - "Participation and Urban Built Environment Change for Healthy Ageing" implemented by the Institute of Social Sciences (ICS) and Institute of Ageing of the University of Lisbon, in partnership with local organizations and senior citizens

Keywords:
Innovation, action, applied
Website:
Initiative status:
Completed

Background

Geographical scope:
Countries involved:
Portugal
Regions involved:
Portugal

Organisation

Organisation name:
Instituto do Envelhecimento, ICS (University of Lisbon)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Mariana F. Almeida
Email:
mariana.almeida@ics.ulisboa.pt

VITLAB – eHealth and eInclusion Innovation Ecosystem

VITLAB is an open innovation platform to promote an ecosystem to favor collaborative innovation processes in the field of e-Health and e-Inclusion. These processes are based on the capabilities of different agents involved in the creation of methodologies, tools and structures oriented to the development and the improvement of solutions for the main challenges in this field of SUDOE countries. VITLAB is a tool for supporting and exchanging of knowledge in order to encourage the development of social and healthcare innovation, mainly in rural areas.

Keywords:
Policy, Communication, Monitoring, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Spain
Regions involved:
Noroeste

Organisation

Organisation name:
INTRAS Foundation
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

European funding

Contact details

Name:

Rosa Almeida

Email:

admin.vitlab@intras.es

Mobilt dokumentationssystem inom hemtjänsten/Tidsregistrerings- och dokumentationssystemet, ParaGå

The time registration system ParaGå enables better monitoring, improved quality and more efficient administration. With ParaGå, the municipality can monitor the amount of time care providers spend in/attend the elderlys home in a completely different way, so that the elderly people get the time and services they are paying for and the city re-imburses. Before, this was manually handled. Today, about 6 000 people regularly use ParaGå to register visits and other kind of services provided. Each month a total of one million visits to nearly 20 000 people with home care services, is registered. MORE TIME FOR THE ELDERLY PERSON For the home care providers, the new system stimulates more time spent at the elderly person's home. It is now also possible for the municipality assessors to follow up the services provided. At the same time this also saves Money both for the municipality and for the (private) home care providers. All staff within home care service has been equipped with smart phones and through the application ParaGå Android - which is connected to the City's IT-system, they register the time spent with the elderly and are also able to make journal entries/notes.

Keywords:
Monitoring
Website:
Initiative status:
Completed

Background

Geographical scope:
Local level
Countries involved:
Sweden
Regions involved:
Stockholms län

Organisation

Organisation name:
The Elderly Services Administration, City of Stockholm
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Raili Karlsson

Email:

raili.karlsson@stockholm.se

Promoting Physical Activity and Health in Ageing

The Promoting Physical Activity and Health in Ageing (PAHA) project is a tailored intervention for older adults with different functional capacities. Through a supervised and structured exercise programme for senior citizens (55-65 years old), PAHA intends to convert currently inactive people into regular exercisers at a level that is beneficial to their health, supporting the EU Guidelines on Physical Activity and the European Week of Sport. In each one of the 8 project partner countries – Denmark, Finland, Germany, Greece, Hungary, Ireland, Portugal and the United Kingdom – 3 fitness centres will run 3 trial sessions of supervised exercise of 6 weeks duration, for 15 participants at each session. For that purpose, the fitness coaches, instructors and other community workers involved in the project will receive specific training on both motivational skills and in active ageing promotion. The participation in the trial periods will be free and the older adults who take part in the project will be offered preferential arrangements for them to continue exercising for a minimum of a further 6 months period as well as some non-monetary incentives. Last but not least, proper measurement and assessment will be crucial. Through a comprehensive evaluation system, the PAHA Project will develop transversal standards that will be made available for education structures of sports organisations across Europe. The aim is to create a methodology that can easily be adapted and replicated in different settings, allowing more citizens to take up regular exercise and health-enhancing physical activities. The PAHA project Delivery Partners: EuropeActive – EU/BE Fundación General de la Universidad Europea de Madrid (UEM) – ES Johann Wolfgang Goethe-Universität - DE SkillsActive - UK Portuguese Health and Fitness Association (AGAP) - PT The Hungarian Health and Fitness Association (HFHA) - HU Sport-Ionad Reiguinach Chorcai Teo (Leisureworld) (IrelandActive) - IE Finnish Health and Fitness Center's Association (SKY) - FI Attic Union of Gym Owners (AUGO) - EL And, as part of the delivery of the trial programmes Fit & Sund - DK The project runs for 18 months and started on January 1st 2015.

Keywords:
Innovation/action/applied
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Belgium
Regions involved:

Organisation

Organisation name:
EuropeActive
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
European funding

Contact details

Name:
Jose Costa
Email:
jose.costa@europeactive.eu

eZaintza

eZaintza is a system that provides care for people with problems of temporal and spatial orientation, and support for their carers. Its aim is to improve self-esteem, confidence, wellbeing and, at the end of the day, the autonomy of people, in addition to improving social and medical intervention in prevention and care. It can be used in a family environment, or can be a work tool for professional carers, and can even be connected with telecare services.

Keywords:
Innovation/action/applied, Communication, Monitoring
Website:
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:

Organisation

Organisation name:
University of Deusto
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Regional funding

Contact details

Name:

Begoña García Zapirain

Email:

mbgarciazapi@deusto.es

KINEAGE: Adapted Kinect game for exercise and fun

Kineage system is divided into two sections, devoted to physical and cognitive rehabilitation respectively: Physical Rehabilitation: This part of the game consist of three different levels in which the user should collect various objects appearing on the screen by moving the arms, in order not to let the objects fall, promoting this way both the mobility of the user during the training (game play) and the cognitive process. Firstly, and in order to do the game more generalized, the game allows to specify the typology of the user, i.e., with or without any movement in their legs (use of the wheelchair), and giving the player the option to play standing or sitting. Additionally, users may present limit mobility in either arm (even absence of absolute movement in either of the two members), thus being the game configured in such a way that the user can choose if it wished to play with the left arm, right arm or both. The game displays three different levels of three minutes each to avoid fatigue in training. In the first level, the objects (cupcakes and bottles of wine) shall follow a vertical path. In the second level the number of these objects increases and in the level three the objects follow a horizontal path. At the end of each one of the levels the user shall reach a piece of cake, until achieving as a final reward a whole cake after finishing the three levels. Cognitive Rehabilitation: The main purpose of this part is to improve the memory and psychomotor activity by performing activities, as well as encouraging them to do physical exercise. A range of exercises, in which the user must perform various physical motions in order to solve them, have been developed following the clinicians' recommendations. In these activities the user has to memorize images or relate numbers to their corresponding denition (1-one), amongst others. The objective is to choose the correct answers (images) by moving the correct arm and thus improving the psychomotor activity of the patient. Even by having a total lack of knowledge of new technologies, the users are able to play the game, learn about its use and apply this knowledge in other technological fields,addressing the problem of the digital divide. This project, which funding has been provided by the Provincial Council of Bizkaia, was selected among the 20 finalists of "Social Innovation in Ageing - The European Award 2014", in which 220 institutions around Europe participated.

Keywords:
Innovation/action/applied, Sensoring, Physical adaptations
Website:
Initiative status:
Completed

Background

Geographical scope:
European level

Countries involved:
Spain
Regions involved:

Organisation

Organisation name:
University of Deusto
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Begoña García Zapirain
Email:
mbgarciazapi@deusto.es

REHACOP & REHACOG brain training for prevention of disability

This practice has just recently been completed and local institutions through the Regional Government (Diputación Foral de Bizkaia), are looking forward to extending the experience to further similar environments for the maximum population benefit. This initiative was presented initially in the participants' environment to know the process and encourage them to participate. They also provided feedback to the agents about their thoughts, worries and recommendations of improvements. This feedback, when possible, was implemented into the activity.

Keywords:
Innovation, action, applied, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Spain
Regions involved:

Organisation

Organisation name:
University of Deusto
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Not-for-profit

Contact details

Name:

Dr. Natalia Ojeda

Email:

nojeda@deusto.es

Durango, ciudad amigable con las personas mayores / Durango, Age-Friendy City

they may engage in participatory processes that examine how friendly their municipality is towards seniors in terms of housing, transportation, outdoor spaces and buildings, community support and health services, communication and information, civic participation and employment, respect and social inclusion, and social participation. The project has accomplished a thorough and participatory diagnostic study of the factors that enable and contribute towards active and healthy ageing processes, and has identify areas that need improvement. These areas have been included in an action plan that will be carried out in the next three years. The University is interested in finding out to what extent the participants in this process benefit form takin part in it in terms of wellbeing, and a sense of community. The municipality of Durango has recently joined the World Health Organization's Global Network of Age Friendly Cities and Communities.

Keywords:
Innovation,action, applied, Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Spain
Regions involved:

Organisation

Organisation name:
University of Deusto
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Pedro Ferández de Larrinoa
Email:
pedro.larrinoa@deusto.es

ALFRED project

ALFRED will realize a virtual mobile, personalized Butler for elderly people helping them to stay independent, to coordinate with carers and to foster the active participation in society. This assistant will be realized as a mobile device running on day-to-day Android smartphones allowing a wide impact of the project results. ALFRED will be fully voice-controlled and combine latest scientific research results from mobile development, data management, context aware services, speech recognition and personal data management, combined with activities from behavioural and social science. ALFRED is developed in cooperation among 5 European countries (Germany, Sweden, the Netherlands, France and Spain) and involving SMEs, universities, research institute and end-user organisations. The project started in October 2013 and runs for three years.

Keywords:
Innovation, action, applied, Communication, Monitoring, Physical adaptations, Technology, Other
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
France
Regions involved:
France

Organisation

Organisation name:
E-Seniors
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:

Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Dr. Sven Abels (Project Coordinator)
Email:
abels@ascora.de

Aiding SuStainable Independent Senior TrAvellers to Navigate in Towns

ASSISTANT contributes to maintaining the mobility of older people in Europe, in order to safeguard their social and economic participation in an increasingly ageing society. It does this by helping them to travel safely and independently by public transport, enabling them to relax and enjoy the journey whilst doing so. ASSISTANT includes: • an on-line means of planning a trip • guidance on making multi-step journeys • an alert which tells the user when it is time to leave the vehicle. The project offers seamless support for the entire length of a journey, across different means of public transport, and in both rural and urban environments. The target group for ASSISTANT is essentially mobile older people, but the system is designed so it is accessible for all potential users.

Keywords:
Innovation, action, applied, Other, Communication, Monitoring, Technology
Website: http://www.aal-assistant.eu/Overview/Outputs/

Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
United Kingdom
Regions involved:
Shropshire and Staffordshire

Organisation

Organisation name:
Transport & Travel Research Ltd
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:

Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
European funding

Contact details

Name:
Samantha Jones
Email:
aal.assistant@ttr-ltd.com

ICT-based Cognitive behavioral treatment

Meaning for science and Europe: The innovative I-ACCEPT-AD approach provides the necessary knowledge basis for empowering current and future generations of older individuals with many symptoms. It delivers multidisciplinary and integrated knowledge on better-targeted care by developing a technology-facilitated solution, testing it, and implementing it to permit future uptake of results. The project aims for sustainable innovation in individual health care promotion dedicated to the rapidly growing target group with a particularly poor prognosis.

Keywords:
Innovation, action, applied, Communication, Monitoring, Technology, Knowledge transfer
Website:
Initiative status:
Planned

Background

Geographical scope:
European level
Countries involved:
United Kingdom
Regions involved:

Organisation

Organisation name:
Primary Care Research Centre Manchester
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Not-for-profit

Contact details

Name:

Harm van Marwijk

Email:

harm.vanmarwijk@manchester.ac.uk

Äldreomsorgens värdegrund - fundamental values in elderly care

GOALS FOR ELDERLY CARE IN THE CITY OF STOCKHOLM Elderly care in the City of Stockholm shall be characterised by high quality, influence, individualisation and security. The nature of the support provided shall be characterised by the right to choose. Dignity and respect shall be the starting point so that each individual is able to live his or her life as he or she wishes. The City of Stockholm's fundamental values Elderly care in the City of Stockholm shall be characterised by self determination, individualisation and freedom of choice. The nature of the support provided shall focus on ensuring that senior citizens can live a dignified life with well-being, peace of mind and a sense of meaningfulness. The fundamental values for the City of Stockholm's elderly care should work as a guide and a tool to create an elderly care of world class. The fundamental values have been disseminated through education/work shops, written materials as well as movies. The aim is that all employees in the city's elderly care should know and follow the intentions of the fundamental values. The City of Stockholm also has a dignity guarantee, stating that the elderly: • has the right to obtain information and guidance when he/she need support and care • is involved in the investigation that is the basis for the support and care he/she will be granted • has the right to choose and change among the providers included in Stockholm's system for freedom of choice • have the right to influence how and when support is to be given. In order to ensure his/her right to influence this, a written agreement between he/she and his/her providers about how he/she want his/her care, a so-called implementation plan, is established. • given the opportunity to join the Care Diary so he/she can follow the documentation is written about him/her.

Keywords:
Policy, Knowledge transfer, Other
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Sweden
Regions involved:
Stockholm

Organisation

Organisation name:

Elderly Services Administration, City of Stockholm

Organisation address:

Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

National funding

Contact details

Name:

Lena Alksten

Email:

lena.alksten@stockholm.se

La Vida Eco Village

La Vida Eco Village is a retirement village in l'Ametlla de Mar, Tarragona, which provides the opportunity for its community to live healthy, engaged and active lifestyles. The Village offers services specifically designed to optimise well-being amongst the over-50s. Our facilities include a wellness centre with a gym, spa, swimming pool and therapy room. We offer classes in yoga, tai chi, dancing and other sports known to be beneficial as people age. There is an on-site medical suite with qualified staff on call and carers available if needed. It is not just about physical health: La Vida Eco Village also promotes mental and emotional well-being by encouraging new hobbies and new learning. A communal multi language library with internet access and computers will allow people to pursue their own interests. We will build links with local universities offering courses for the over-50s. Social events will be organized and excursions to places of local interest. And finally with a view to developing an age-friendly environments, we will work with the municipality of l'Ametlla de Mar to encourage cross-generational exchanges, programmes with schools etc. The Village will offer an option of short and long term accommodation for those who wish to access our services and facilities. Services will also be open to the population of over-50s living in L'Ametlla de Mar and surrounding areas. Our homes, communal buildings and landscaped gardens are developed using ecological methods and the Village will make use of water recycling and renewable power to ensure that we minimise our urban footprint.

Keywords:
Other
Website:
http://www.lavidaecovillages.com/
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Spain
Regions involved:
Tarragona

Organisation

Organisation name:
La Vida Eco Village

Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
For profit

Contact details

Name:
Anna-Louise van der Merwe
Email:
annalouise@lavidaecovillages.com

Gründer 50plus

We support people over 50 who are at risk of poverty in old age and play with the idea of starting a business. Due to the demographic development, a growing number of people in Germany are affected. For many, the start-up is the only way to a livelihood with dignity. But there are also a large number of older people who wish to implement a year-long cherished social business idea into reality. The team of Gründer 50plus support through workshops and coaching the development of unique business ideas. Focus is the support before the foundation. We promote the personal responsibility of entrepreneurs and help them through methodological skills. Very important is also the test of business ideas before implementation. We work in a nationwide network of franchise partners. Public relations are an important aspect of our work.

Keywords:
Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Germany
Regions involved:
Deutschland

Organisation

Organisation name:
Gründer 50plus UG
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:

Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
For profit

Contact details

Name:
Ralf Sange
Email:
sange@gruender50plus.de

Salute & Risparmio

Our goal is to take care of everyone's health. We would like to allow anyone to benefit from high quality, timely and cost-effective diagnostic health services. We would like to develop and improve the prevention phase, extremely too expensive, both for the Sate and the traditional Insurances.

Keywords:
Innovation, action, applied, Communication, Monitoring, Technology
Website:
Initiative status:
On-going

Background

Geographical scope:
National level
Countries involved:
Italy
Regions involved:
Roma

Organisation

Organisation name:
SARI 2000 SRL
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Contact details

Name:
Luca Pardo
Email:
l.pardo@sari2000.com

European Later Life Active Network

Europe faces severe population ageing in the near future. A new vision of ageing and promotion of positive possibilities in older age is needed. The challenge is how to transfer this vision into practice. Higher education institutions have a crucial role in meeting this challenge. This project promotes European cooperation and exchange of innovation and good practice related to the ageing population and to the educational preparation of those who work with older people. The project reconstructs the diverse educational approach by developing a European Competences Framework for working with older people, sharing innovation in teaching and identifying factors that influence students in choosing to work with older people thus strengthening the quality of higher education for professions providing care for older people. The project directly targets educators and management staff at the partners and other higher education institutions in Europe. The indirect target groups are the students, professional communities and older people themselves. The consortium will conduct analyses of competencies required of personnel working with older people from the viewpoint of literature, research, professionals, students and older people themselves. The results will be exploited in the development of higher educational curricula, as well as the promotion of a more positive vision of working with older people through national and European networks. The European Competences Framework, along with best practice in teaching will improve the quality of education for health and social care professionals and positively influence their motivation to work with older people. Thus, the impact of ELLAN consists of better education, enhanced mobility of personnel and improved older people's care in Europe. This project has been funded with the support of the Lifelong Learning Programme of the European Union.

Keywords:
Innovation, action, applied
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Finland
Regions involved:
Pohjois-Savo

Organisation

Organisation name:
Savonia University of Applied Sciences ltd
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
European funding

Contact details

Name:
Irma Mikkonen
Email:
irma.mikkonen@savonia.fi

Maintaining self-sufficiency community dwelling people with dementia

Maintaining self-sufficiency, functional independence and social inclusion of community dwelling people with dementia and their informal caregivers. The aim of the research is the development and implementation of the integral approach, to identify and respond to the needs of 25-30 couples consisting of a person with dementia and informal caregiver. To achieve a higher quality of life and continued independent living. The possible interventions are: Functional Task Exercise, Community Occupational Therapy in Dementia, ICT solutions, consolidation and activation of the social network, advising the person with dementia and caregiver on the home environment and neighbourhood adaptation.

Keywords:
Fundamental, Policy, Communication, Monitoring, Physical adaptations, Technology, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Netherlands
Regions involved:
Groot-Rijnmond

Organisation

Organisation name:
TNO
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:

Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
National funding

Contact details

Name:
Willeke van Staalduinen
Email:
willeke.vanstaalduinen@tno.nl

Cities in Balance

CIB explored : empowering seniors to participate fully in community life; information and communication provision; securing social, financial and digital inclusion; business and employment opportunities.

Keywords:
Innovation, action, applied, Knowledge transfer
Website:
Initiative status:
Completed

Background

Geographical scope:
European level
Countries involved:
United Kingdom
Regions involved:
United Kingdom

Organisation

Organisation name:
Stockport Council
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:
European funding

Contact details

Name:
Andy Bleaden
Email:
andy.bleaden@stockport.gov.uk

Virtual Elderly Care Services on the Baltic Islands

On the VIRTU, you can: Keep in touch with other users Speak to the care staff Participate in exercise, relaxation and singing sessions held by health and social care students Get news, up-to-date information about nutrition and health Take part in discussions

Keywords:
Website:
http://www.virtuproject.fi/
Initiative status:
Completed

Background

Geographical scope:
Countries involved:
Estonia
Regions involved:

Organisation

Organisation name:
Saaremaa Arenduskeskus SA
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Triin Arva
Email:
triin.arva@sasak.ee

Tourist movement in Krakow

Extension of the researches in the field of tourism in Krakow, on the analysis of Senior tourism.

Keywords:
Policy
Website:
http://www.bip.krakow.pl/
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Poland
Regions involved:

Organisation

Organisation name:
Municipality of Krakow- Department of Information, Tourism and promotion of the city
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Local funding

Contact details

Name:
Agnieszka Karon
Email:
agnieszka.karon@um.krakow.pl

The older people family foster care model in the City of Tampere

The number of elderly and frail elderly people in Finland is rising, along with the cost of care homes and nursing homes. Public authorities, health policy experts, families and the elderly are looking for alternatives to both save money and afford older people the greatest freedom in choosing a safe and comfortable place to live. Family foster care of older people is care at private home other than elderly person´s own. It is a service alternative between an elderly person living at his/her own home and institutional care. Family foster care for older people is in the beginning in Finland. Elderly Foster Care homes are municipality licensed private homes that offer assisted living to those who require help with day to day activities but are not in need of full term nursing care. A family foster carer is paid to take in elderly people and provide them a home -- meals, laundry, a place to sleep, someone to talk to and watch over them. In the long-term (permanent) family foster care the older person moves permanently to live with the foster family. in the short-term (temporary) family foster care the older person spends short times at the family foster home e.g. during the permanent caregiver's day off. Care at family carer´s home can be full-time (24/7) or part-time i.e. daycare. In the part-time family foster care an elderly person spends the daytime with the foster family. Family foster care of older people is arranged, supported and supervised by the municipality.

Keywords:
Website:
Initiative status:

Background

Geographical scope:
National level
Countries involved:
Finland
Regions involved:

Organisation

Organisation name:
The City of Tampere
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Armi Lampi
Email:
armi.lampi@tampere.fi

Strategy for the development of Social Care in the City of Ljubljana for the period from 2013 to 2020

On 13th May 2013 the City council of Ljubljana adopted the Strategy. In Strategy various programs and services for specific target groups, among them also programs for the elderly, are presented. The Strategy also defined specific objectives, measures and indicators for different target group.

Keywords:
Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Slovenia
Regions involved:
Slovenija

Organisation

Organisation name:
The City of Ljubljana
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

The City of Ljubljana

Email:

ozsv@ljubljana.si

Statutory activities

Encourage to submit proposals for acquisition of municipal premises.

Keywords:
Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Poland
Regions involved:

Organisation

Organisation name:
Municipality of Krakow- The management of Municipal Buildings in Krakow
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Agnieszka Karon
Email:
agnieszka.karon@um.krakow.pl

Socio - Intergenerational Centre Celje

With every day workshops and lectures we ensure better social life and higher informal education for our users. We consult,inform, motivate,raise awareness, encourage and offer self-help groups for our users. They have the chance to talk about their life experiences and to listen someone else's experiences. We aim to create or to strengthen the bridge between young and old generation, which is in our opinion one of the foundation for creating age friendly environment.

Keywords:
Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Slovenia
Regions involved:

Organisation

Organisation name:
Public institution Socio
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

National funding

Contact details

Name:

Mrs. Suzi Kvas

Email:

anja@socio-rcmd.si

Social service

Social service is contained from assistance in domestic and other chores in the event of disability, ageing, illness, accidents and other cases where such assistance is necessary to include people in everyday life. It includes pedicure, hairdressing, general cleaning, escort, etc.

Keywords:
Other
Website:
http://www.zod-lj.si/
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Slovenia
Regions involved:
Slovenija

Organisation

Organisation name:
Institute for home care Ljubljana
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Not-for-profit

Contact details

Name:

Simona Topolinjak

Email:

simona.topolinjak@ljubljana.si

Social alarm button service developed and provided by Tallinn City, capital of Estonia

The objective of the service is to increase the feeling of security of the elderly and disabled people by using the mobile alarm button service. The objective of the service is not receiving ordinary home services and personal help service (for example taking care of bed-ridden sick people, providing of foodstuffs, etc). The service enables the elderly to live as long as possible in their homes, it is substantially cheaper than taking care of the person in an institution. The objective of the use of the service includes summoning of help above all in situations, where the client is unable to move and independently open the door to the helpers, for example: 1) unexpected need of medical help to which inability to move is added; 2) unexpected need for so-called personal help (falling, temporary immobility, getting trapped in interior rooms, etc); 3) situations requiring rescue service (fire, explosion, etc).

Keywords:
Monitoring
Website:
http://www.tallinn.ee/eng/Teenus-Panic-button-service
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Estonia
Regions involved:

Organisation

Organisation name:
Tallinn Social Welfare and Health Care Department
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:

Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Maarja Seppel
Email:
maarja.seppel@tallinnlv.ee

Smart technologies for self-service to seniors in social housing

"Smart technologies for self-service to seniors in social housing" – HOST – is a AAL funded project (AAL-2010-3-041) aimed to provide easy-to-use technologies and services in social housing flats to allow better quality of communication and a better access to package services for the elders.

Keywords:
Communication, Monitoring
Website:
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
España

Organisation

Organisation name:
Polibienestar Research Institute - University of Valencia
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

European funding

Contact details

Name:

Jordi Garcés

Email:

jordi.garces@uv.es

SIforAGE

The primary objective of the project is strength the cooperation mechanisms and tools among stakeholders working in the field of active and healthy ageing.

Keywords:
Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Poland
Regions involved:

Organisation

Organisation name:
Municipality of Krakow- Department of Municipal Economy
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Agnieszka Karon
Email:
agnieszka.karon@um.krakow.pl

Mapping age friendly environments for the elderly and for people with physical disabilities

"Friendly Cities for All" is a citizen science project in which Secondary Education (ESO) students get involved in the reporting of urban accessibility of their environment. To this end, a space for collaboration between ESO students, professional users and elderly people associations, teachers, researchers and representatives of the municipal administration will be generated; where the scientific role will rely on ESO teachers while the other agents act as chaperones in the process of the scientific action The ultimate goal is that ESO students complete all the phases of a scientific project which promotes civic awareness on urban accessibility: with the formulation of hypotheses; data collection, interpretation and analysis and presentation of findings to stakeholders. For this it is indispensable to form students "technologically" (open data sources, tools for visualization and analysis of geospatial data, etc.) and "socially" (concepts of accessibility). Thus, from different areas, knowledge and community experts, they learn how to do science while making a real contribution to their environment (Service-Learning methodology) with specific products (such as making accessibility reports or friendly routing). In fact, the foundation of the project from the perspective of the functional diversity, allows a broader conception of disability and / or aging; not only in terms of age groups and barriers, but from a global perception of the rights, opportunities / bias settings, surpassing the model that highlights the difficulties in and from the people. Interdisciplinary and cooperative learning are essential in this proposal. Thus, the relationship between the scientific process, technological development and civic engagement of students in dialogue with society is consolidated.

Keywords:
Communication
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
España

Organisation

Organisation name:
University of Deusto
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Cruz Enrique Borges
Email:
cruz.borges@deusto.es

Living Lab Care iMinds

The ‘Care Living Lab The ‘Care Living Lab Flanders’ is an innovation instrument to create a space for testing and experimentation of new services, processes and products by end-users. The focus of the initiative is the demand for care by the elderly. It will apply an open innovation approach and a broad multiple helix eco-system of partners along the care-value chain (primary care, government, end-user, etc.) The ‘Care Living Lab Flanders’ program provides the following mechanisms that will contribute to the ultimate goal of testing the societal and economical impact of innovative solutions in elderly care: 6 platforms offering test infrastructure (user panel, Living Lab methods, real-life infrastructure, etc.), 23 projects using the test infrastructure and for each platform an end-user committee. The latter places the end-user in a central position. Elderly, patients and informal caregivers will be in charge of the co-creation process; i.e. development, testing and adjusting of the selected projects of care innovation in their own work and living environment. There will be over 2.000 persons involved from different segments in the population (independent & dependent elderly, informal caregivers). The foreseen budget is estimated on max. 12 million Euros.

Keywords:
Monitoring, Sensoring
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Belgium
Regions involved:
Belgique-België

Organisation

Organisation name:
iMinds vzw
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Regional funding

Contact details

Name:

Birgit Morlion

Email:

birgit.morlion@iminds.be

Krakow Senior Center

Krakow Senior Center brings together senior volunteers who want to work for the integration and activation of Krakow environment of the elderly.

Keywords:
Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Poland
Regions involved:

Organisation

Organisation name:
Municipality of Krakow- Department of Social Affairs-Department of Youth and Seniors Affairs
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Local funding

Contact details

Name:
Agnieszka Karon
Email:
agnieszka.karon@um.krakow.pl

Life Long Living – maintaining independent living as long as possible

"Life Long Living" is a new model of interaction between the municipality and the elderly citizen who request practical or personal care and assistance. The intension of the initiative is to change the conditions of future care by focusing on the resources of each individual, and support empowerment instead of delivering traditional, compensatory and pacifying care. The focus in the welfare services is extended from providing care and practical assistance, to an overall focus on regaining physical, social and cognitive abilities. The objective is to postpone age-related weakening and dependence, and maintain independent living as long as possible

Keywords:
Innovation, action, applied, Policy, Other
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Denmark
Regions involved:
Extra-Regio NUTS 3

Organisation

Organisation name:
Pleje og Sundhedsafdelingen; Fredericia Kommune (The Health and Care Department; Municipality of Fredericia)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Britta Hallin

Email:

britta.hallin@fredericia.dk

Krakow Council of Seniors

The Council has 25 members, including 11 men and 14 women. - All members of Council already crossed 60 years of age and are residents of the City of Krakow. Members of the Steering Committee are working on a voluntary basis without receiving any remuneration for their work in the Council. Meetings are held once a month, while the Management Council meets weekly. Currently, Council is focused on creating an internal organizational structure that ensures smooth operation. Work Regulations was already based on the Statute of the Krakow Council of Seniors. Regulations provides for five Thematic Commission: The Commission for activation of the elderly, cooperation with institutions of Elders and intergenerational relationships, The Commission for prevention, health promotion and protection of Seniors The Commission for sports, tourism and recreation and infrastructure for Seniors, The Commission for Economic and living conditions of the premises and the prevention of social exclusion Seniors, The Commission for education, security, culture and national heritage. Members of the Council take part in conferences, symposiums and training sessions organized by NGOs and on a broader policy pursued by the senior state and local government bodies. It will be a Collegial advisory body in the Municipality of Krakow.

Keywords:
Policy
Website:
http://dlaseniora.krakow.pl/129581,artykul,r_k_s.html
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Norway, Poland
Regions involved:
Polska

Organisation

Organisation name:
Municipality of Krakow
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Agnieszka Karon

Email:

agnieszka.karon@um.krakow.pl

Kavalir

In the pedestrian zone of the old city center free transport with 3 electric vehicles Kavalir are ensured. For this project the City of Ljubljana was awarded the Euroepan mobility week award for 2013.

Keywords:
Other
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Slovenia
Regions involved:
Slovenija

Organisation

Organisation name:
Ljubljana Public Transport
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Contact details

Name:
Ljubljana Public Transport
Email:
ozsv@ljubljana.si

Joining up ICT and service processes for quality integrated care in Europe

SmartCare aims to define a common set of standard functional specifications for an open ICT platform enabling the delivery of integrated care to older European citizens.

Keywords:
Monitoring
Website:
http://pilotsmartcare.eu/home/
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Estonia
Regions involved:
Eesti

Organisation

Organisation name:
Lead partner AZIENDA PER I SERVIZI SANITARI N.1TRIESTINA. Local partner Tallinn Social Welfare and Health Care Board
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

European funding

Contact details

Name:

Aire Johanson

Email:

aire.johanson@tallinnlv.ee

Integration between generations in support centres

The basic premise of the support system of the elderly and disable in Krakow, is to give them the fullest and longest functioning in the family, a neighborhood, the place of residence. Institutional forms-clock care, are the last form of assistance, which should be used only in case of inability to solve problems in other ways.

Keywords:
Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Poland
Regions involved:

Organisation

Organisation name:
Municipality of Krakow-Urban Resort of Social Assistance
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:
Local funding

Contact details

Name:
Agnieszka Karon
Email:
agnieszka.karon@um.krakow.pl

iPad café

Today a lot of information is spread and communication is done through the Internet, replacing other channels of communication. For those who do not have access or know how to use the Internet, this can lead to exclusion. The iPad café is for people aged between 65 and 95 years old, wanting to learn and become familiar with new technologies. The iPad café is one of the most popular activities at Aktivitetshuset Tuben, a meeting place for seniors in the neighborhood area. The content of each iPad café is based upon the participants' wishes and needs. Visitors often express curiosity, wanting to keep up with the development. Questions may involve: - Curiosity about the new technology as an iPad represents - If I want to buy something – what should I buy? - How do I use my iPad (for visitors who have bought an iPad and need to start and know what to do with it)? The organization has eight iPads for the visitors to borrow, in case they do not have their own, which many do. Three employees hold the iPad café and together with the participants they help each other understand and get around in the digital world.

Keywords:
Other
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Sweden
Regions involved:
Sverige

Organisation

Organisation name:
Aktivitetshuset Tuben, City of Stockholm
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
Local funding

Contact details

Name:
Maria Kleine
Email:
maria.kleine@stockholm.se

Healthy Krakow 2013-2015

1.Vaccination program after 65 years old. 2.Program of prevention of obesity, type 2 diabetes, hypertension and atherosclerosis. 3. Healthy program in the field of prevention and detection of cardiovascular disease in a population of inhabitants of the province of Malopolska.

Keywords:
Policy
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Poland
Regions involved:

Organisation

Organisation name:
Municipality of Krakow- Office for Health Protection
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:
Local funding

Contact details

Name:
Agnieszka Karon
Email:
agnieszka.karon@um.krakow.pl

Grants for the basic functional adaptation of the dwellings, supporting the Andalusia Families

The Government of Andalusia approved the Decree 137/2002 of supporting to the Andalusia Families. Between the measures referred, the article 29, regulates home basic functional adaptation, when it is the permanent and habitual residence of elderly, disable and dependent people. Because of that, the Regional Ministry of Public Work and Transport, has develop the grant for this measure, establishing the process and mechanism to make this grants effective. This is an innovative practice as one of the elements of the Andalusia Strategy of Elderly People, which has been nominated as reference site with three stars, last year by the EIP on AHA.

Keywords:
Website:
Initiative status:

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:

Organisation

Organisation name:
Regional Ministry of Equality, Health and Social Policies (Government of Andalusia)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Contact details

Name:

European and International Affairs Department of the Regional Ministry of Equality, Health & Social

Email:

coord.accionexterior.csbs@juntadeandalucia.es

Flanders' Care

Flanders' Care is a programme of the Government of Flanders that strives to improve the quality of care through innovation and to promote accountable entrepreneurship in the care economy.

Keywords:
Website:
http://www.flanderscare.be/en
Initiative status:

Background

Geographical scope:
Regional level
Countries involved:
Belgium
Regions involved:

Organisation

Organisation name:
Flemish Government - program Flanders'Care
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Kimpe
Email:
katrien.kimpe@wvg.vlaanderen.Be

Family Assistance at Home

FAH (public service - co-financed by local community in the amount of 80%) include every-day needs of users: assistance in daily tasks, household assistance and help in maintaining social contacts.

Keywords:
Innovation, action, applied, Other
Website:
http://www.zod-lj.si/
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Slovenia
Regions involved:
Slovenija

Organisation

Organisation name:
Institute for home care Ljubljana
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Simona Topolinjak

Email:

simona.topolinjak@ljubljana.si

eHealth services developed and provided by Estonia

There are following eHealth sevices in Estonia: Electronic Health Record, Digital Registration, Digital Image, Digital Prescription

Keywords:
Innovation, action, applied
Website:
http://www.e-tervis.ee/index.php/en/health-information-system
Initiative status:

Background

Geographical scope:
National level
Countries involved:
Estonia
Regions involved:

Organisation

Organisation name:
The Estonian eHealth Foundation
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
The Estonian eHealth Foundation
Email:
etervis@e-tervis.ee

Energy efficient lighting improving the well-being of elderly people

Research suggests that artificial lighting can have a positive impact on the elderly's well-being, but there is not enough evidence-based knowledge on the subject. The project therefore brings together a number of experts within eye research, photonics, lighting design and management, to conduct experimental testing on whether the right lighting can improve health and well-being in the elderly. If this research can demonstrate a positive effect, it can contribute to accelerate the use of energy efficient LED lighting in private homes, as well as increase the use of LED in conjunction with the establishment or the renovation of municipal nursing homes.

Keywords:
Innovation, action, applied
Website:
http://www.gate21.dk/Projekter/LED-lys-til-aeldre/
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Denmark
Regions involved:

Organisation

Organisation name:
Gate 21
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Contact details

Name:
Ida Maj Emborg
Email:
ida.maj.emborg@gate21.dk

DREAMING – elDeRly-friEndly Alarm handling and MonitorING

The project considers a better combination between technical and non-technical services is essential for supporting the autonomy of elderly people.

Keywords:
Innovation, action, applied
Website:
Initiative status:
Completed

Background

Geographical scope:
Countries involved:
Estonia
Regions involved:

Organisation

Organisation name:
East Tallinn Central Hospital (leadpartner in Estonia)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Marko Parve
Email:
marko.parve@itk.ee

Daily centres of activities for older people (DACs)

DCAs provide highly varied programmes with the possibility for older people of having daily social contacts. With support of the City of Ljubljana, the eighth such day-care centre was opened in 2013.

Keywords:
Other
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Slovenia
Regions involved:
Slovenija

Organisation

Organisation name:
The City of Ljubljana
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:
Local funding

Contact details

Name:
Simona Topolinjak
Email:
simona.topolinjak@ljubljana.si

Campania Small Municipalities Collaborative Network

The current economic crisis has been determining a general reduction of the services provided to European citizen, due to spending reviews applied to the Health Care system, to the Social Services, to Schools. This has determined a further reduction of funding allocated to city environments and spaces, that are currently unfit to the challenge of an aging population. Most small municipalities do not possess alternative funding, and cannot sustain the initial investment required by the internationalization effort. Aim of this project is to create a network of small Municipalities in Campania Region, to build up their capacity to join European initiatives.

Keywords:
Innovation, action, applied, Communication, Monitoring, Sensoring, Physical adaptations, Technology, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
Regional level
Countries involved:
Italy
Regions involved:

Organisation

Organisation name:
Campania EIP-AHA Reference Site
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Maddalena Illario

Email:

illario@unina.it

Alzheimer: Tremplin intergénérationnel d'Insertion Sociale et Professionnelle: The Spanish implementation

Training unemployed people to develop musical reminiscence and intergenerational activities with people with Alzheimer´s disease (AD).

Keywords:
Innovation, action, applied
Website:
Initiative status:
Completed

Background

Geographical scope:
Regional level
Countries involved:
Spain
Regions involved:
España

Organisation

Organisation name:
Polibienestar Research Institute and Spanish Society of Social and Health Care
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:
European funding

Contact details

Name:
Jordi Garcés
Email:
jordi.garces@uv.es

Action Plan Age friendly Ljubljana

On 18th March 2013 the City council of Ljubljana adopted an Action Plan Age friendly Ljubljana for the period from 2013 to 2015. Action Plan was set up on the basis of different reports and focus group discussions. It contains 98 individual measures with 13 goals, which are arranged in 8 key areas, defined by the WHO.

Keywords:

Website:

Initiative status:

On-going

Background

Geographical scope:

Local level

Countries involved:

Slovenia

Regions involved:

Slovenija

Organisation

Organisation name:

The City of Ljubljana

Organisation address:

Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Local funding

Contact details

Name:

Simona Topolinjak

Email:

simona.topolinjak@ljubljana.si

Textiles for an Ageing Society

The TAGS project has four topics of research: Bedding Textiles Clothing Hygiene and Personal Care Textiles Therapeutic and Recreational Textiles For each topic we look into and asses the types of textiles currently in used by caregivers and/or the elderly. Through means of questionnaire analysis we also look into desired functions or features which would benefit both caregiver and elderly in terms of textile functionality. The idea is to collect new ideas/initiatives to generate new projects in which innovative textiles solutions are implemented into the manufacturing chain.

Keywords:
Innovation, action, applied, Monitoring, Sensoring, Technology, Knowledge transfer
Website:
Initiative status:
On-going

Background

Geographical scope:
European level
Countries involved:
Austria
Regions involved:
Österreich

Organisation

Organisation name:
Universität Innsbruck Forschungsinstitut für Textilchemie und Textilphysik
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

European funding

Contact details

Name:

Ann Blaylock

Email:

ann.blaylock@uibk.ac.at

SIMPLIT. New certificate which attests that a product is simple, practical and user-friendly

WHAT IS SIMPLIT? SIMPLIT is a new certificate which attests that a product is simple, practical and user-friendly. It guarantees that products have been developed with a design based on elderly people, fostering an increase in the quality of the products available on the market, and engaging elderly people in assessment. It pursues a twofold objective: -• To respond to companies that are interested in this increasingly more demanding group. -• To guarantee that the certified products are easy for people of all ages to use. With the SIMPLIT certificate, companies will be able to accredit suitability control to guarantee product design: televisions, cupboards, mobiles, ovens, etc. Any product may bear this certificate if it demonstrates that it has been designed according to easy-use criteria, targeting elderly people. By guaranteeing simplicity, SIMPLIT benefits everyone. In most cases, creating a product suited to elderly people means creating an ideal product for everyone. HOW DOES SIMPLIT WORK? SIMPLIT rates aspects such as how easy a product is to learn to use, and its efficacy. The application of the inspection procedure, which concludes with the issue of the SIMPLIT certificate, will always require the participation of a group of older people, since this is regarded as a characteristic and distinguishing aspect of the certificate. The development of the SIMPLIT certificate involved the revision of compulsory legislation at international, European and national level of all kinds of products, with a bibliographic review of more than 100 standards catalogued and classified according to the type of product and which permit rapid verification of compliance. Moreover, a systematic procedure has been developed to make it possible to measure how easy it is to use a product based on efficiency in the implementation of tasks and the identification of usage problems. This process was validated in a pilot study with 5 products differentiated by target, context of use and level of technology. The inspection procedure was applied in the pilot phase, with 10 users per evaluation. This phase rendered it possible to define the inspection and its systematic treatment for any type of product.

Keywords:

Innovation, action, applied

Website: www.simplit.es

Initiative status:

On-going

Background

Geographical scope:

European level

Countries involved:

Spain

Regions involved:

Organisation

Organisation name:

Instituto De Biomecánica De Valencia

Organisation address:

Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:

Evidence of practice:

Maturity level:

Time of impact:

Description of impact:

Transferability level:

Initiative

Stakeholders concerned:

Source of funding:

Not-for-profit

Contact details

Name:

Miguel López-Torres

Email:

miguel.lopez@ibv.upv.es

Groningen Active Ageing Strategy: A sustainable Dutch approach to enhance active ageing in community-dwelling older people living in deprived neighbourhoods

The GAAS project has four building blocks: (1) Tailoring of the project; (2) Recruitment of physically underactive older people; (3) Bonding (encourage social cohesion) and empowerment of participants; (4) Bridging (encourage social participation) and maintenance of behavioural change. First, we started close collaboration with the community association to tailor the project approach. Projects aimed at enhancing active ageing struggle to recruit participants in deprived neighbourhoods. Therefore, the recruitment strategy and the intervention were tailored to the wishes of the community. Second, together with residents of the neighbourhood a recruitment strategy was developed adjusted to the targeted participants' perceptions. A composite recruitment strategy arose, consisting of door-to-door visits, a back-door method, and a network method. Recruited participants participated in an active ageing intervention, consisting of weekly group exercise sessions in combination with integrated lifestyle modules to help participants overcome feelings of depression and loneliness, and to promote daily physical activity and healthy diet. The sessions were held in a community centre located in the middle of the neighbourhood. The third stage focused on increasing social cohesion within the groups, and on participant empowerment. From the beginning, the community and the participants ‘owned’ the project. We aimed to transfer the project responsibilities to the participants themselves after the intervention period. In the fourth stage, we aimed to support social participation and to keep the previously formed exercise groups active in their neighbourhood. A specific empowerment method was applied to realise the bridging and maintenance of behavioural change of the participants.

Keywords:
Policy, Physical adaptations
Website:
Initiative status:
On-going

Background

Geographical scope:
Local level
Countries involved:
Netherlands
Regions involved:
Nederland

Organisation

Organisation name:
Hanze University of Applied Sciences Groningen
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:
National funding

Contact details

Name:
Annemiek Bielderman
Email:
j.h.bielderman@pl.hanze.nl

The older people family foster care model in the City of Tampere

The number of elderly and frail elderly people in Finland is rising, along with the cost of care homes and nursing homes. Public authorities, health policy experts, families and the elderly are looking for alternatives to both save money and afford older people the greatest freedom in choosing a safe and comfortable place to live. Family foster care of older people is care at private home other than elderly person´s own. It is a service alternative between an elderly person living at his/her own home and institutional care. Family foster care for older people is in the beginning in Finland. Elderly Foster Care homes are municipality licensed private homes that offer assisted living to those who require help with day to day activities but are not in need of full term nursing care. A family foster carer is paid to take in elderly people and provide them a home -- meals, laundry, a place to sleep, someone to talk to and watch over them. In the long-term (permanent) family foster care the older person moves permanently to live with the foster family. in the short-term (temporary) family foster care the older person spends short times at the family foster home e.g. during the permanent caregiver's day off. Care at family carer´s home can be full-time (24/7) or part-time i.e. daycare. In the part-time family foster care an elderly person spends the daytime with the foster family. Family foster care of older people is arranged, supported and supervised by the municipality.

Keywords:
Website:
Initiative status:

Background

Geographical scope:
Countries involved:
Finland
Regions involved:

Organisation

Organisation name:
The City of Tampere
Organisation address:
Kind of organisation:

Viability

Time for deployment:

Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:
Email:
armi.lampi@tampere.fi

Life Long Living – maintaining independent living as long as possible

"Life Long Living" is a new model of interaction between the municipality and the elderly citizen who request practical or personal care and assistance. The objective is to maintain physical, social and cognitive abilities in order to postpone age-related weakening, and maintain independent living as long as possible.

Keywords:
Website:
Initiative status:

Background

Geographical scope:
Countries involved:
Denmark
Regions involved:

Organisation

Organisation name:
Pleje og Sundhedsafdelingen; Fredericia Kommune (The Health and Care Department; Municipality of Fredericia)
Organisation address:
Kind of organisation:

Viability

Time for deployment:
Investment per citizen / service user / patient:
Evidence of practice:
Maturity level:
Time of impact:
Description of impact:
Transferability level:

Initiative

Stakeholders concerned:
Source of funding:

Contact details

Name:

Email:

britta.hallin@fredericia.dk