JADE CARE

Joint action on implementation of digitally enabled integrated person-centered care

D4.1 LOCAL GOOD PRACTICES AND ACTION PLANS

Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)

Date: 04/2/2022
Doc. Version: 2.0

PUBLIC DOCUMENT

www.jadecare.eu

Co-funded by the Health Programme of the European Union

This document was funded by the European Union's Health Programme (2014-2020) under Grant Agreement 951442.

Title	Joint action on implementation of digitally enabled integrated person-centred care
Acronym	JADECARE
GA Number	951442
Work Package	WP4 INTEGRATION IN NATIONAL POLICIES AND SUSTAINABILITY
Type of instrument	Local Good Practices and Action Plans
Topic	Integration in national policies and sustainability
Dissemination Level	Public
Date	30/12/2021
Document version	V1.0
Document Author	Paolo Michelutti, Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)
Website	www.jadecare.eu

List of contributors

The list of contributors to this deliverable are presented in the following table:

Contributors	Organization
Paolo Michelutti	Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)
Mariarita Cafulli	Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)
Stella Lanzi	Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)
Federica Vitello	Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)
Lisa Baldini	Agenzia Nazionale Per I Servizi Sanitari Regionale (AGENAS)
Ane Fullaondo	KRONIKGUNE (KG)
Jon Txarramendieta Suarez	KRONIKGUNE (KG)
Esteban de Manuel Keenoy	KRONIKGUNE (KG)
Yhasmine Hamu	KRONIKGUNE (KG)
Martina Rimmele	Bavarian Health and Food safety Authority (LGL)
Next Adopters	Agenzia Regionale di Sanita della regione Toscana (ARS TOSCANA) - Italy Azienda Unità Sanitaria Locale Umbria 1 (USL UMBRIA 1) – Italy Regione Lombardia (LOMBARDIA) – Italy Azienda Sanitaria Locale Napoli 2 Nord (ASL NA2) - Italy Regione Marche (MARCHE) – Italy School of Medicine, Aristotle University of Thessaloniki (AUTH) - Greece Central Administration of the Health System (ACSS) – Portugal Ministry of Health of Republic of Serbia (MoHRS) – Serbia Jahn Ferenc Dél-pesti Kórház és Rendelőintézet (JFDPK) – Hungary Eurometropole de Strasbourg (EUSTRAS) – France Health Insurance Institute of Slovenia (ZZZS) – Slovenia Communauté germanophone pour une vie autodéterminée – Belgium Childrens Clinical University Hospital (CCUH) – Latvia Consejería de Salud y Familias Junta de Andalucía (CSFJA) and Fundación Pública Andaluza Progreso y Salud (FPS) – Spain Servicio Cántabro de Salud (SCS) and Instituto de Investigación Marqués de Valdecilla (IDIVAL) – Spain Gerencia Regional de Salud de Castilla y León (SACYL) – Spain Servicio Murciano de Salud (SMS) and Fundación para la Formación e Investigación sanitarias de la región de Murcia (FFIS) – Spain North Denmark Region (RND) - Denmark Croatian Institute of Public Health (CIPH) – Croatia Viljandi Hospital (VH) – Estonia University Hospital Olomouc (UHO) – Czech Republic

Version history

Revision	Date	Editor	Comments
0.1	30/10/2021	Paolo Michelutti, AGENAS	Table of content
0.2	01/12//2021	Paolo Michelutti, AGENAS	First draft
0.3	18/12/2021	Martina Rimmele, LGL	Peer review
1.0	29/6/2021	Jon Txarramendieta, KG Yhasmine Hamu, KG Ane Fullaondo, KG Esteban de Manuel, KG	Quality assurance review
2.0	4/2/2022	Yhasmine Hamu, KG Jon Txarramendieta, KG	Minor corrections

Keywords

Local good practice, action plan, transferability, change management, integrated care, digitally enabled, Next Adopters, innovation.

Disclaimer

Table of contents

Executive summary

The JADECARE Joint Action supports EU Member States to reorganise their health systems towards a digitally enabled integrated person-centred care through a methodology, tools and a process of transferring original Good Practices. Twenty-one so-called "Next Adopters" are therefore committed to transferring to their local sites, elements (Core Features) of four original good practices according to their needs, expectations and priorities. The original Good Practices are related to different components of a digitally enabled integrated person-centred care system. These are: systems for the analysis of needs and stratification of the risks of the population, communication systems and integration between the different health and social care providers and health professionals, systems of involvement and citizens' empowerment and related digital tools, etc.

For the transfer and adoption process, an implementation strategy has been developed, consisting in three phases: pre-implementation, implementation and post-implementation. The pre-implementation phase, addressed at this document, is in turn divided into three steps:

1. In-depth study of the Core Features of the original Good Practices by Next Adopters, assessment of the maturity level necessary to transfer and adopt them in new contexts (Next Adopter environment) and definition of the scope of the implementation.
2. Situation analysis to identify strengths and weaknesses as well as opportunities and threats of the good practice transferring.
3. Design of the practice to be deployed in the Next Adopter context and elaborate development of the local action plan.

From the point of view of the Next Adopters, JADECARE has been an opportunity to put the seed of innovation or to speed-up an innovation process in terms of digitally enable integrated person-centred care. The Next Adopters have adopted, based on their needs and their level of maturity, either individual Core Features of a single original Good Practice (one-to-one approach), a choice adopted by 17 Next Adopters, or to Core Features from more than one good practice (mix & match approach), a choice adopted by 4 Next Adopters.

According to the implementation science foundations, the transfer of a good practice needs to be managed with the tools and techniques that the theories of change management make available. One of the key elements for the successful transfer of good practice is the clear definition of the practice to be carried out (Local Good Practice) and the elaboration of a consequent effective action plan.

The Next Adopters, before starting the implementation phase, have designed their future local Good Practice and have defined their Local Action Plan to achieve it. Experts of the 4 original Good Practices as well as experts of the transferring methodology supported the Next Adopters providing them specific guidelines and tailored advice.

The Local Good Practices and Action Plans are collected and described in this report, reflecting the strategic value provided by the transfer methodology and the support of JADECARE experts.

Structure of the document

The document collects the local good practices and the related action plans developed by 21 Next Adopters to develop the implementation phase of the Core Features of interest. It then provides an analysis of the ambitions of the Next Adopters and how they intend to transfer the good practice of reference in their local sites, describing the proposed methodology, the support provided by the oGP leaders during this phase and underlining its strategic value to better guarantee the success of the transfer.

The present report is organised as follows:

- **Section 3** provides a general overview of the context in which the project JADECARE aims to bring innovation.
- **Section 4** introduces the structure of the JADECARE project.
- **Section 5** describes the main content of the four original good practices and lists the Core Features to be transferred.
- **Section 6** details the methodologies applied during the pre-implementation phase with in-depth description of the local good practice and action plan definition methodology.
- **Section 7** offers an overview of the twenty-one Next Adopters' local good practices.
- **Section 8** collects the original twenty-one local good practices and action plans.
- **Section 9** provides conclusive remarks.

Introduction

As a result of demographic changes and the increase in chronic and complex diseases, Europe's health systems are facing major challenges. More and more people are getting older and therefore increasingly dependent on care and support in everyday life. For this reason, it is necessary to strengthen the networking between the various health sectors involved in the health challenges, mainly the primary care sector with the hospital care sector (intra-sectoral integration) as well as between the health sector and the other sectors involved (social, education and the labour sectors).

Historically, health care has pursued organisational models based on medical knowledge and from this therefore has inherited the division into areas of care that coincide with the domains of medical knowledge. Thus, over the last few decades specialisations and fragmentations have increased to the advantage of knowledge on a specific disease but to the disadvantage of a global and holistic vision of the patients (their needs, state of health, living environment and socio-cultural context). From this extreme fragmentation arises the need for a remodelling of the care process and consequently the need for new models of "integrated care". This requires improving the inter-professional connection and cooperation between all the actors of the "health" system, who are responsible for the optimal coordination of care provision.

The basic assumption of such collaborative models is that inter-professional coordination and collaboration between all service providers can improve the quality of care and simplify communication channels. In addition, thanks to local and regional supply networks and integrated solutions from a single entity between outpatient and hospital services, synergies can be exploited, and costs reduced.

In this integrated context, digital solutions assume a high strategic value, both because they facilitate and speed up the connection between the different sectors, environments, settings, and the related professionals involved and because they themselves become enabling factors for the integration of care, like other factors[1], such as:

- Empowering and engaging people, providing them with opportunities, skills and resources;
- Strengthening governance and accountability of health system operators and managers, promoting transparency in decision-making and the creation of robust systems that align governance, accountability and incentives);
- Re-orienting the model of care so that efficient and effective health services are purchased or delivered through care models that prioritise primary and community care services and health co-production;
- Coordinating services around people's needs, at all levels of care, as well as promoting activities to integrate different health professionals and create effective networks between health and other sectors;
- Creating an enabling environment that brings together different stakeholders in order to undertake change, modify the legislative framework, financial aspects and incentives, reorienting the workforce and public policies.

[1] World Health Organization. (2015). WHO global strategy on people-centred and integrated health services: interim report. World Health Organization. https://apps.who.int/iris/handle/10665/155002

Digitalisation and the possibility of digitally developing and coordinating the various health services are increasingly important. New contact points, platforms and services, for example in pharmacies and applications on smartphones complement or enhance existing structures. The goal is to create care pathways that are as complete, flexible, efficient and patient-oriented as possible.

The orientation of care and health care services towards a perspective centred on the patient and his/her needs. The integration between the different services involved and the digitalisation of healthcare translate into a project of change whose success also depends on how it is managed. Among the many models of change management proposed by the literature, the Knoster model (or Lippit-Knoster model) is reported below. According to the model, there are six elements necessary for effective change: vision, consensus, skills, incentives, resources, and an action plan. If one of these elements is missing, the change effort will fail, with various negative outcomes of change. To promote the process of change and thus facilitate the creation and activation of the six elements of change, it is useful and recommendable to refer to good practices already successfully developed in other contexts. They are considered a reference and can help to the organizations which are making the change at the present time. By now the science of implementation and several projects have remarked the validity and effectiveness of the transfer of good practices as a methodology for successful change and improvement, including transfers in the health sector (among all, see the Joint Action Chrodis and Chrodis Plus "Implementing good practices for chronic diseases"[2].

Basing a path of improvement and change on the transfer of good practice can have a number of advantages:

- Vision: if the actor already has a vision to achieve, good practice helps to visualize its concrete applications; in the event that the vision is not yet defined or needs more clarity, good practice can be an example to follow.
- Consensus: the consensus around the vision and therefore around the project of change by the stakeholders and subjects involved in the project increases and is easier to obtain if there's the opportunity to show what the concrete results of the change will be, as is shown in the implementation of a good practice.
- Skills: Experts working in a good practice can make their experience and knowledge available to help and support the subject who wants to implement change by transferring good practice.
- Incentives: Benchmark good practices can provide useful examples of how best to incentivise people to contribute to change.
- Resources: the good practice of reference can facilitate the definition of the necessary staff in the new "to be" situation, for which training and recruitment actions can be implemented immediately by the subject involved in the change.
- Action plan: the owner of the good practice can help the subject engaged in change to define an action plan for the transition from the current situation to the "to be" situation.

[2] http://chrodis.eu/)

1. JADECARE Joint Action

JADECARE (Joint Action on implementation of Digitally Enabled integrated person-centred CARE) involves 17 Competent Authorities and 31 Affiliated Entities from 17 countries across Europe. Among them, there are 21 "Next Adopters" (NA) and 4 “Early Adopters” of Good Practices in integrated person-centred digital care. JADECARE aims to make available to the 21 Next Adopters the 4 original Good Practices (oGP) and to accompany them in the transfer and adoption process. In doing so, JADECARE pretends to contribute to the development of innovative, efficient and sustainable health systems in the beneficiary countries. The four oGPs concern the integration of care, chronic conditions, multimorbidities, fragile people and patients with complex needs, self-care, prevention and health of the population, disease management and case management and are as follows:

- The Basque Health Strategy on Ageing and Chronicity: Integrated Care (Spain)
- The Catalan open innovation hub on ICT-supported integrated care services for chronic patients (Spain)
- The OptiMedis Model-Population-based integrated care (Germany)
- The Digital roadmap towards an integrated health care sector (Denmark)

The transfer methodology proposed by JADECARE takes into account the local context, the maturity of the integrated care models, the legal frameworks, the culture/values of the NAs, allowing the transfer in different contexts. Thanks to the transfer methodology and the support provided by the "Early Adopters", NAs are: (i) strengthening their ability to move to a digital, integrated and person-centred care; (ii) improving knowledge in the use of implementation methodologies; (iii) systematically assessing the quality of the transfer of practices and (iv) including elements of sustainability in the Local Good Practices (LGPs). Transfer support includes participation in a stakeholder community exploring ways to promote and leverage the inclusion of digital, integrated, person-centred care at the political level.

The methodology of transferring original Good Practices to NAs concerns the preparation of the local environment for implementation in the adopting sites, the formulation of the appropriate strategies, the creation of a learning community to develop, collect and exchange knowledge through "twinning actions", dedicated seminars and workshops and other activities.

This document describes how next Adopters have designed the practices to be implemented in their context, namely the Local Good Practice (LGP) and the related Local Action Plans (LAP) containing the actions, the times and the resources necessary for the realisation of the LGP. Subsequently, the LGP and LAPs of the 21 Next Adopters are then reported.

Original Good Practices

Basque health strategy in ageing and chronicity: integrated care

Leader

Kronikgune Institute for Health Services Research

Objectives

- Improve of the population,
- Enhance the health system quality, efficiency and sustainability and
- Increase the collaboration with social services and the Community.

Focus

The approach focuses on risk stratification, digitally enabled integrated care and patient/citizen empowerment, by means of new organisational models, professional roles, pathways and processes and digital tools and analytics.

Main blocks and their Core Features

B1. Risk stratification

Its objective is to achieve an appropriate level of distribution of health and care resources defined by the dynamic needs of the patients and populations addressed, enhancing risk prediction in the clinical scenario.

The goal of stratifying is to identify and select a target group that may benefit from specific programs of action. The implementation and successive deployment of a risk stratification (RS) in the Basque Country had two main aims: case finding and risk adjustment and capitative payment.

Consequently, Integrated Intervention Programs for multi-morbid and specific diseases patient groups (e.g., for diabetes, COPD, etc.) have been deployed. The objective is to provide anticipatory care and coordinated care to all patients identified through the risk stratification tool.

B1 Core Features:

1. Stratification Data extraction process and construction of dashboard.
2. Classification of patients.
3. Stratification in the framework contract.

B2. Integrated Care in the Basque Country focusing on clinical and functional organisational integration

Integrated care in the Basque Country is based on four pillars:

- Integrated governance: establishes the agents participating in the organization and provision of integrated care services, including the organization of the care process management.
- Population approach: implies coordination with social and public health agents.
- Multidimensional assessment and action in people aged 70 or older (Care Plan for the Elderly).
- Culture and values: a change from a culture of fragmentation to a culture of integration.

B2 Core Features:

4. Creation of Integrated Healthcare Organizations
5. Deployment of integrated communication and information systems
6. Care coordination and communication between health providers

B3. Patient empowerment through a series of online services and information

Osakidetza has developed a series of online services and information resources to facilitate citizen access to health services and improve their capacity to make decisions and manage their illness.

B3 Core Features:

1. Deployment of a School of Health
2. Empowerment programs for chronic and/or multimorbid patients

Catalan Open Innovation Hub on ICT-Supported Integrated Care Services for Chronic Patients

Leader

Institut d'Investigacions Biomèdiquest August PiiSunyer (IDIBAPS)

Objectives:

- Promote synergies among relevant stakeholders of the health and social care system
- Guarantee the healthcare continuum with support of digital tools
- Complement the individual approach with a population-based perspective

Focus

The approach encompasses both vertical (specialized vs. community-based care) and horizontal (healthcare vs. social support) integrations. It combines a population-health orientation with a collaborative adaptive case management approach of specific integrated care services.

Main blocks and their Core Features

B1. Health Risk Assessment

The regional population-based health risk assessment tool, named GMA (Adjusted Morbidity Groups), developed and adopted in Catalonia, is fully operational for health policy purposes and for clinicians in the workstation of primary care. It is updated periodically (every six months or annually) and used to elaborate the health risk strata pyramid of the general population of Catalonia with a threefold purpose:

- Support decisions on healthcare services and policies;
- Identify subsets of patients with high risk of undesirable events (case finding strategies) that may require preventive interventions; and,
- Contribute to enhanced clinical decision support through multisource predictive modelling.

B1 Core Features:

1. Assessment of transferability, and identification of steps for adoption, according to intellectual property rules, of the Catalan population-based risk stratification tool into the ecosystem of the Next Adopter.
2. Health data management strategies (Catalan Health Surveillance System, CHSS).
3. Development of enhanced risk prediction modelling for health policy purposes and/or clinical risk prediction.

B2. Promotion of healthy lifestyles

The adopted approach adopted is to learn from the implementation of preventive perioperative interventions, specifically from the deployment of prehabilitation in high risk candidates to major surgical procedures. Three-step approach is proposed to Next Adopters. It includes:

- transferability of the current prehabilitation programme;
- perioperative care with a population-heath approach including community-based programmes;
- implementation of enhanced modalities of rehabilitation for chronic patients and citizens at risk for common multimorbid conditions.

B2 Core Features:

1. Transferability of the prehabilitation program
2. Perioperative care with a population-health approach
3. Rehabilitation of chronic patients and prevention of multimorbidity
4. Vertical – Horizontal integration experiences

B3. Vertical – Horizontal integration experiences

Includes four initially selected examples successfully assessed in the EU project ACT@Scale17. Each of the experiences encompasses several key dimensions:

- change management and reorganization of the existing care delivery;
- embedding digital technologies and tools in care services, re-organization of patient pathways;
- changes in health workforce roles and skills with digital technologies and data;
- building the capacity of individuals and communities to participate in the care process;
- citizen empowerment;
- use of patient reported data;
- new payment methods;
- performance assessment of new care models.

B3 Core Features:

1. Programme for chronic and frail patients (Badalona Serveis Assistencials, BSA).
2. Support for complex case management including home hospitalization, transitonal care and vertical & horizontal integration supported by digital tools.
3. Healthcare support programmes for nursing homes.
4. Integrated Care for admission avoidance of subacute and frail patients.

B4. Innovative assessment & Regulatory issues

This block includes three different items:

- health care planning and health delivery assessment;
- regulatory issues regarding patients' self-tracking data;
- regulatory aspects regarding data privacy and sharing.

B4 Core Features:

1. Catalan Health Plans and Practicalities of healthcare delivery assessment
2. Regulatory aspects associated with patient' self-tracking data
3. Regulatory aspects of health data management for research purposes and quality assurance purposes.

B5. Digital support to integrated care

Digital support of health services in Catalonia involves regional interoperability among an extensive network of healthcare providers with highly heterogeneous health information systems

B5 Core Features:

1. Regional information exchange platform

2. Primary Care electronic Medical Record and Electronic Prescription
3. Personal Health Folder (LaMeva Salut)
4. ICT tools supporting adaptive case management & collaborative work
5. Cloud-based strategies

OptiMedis Model – Population Based Integrated Care Good Practice

Leader

OptiMedis

Objectives

To build integrated healthcare structures as regional networks of doctors, therapists, hospitals, pharmacies and many other partners work in association and overcome working in professional silos.

Focus

- A regional integrated care concept based on incentives and a mutual benefits approach managed by an independent integrator.
- Regionally optimised organisation and activation of patients.
- Unified interest and participation of regional health actors – digitally supported.
- Targeted additional payments and interventions reward the prevention of disease progression/positive health commitment.

Main blocks and their Core Features

B1 - Shared savings contract with reimbursement/commissioning organizations

A key characteristic is the value-oriented population-based shared savings contract. This model maintains existing reimbursement schemes and financial flows, but the integrator company assumes virtual responsibility for the development of the so-called contribution margin. The contribution margin is the difference between the amount the purchaser receives from the central health care fund for the expected (risk-adjusted) mean costs of care of all insured and the costs that were actually incurred by their population, adjusted for baseline differences before the start of the intervention. A positive contribution margin is then shared between the insurance companies and the integrator to compensate investment costs. Another key characteristic of the model is that the integrator company is financially accountable for all people in the population served, not just for those who are registered members or receive care from physicians that form part of the network, thus reducing the risk of cream-skimming and incentivising prevention and health promotion.

B1 Core Features:

1. identifying current contractual arrangements and assessing possibilities for value-based contracting
2. defining data standards and appropriate outcome measures
3. designing the valued-based payment framework
4. constructing the analytical model to execute the contract

B2 - A model including strong stakeholder engagement

OptiMedis sets up population-based integrated care health system as an independent company (normally as an LTD) in coordination with local stakeholders, mostly physician networks and other health care providers. Governance arrangements focus on strong representation of local user groups and social organizations to ensure sustainability of the network and alignment with local needs.

B2 Core Features:

1. Identifying and liaising with stakeholder groups.
2. Creating appropriate governance structures.

B3. Electronic integration across providers

In order to influence the health of the population, an understanding of the determinants of health in the life cycle is necessary and, based on this, the derivation of measures for a comprehensive population health management (PHM). PHM differs from classical support services for the chronically ill in several respects: It includes several chronic diseases and conditions, takes into account co-morbidities, includes proactive health promotion management, includes predictive models for health development and - based on these - strategies for case management of high-risk patients as well as for personal health management at population level for people with a low risk of disease or morbidity. PHM requires a constant exchange of data from all health care providers as well as other sources of data on population health. Moreover, PHM is not only an IT suite, but requires a regional manager who derives relevant decisions for the clinical and non-clinical management of health potentials from the multitude of data. OptiMedis is IT agnostic and helps regions procure and deploy the most appropriate IT solution.

B3 Core Features:

1. Assessing state of current health IT integration and IT tools in use
2. Market assessment on tools adequate to improve IT connectivity of providers
3. Training with providers to assess incentives for IT deployment and usability assessment

B4. Patient involvement and empowerment

The patient-centred care approach is paramount to the success of the OM model and embedded at three levels: at the structural level, in the planning of interventions, and in the interactions between physicians and patients. At the structural level, patients are represented in patient advisory boards, which elect their representatives on a biannual basis and are given the opportunity to contribute to identifying and developing new programmes. At the level of intervention planning there is a strong focus on shared decision-making and self-management support, which is embedded in design and development. At the level of individual interactions of patients with health professionals, patients joining first undergo a comprehensive health-check based on which they may be offered to participate in any of the health promotion and disease prevention programmes HK. Patients are also given the opportunity to develop health-related goals, which are discussed with the doctor and then monitored over time, accompanied by individual support and participation in patient education and self-care programmes as needed. In order to support the patient-centred care approach, physicians, other health professionals and practice staff are offered training.

B4 Core Features:

1. Patient advisory boards
2. Shared-decision making tools and self-management support
3. Comprehensive health checks and health-related goals
4. Providing training on incentives and tools to implement patient centred care

B5. Data-driven management

OptiMedis provides overarching management support, business intelligence and health data analytics, whereby the data driven health analytics propel both the planning of health programmes and guide local practice improvements via feedback reports to participating physicians. These reports are based on a balanced scorecard approach, which uses structure, process and outcome indicators and is designed to be interactive in that it allows users to select indicators to retrieve more detailed information. Some indicators are supported by targeted improvement activities.

B5 Core Features

1. Potential analysis tool
2. Performance dashboards
3. FORTA tool to identify over- and underutilization regarding prescriptions

B6. Prevention, health promotion and public health

In order to reach the Triple Aim, a set of activities and programmes were established, which all draw on a common set of underlying features:

a) individual treatment plans,
b) care planning based on the Chronic-Care Modell (Barr VJ et al 2003),
c) patient coaching.

The following Prevention and Health Promotion Programmes that have been developed so far: Strong heart (programme targeting heart failure), Healthy weight (for metabolic syndrome, including diabetes), Good prospects (care services for children), In balance (blood pressure), Strong muscles – solid bones (osteoporosis), Staying mobile (treating early stager heumatism), Strong support - healthy back (chronic back pain), Better mood (depression), Good counselling (help, advice and support in critical times), Psycho Acute (acute psychological issues), Disease management programmes, Smoke-free Kinzigtal (including pre-surgery smoking cessation), Social support (to reduce stress where patients are in critical situations), Liberating sounds (in tune with music) and, a self-management training programme (based on the Stanford Chronic Disease Self-Management Programme).

B6 Core Features:

1. Individual treatment plans and care programmes;
2. Care planning based on Chronic care model;
3. Patient coaching.

Digital roadmap towards an integrated health care sector

Leader

Region of South Denmark

Objectives

To provide patients with a coherent and safe journey through the different sectors and actors in the Danish Healthcare system. The Digital Roadmap's purpose is to improve and strengthen the existing cooperation between the healthcare sectors.

Focus

The Roadmap towards Integrated Care consists of different elements that together make up the foundation for digital and cross-sectorial communication. This is based on a strong collaboration between the different organizations in the regional eco-system of academia, knowledge institutions and private companies. Focus are on user involvement of both professionals and end-users in co-designing solutions and implementation processes and a strong IT infrastructure to make digital communication possible

Main blocks and their Core Features

B1 - Cross sectorial digital communication: standards and agreements

The Danish patient-centred and collaborative approach ensure correct and coherent communication and coordination between the different healthcare sectors in the Region of Southern Denmark. Three Core Features serve as the foundation for all cross-sectorial communication in the healthcare system in the Region of Southern Denmark:

1. The Health Agreement: A regional political agreement and vision that frame the cooperation between the Region of Southern Denmark, the municipalities, and the general practitioners,
2. National digital communication standards: Standardized ways of communicating and sharing data about the patients, that are compliant with the many different IT-system
3. The SAM:BO Agreement: A unique regional cooperation agreement concerning cross-sectorial integrated care and continuity of care. It describes how the organization around the cross-sectoral healthcare of citizens needs to be organized, implemented and followed up. These three elements overall constitute the highway, and a variety of digitally supported health services are connected to the highway: e.g. apps and website for patients, video conferencing for psychiatric patients, toolboxes for healthcare professionals, and national programmes and initiatives.

    B1 Core Features:

    1. Health Agreements
    2. Messaging Standards
    3. SAM:BO Agreement

B2 - Cross sectorial digital communication: Additional solutions to support complex disease areas including Telemedicine and Digital solutions

Some of the future challenges to primary care and prevention in Denmark can be resolved with e.g. telemedicine, home-monitoring, video conference, and other tools to interact with the patients, making them more aware and better at mastering their own health and illnesses. It is proven, that patients recover better and faster in the comfort of their own home, and that the benefits count: reduced risk of further

complications and infections, increase in independence, and that being in familiar surroundings with support from loved ones, family and friends is good for the overall recovery as well as mental wellbeing. Although allocating patients at home can result in a reduction in hospital length of stay, it can however increase overall length of care, which can lead to an increase of cost in the primary sector.

B2 Core Features:

1. TeleCOPD
2. Telepsychiatry
3. My Hospital
4. Online Physical Rehabilitation
5. The Digital Health Centre
6. The GERI Toolbox

2. Pre-implementation phase

The objective of this phase was to identify, specify and analyse determinants that act as barriers and enablers that could influence implementation outcomes, and then to elaborate the Local Good Practices and Local Action Plans to be followed during the implementation.

These three activities were carried out by the so-called 'Next Adopters Working Group': each site set up a Next Adopter Working Group (NAWG), which is responsible to conduct the pilot implementation of the different practices in JADECARE in the local health care, social, and legal context. NAWGs have identified and engaged the local stakeholders (individuals or organizations) considered key for the successful Good Practice implementation and sustainability. The functions and roles covered by the NAWG are: Organizers, Experts, Decision makers, Front-line stakeholders, Implementers (these latter can be the same people as the Front-line stakeholders, but need not to be).

The pre-implementation phase lasted from September 2020 to October 2021. In the beginning of this phase the 21 NAs studied the Core Features of the 4 oGPs. Later, through a specific methodology, they first defined the scope of their implementation (first part) and then carried out a situations analysis, by means of completing a SWOT analysis and supported by study visits (second part). On the basis of the results of these two first sub-phases, Local Good Practices and related Local Action Plans were then elaborated by each NA (third part).

Scope definition

The scope means the extent of the area or subject matter that an intervention covers, i.e., the range of the project. Defining the scope means selecting the Core Features of the oGP(s) that will be implemented and integrated in routine practice in each NA site. The scope definition process followed by all NAs envisaged the steps described below.

1. The NAWG analysed in depth the information provided by the oGPs, including:
    - A narrative part focussing on the trigger that enabled their oGP to come into existence, the Network, the Scope, Main facilitators and barriers of the implementation of the good practice and finally Elements related to the sustainability of the practice.
    - Blocks and Core Features of the oGP.
    - The assessment of maturity requirements for their implementation (using Scirocco Tool).
2. Then, according to the oGPs' blocks, each NAWG analysed their own site, including aims, challenges, and local existing interventions and local needs to be covered. These needs were grouped and prioritised for each of the Main Block(s) of interest.
3. The Core Features of the Main Blocks were analysed according to their relevance and feasibility. Relevance was assessed mapping local needs with original Good Practice(s) Core Features. To assess feasibility, Next Adopters cross-checked the maturity requirements identified with their local capabilities.
4. Through a final graphical representation, NAs were able to select and report the Core Features to implement during JADECARE, as they could clearly identify the most relevant and feasible ones.

Situation analysis

The purpose of the Situation Analysis is to analyse the organisational position within the local environment, in order to become aware of risks and chances and to identify the best courses of action for the project definition and implementation in each NA site. In the frame of JADECARE, the SWOT analysis was used ex-ante, preceding the implementation phase, specifically from January to April 2021.

For the Situation Analysis, each Next Adopter site undertook the SWOT analysis, which is a structured, strategic planning tool used to explore, describe, and evaluate the Strengths (S), Weaknesses (W), Opportunities (O), and Threats (T) of a project, intervention, program, or policy, addressing both internal (S&W) and external (O&T) conditions that my affect its success. SWOT analysis was focused on the Core Features selected in the scope definition.

The SWOT analysis addresses and highlights all the characteristics, relationships, and synergies among internal and with external variables of an initiative (i.e., policy or program). A two-by-two matrix is used to build a SWOT analysis, with horizontal pairings of internal (strengths and weaknesses) and external (opportunities and threats) factors, and vertical pairings of helpful (strengths and opportunities) and harmful (weaknesses and threats) factors in achieving an objective. Strengths, weaknesses, opportunities and threats can be scored according to what is seen as relevant regarding the Local Good Practice implementation and sustainability.

At a practical level, the NAWG performed a SWOT analysis according to the objectives of the scope they had previously defined (oGPs' Core Features). A coordinator for the entire process was selected, who then presented the SWOT analysis process to the NAWG, illustrating its aims, steps, timing, the contribution expected from each participant (as key stakeholder). The NAWG performed the SWOT analysis through an online workshop in which all participants expressed their opinion regarding the strengths, weaknesses, opportunities and threats to implement in their local site the Core Features selected in the scope definition.

Finally, the output from SWOT Analysis was used as the basis for designing the Local Good Practices and Action Plans. The group outlined a set of "Strategic Intervention Areas" (SIAs) that had to be addressed in order to implement the Good Practice.

Definition of the Local Good Practice and Action Plan

The definition of the Local Good Practice and Action Plan was carried out from June to October 2021 (final stage of the pre-implementation phase).

In this stage of the pre-implementation phase, the NAWG defined its Local Good Practice and its Action Plan starting from the analysis performed in the previous stages. During the development of the LGP and LAP, particular emphasis was placed to ensure the sustainability of the LGP beyond JADECARE.

Kronikgune has provided all Next Adopters with a guide for defining local Good Practices and Action Plans (see Annex 1). The content of this guide was presented to all recipients in a webinar in June 2021. AGENAS, as leader of the task "T4.3 Definition of the Local Good Practices and Action Plans", then provided methodological support to all Next Adopters for the correct application of the guide. The leaders of the 4 oGPs held regular meetings with NAs who selected elements of their practice. They accompany NAs in defining objectives and the activities necessary to achieve them, verifying the consistency between the conditions of the Next Adopters (context, level of maturity, purpose, and impact) and the Core Features to

be transferred. Some NAs at this stage have redefined their purpose in the light of the evidence emerging from the analysis and discussions with the oGP. The 4 NAs following by the Mix & Match approach have benefited from a particular support by AGENAS. In addition to the meetings with the single oGPs of interest, meetings have been organized with all the oGPs and the representatives of the NAWG, in order to guarantee the coherence also among the Core Features of different oGPs.

The guidelines for development of the Local Good Practices and Action Plans are summarized below.

First, the NAWG built up the LGP which includes a description of the local intervention, its local Core Features (LCFs) and their components, the target population, the setting(s) where it will be implemented and its expected outcomes. When describing the LGP, it was important to understand and highlight what is out of scope of the implementation within JADECARE.

Four steps were followeds:

1. Identify local policies, strategies and interventions intended to address the problem analysed in the scope definition and situation analysis;
2. Define the target population and the setting(s) for the LGP implementation
3. Specify the general aim to be achieved;
4. List the
    i. Expected Outcomes in the target population expected
    ii. LCFs and their components that are needed to get these outcomes
    iii. Inputs needed to implement the intended LCFs and their components.

The Local Action Plan defines the concrete actions (what) to be taken to reach implementation and sustainability of the Local Good Practice during JADECARE, the responsible actors (who), resources needed, timeline (when), settings (where) and the Key Performance Indicators (KPIs) to be measured.

The following information were defined for each of the LCFs:

1. Set a SMART objective for each of the LCFs. The SMART method is commonly stated as the standard for developing effective and measurable objectives useful for the definition of the LAP.
2. Describe the specific activities to be implemented (What), including at least one activity that will be a seed for sustainability after JADECARE ends.
3. Define the actors that will implement the activities (Who)
4. Resources needed: technical, financial, etc.
5. Setting(s) where the activities will be implemented (Where)
6. Timeframe for the actions (When)
7. Key Performance Indicators (Measure) defined for each LCF. They will be process indicators that will be used to monitor the implementation of the LAP.

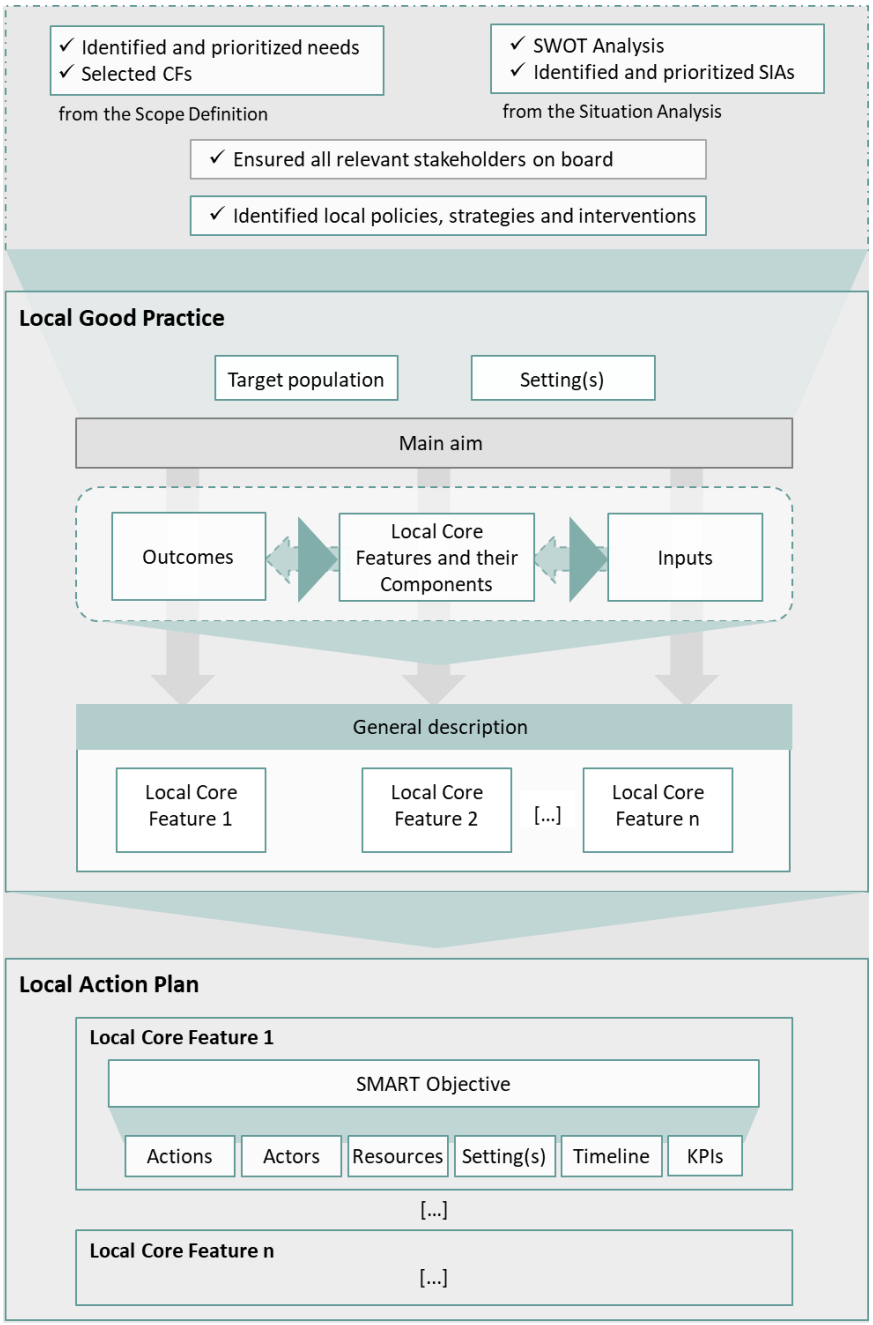

Figure 1. Overview of the general process for the development of the Local Good Practices and Action Plans

3. Overview of the Next Adopters

Next Adopters' adoption strategies

The best practice transfer methodology applied in JADECARE allows for a scalar approach by the NAs according to their needs, their strategies but also their level of maturity, assessed in the "scope definition" phase. The oGPs first assessed the level of maturity sufficient and necessary for the implementation of each Core Feature of the different building blocks of their practice by using the Scirocco tool[3]. Subsequently, each NA assessed their own maturity level of the dimensions proposed by the Scirocco tool with reference to the Core Features of interest (Figure 2), thus being able to evaluate which were implementable in JADECARE and which were not. The possibility of choosing which Core Features to transfer compared to the alternative of transferring the whole Good Practice is an innovative element in implementation science that guarantees a higher degree of success and sustainability in the long term. Often the transfer of Good Practice fails where a part of the transferred Good Practice does not find ready ground and a context mature enough to host it, to let it put down roots and develop.

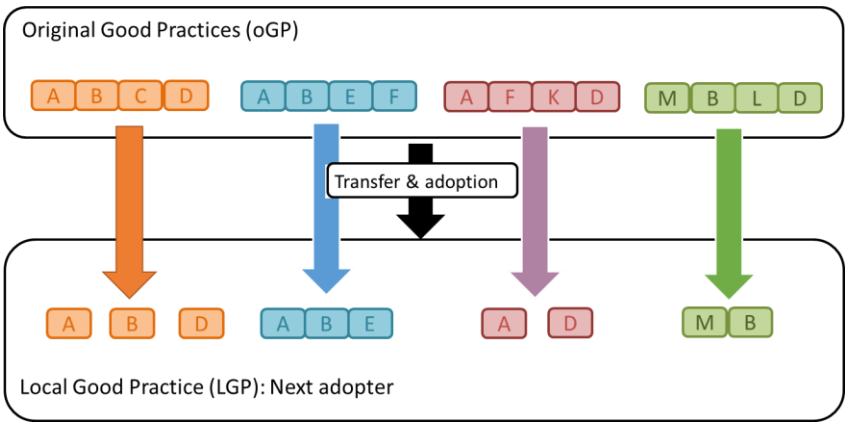

Figure 2: Transferring single Core Features from one oGP to the Next Adopter site

A further added value and innovative aspect of Good Practice transfer has been the possibility for Next Adopters to choose Core Features from different oGPs, thus adopting the so-called Mix & Match approach (Figure 3).

[3] https://www.scirocco-project.eu/scirocco-tool/

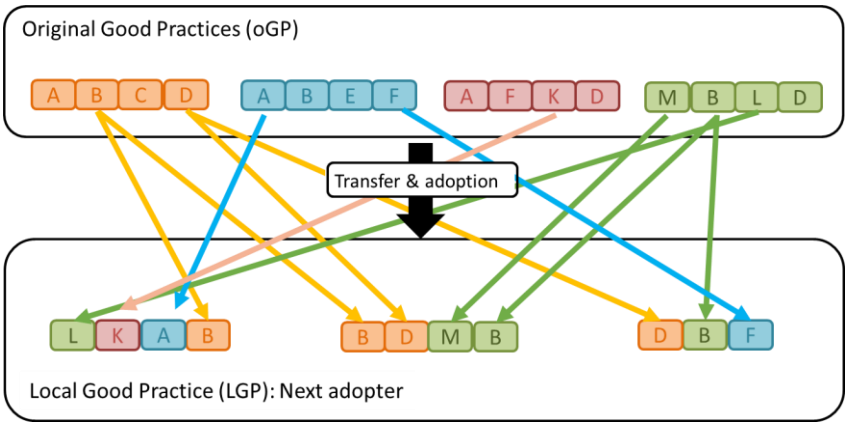

Figure 3. Mix & Match approach

Seventeen NAs chose a single oGP transfer methodology, while 4 adopted the Mix & Match approach.

Next Adopters' ambition

The NAs not only chose different transfer strategies, but also presented different maturity levels for implementing integrated care services, as well as different ambitions and expectations for the implementation of local practice in JADECARE. The starting situation together with political support strongly influenced each NA's choice of goals to pursue in JADECARE as well as their commitment to scale-up or their small-scale implementation capacities during JADECARE.

In order to assess the maturity of the NAs for the implementation of digital integrated care and to evaluate their ambitions, a survey was launched before the start of the Joint Action. Aach NA was asked to perform a self-assessment of their maturity for the implementation of integrated care services (policies, strategies and guidelines; health system infrastructure; digital transformation, including the Electronic Health Record, personal health record and e-prescription; training programmes, and research and innovation initiatives on integrated care). The starting situations were different, although all had started some form of integrated care implementation (Figure 4):

- most had already taken the first steps;
- some were already halfway through the process;
- finally, some were ready for a scale-up.

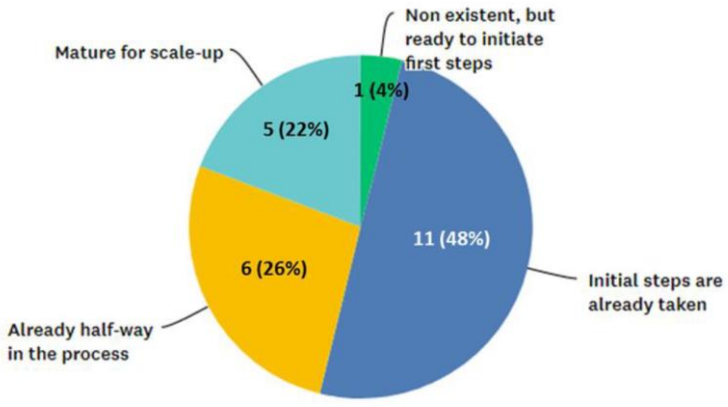

Figure 4. Maturity of Next Adopters to transfer integrated care good practices

It is therefore clear that the transfer of good practice, or rather parts of good practice, was understood by the NAs as a lever to make progress on a strategy that was already defined or at least already outlined. The idea of using the transfer of Good Practices as an accelerator of a change process was also confirmed at the end of the pre-implementation phase, as reported below.

In terms of commitment and ambition for implementation during JADECARE, 66% of the Next Adopters expressed interest in small-scale implementation, only one of the Next Adopters intended to scale up interventions to system level. The other 30 % were interested in increasing their capabilities (knowledge, management development, plans, etc.) for the successful design and implementation of digitally-enabled person-centred integrated care.

Next Adopters' areas of interest

NAs were also asked, before the start of the project, to express their areas of interest, in coherence with their strategies.

The areas of interest among the NAs were very diverse (Figure 5): change management, reorganisation of care pathways and introduction of technology in care services, health workforce roles and skills, use of patient reported outcomes, empowerment of citizens, new payment methods and performance assessment. Most NAs expressed interest in working on various dimensions in JADECARE. The areas of most interest were: use of technology in care services (78%), use of patient reported data (65%) reorganisation of care pathways (61%), workforce roles and skills with technology (52%) and citizen empowerment (57%). In accordance with these ambitions, the NAs then selected the Core Features of the oGPs related to these areas, thus having at their disposal, for each of the areas, several concrete solutions or strategies.

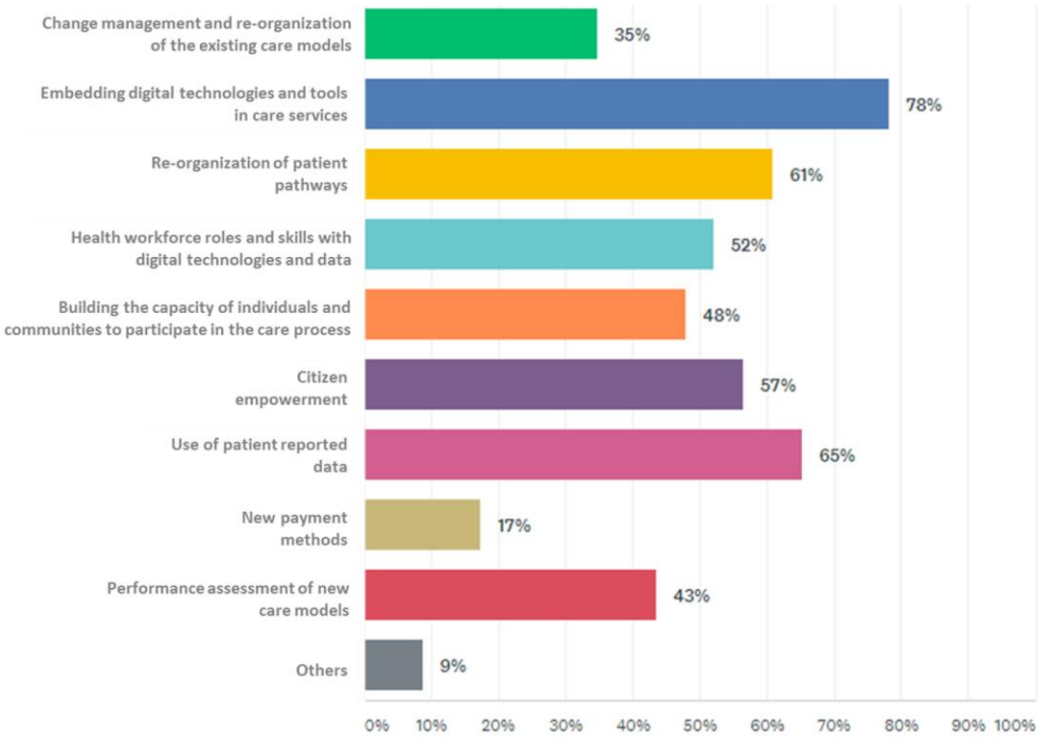

Figure 5: Areas of interest of Next Adopters

4. Summary of the Local Good Practices

Adoption of Core Features from the Basque practice

There are 5 NAs interested in transferring Core Features from the sole Basque Country good practice (*Basque health strategy in ageing and chronicity: integrated care*). On average each of them will transfer 3 Core Features, of which the ones of major interest are:

- "Classification of patients", within block 1 related to risk stratification.
- "Deployment of integrated communication and information systems" and
- "Care coordination and communication between health providers" as part of block 2 on the integration of care.

These are Core Features that will allow the NAs both to adopt an active approach to patients, having previously classified their possible risks and needs, and to integrate and therefore better coordinate the responses to these needs.

The scale of implementation is very varied: from the hospital setting to the local community, to the entire population of several regions.

NEXT ADOPTER	Core Features from the Basque practice to be transferred	Sector and scale of the implementation
Italy - Agenzia Regionale di Sanita - ARS della regione Toscana (ARS TOSCANA)	1.1 Stratification Data extraction process and construction of dashboard. 1.2 Classification of patients 2.3 Integrated care- Care coordination and communication between health providers.	Complex patients with multi-chronicity and management difficulties of the "Piana di Lucca" District zone (6.000 people)
General description		
"Piana di Lucca" District Zone's approach proposes a variety of interventions promoting enhanced integration and proactivity of care for complex patients. These interventions include identifying chronic patients through a stratification process and fostering communication and sharing of care plans among health professionals. Our strategy takes place in a context where the increasing number of patients with multi-chronicity and management difficulties has become a public health priority, and, because of this, our approach is aligned with the National Chronicity Plan and the Health Care Initiative Model. The practice represents an opportunity to integrate and coordinate the efforts for providing timely and integrated care and it is built on the "Basque health strategy in ageing and chronicity: integrated care". Factors that might have a negative impact on our objectives are non-participation of clinical professionals in the process, impediments due to privacy issues and difficulties in tackling communication obstacles.		

NEXT ADOPTER	Core Features from the Basque practice to be transferred	Sector and scale of the implementation
Italy - Azienda Unità Sanitaria Locale Umbria 1 (USL UMBRIA 1)	2.2 Integrated care - Deployment of integrated communication and information systems. 2.3 Integrated care - Care coordination and communication between health providers. 3.2 Empowerment programs for chronic and/or multimorbid patients.	Patients who are carriers of known structural heart disease at high risk of evolution towards Heart Failure (HF) or are already suffering from HF in the following setting: • Perugia Hospital; • "Media Valle del Tevere" Hospital; • Specialist cardiological clinics of the AO of Perugia; • Outpatient clinics of the GPs of the "Media Valle del Tevere" District.
General description		
The project aims to implement the integrated treatment / assistance pathway for patients with known structural heart disease at high risk of evolution towards HF or already suffering from Heart Failure, according to the provisions of the PDTA (Integrated care pathway) on heart failure using the ICT tools, also by promoting patient compliance, through telemedicine systems		

NEXT ADOPTER	Core Features from the Basque practice to be transferred	Sector and scale of the implementation
Greece - School of Medicine, Aristotle University of Thessaloniki (AUTH)	1.2 Classification of patients 3.1 Deployment of a School of Health 3.2 Empowerment programs for chronic and/or multimorbid patients	About 2000 patients of the Hippokration General Hospital and Ahepa General University Hospital, Thessaloniki
General description		
The project aims to empower patients in order to improve their quality of life and avoid unnecessary visits to the Emergency Room. Moreover, the project aims to classify patients to enhance the health system quality and efficiency. Hospitals will provide a large amount of data available which will be used to implement a classification approach based on ACG grouper that will contribute to the transition to digitally-enabled, integrated, person-centred care, with special emphasis on sustainability. At the same time, the empowerment of the patients will be implemented in two different levels. The patients' level and the medical professionals' level. On the patients' level, they will be offered with a large variety of different digital tools, which they can use in order to learn about their diseases and how to manage their symptoms, as well as they will be informed on their rights and obligations when it comes to their healthcare. On the medical professionals' level, they will be trained in empathy, with the use of virtual reality, a skill that is missing from the curricula of the medical schools but is necessary when interacting with patients. Furthermore, the medical professionals will also be informed on the patients' and their own rights and obligations when it comes to healthcare.		

NEXT ADOPTER	Core Features from the Basque practice to be transferred	Sector and scale of the implementation
Portugal - Central Administration of the Health System (ACSS)	1.1 Stratification Data extraction process and construction of dashboard 1.2 Classification of patients 1.3 Stratification in the framework contract 2.2 Integrated care - Deployment of integrated communication and information systems 2.3 Integrated care- Care coordination and communication between health providers	In three regions of the country (Norte, Centro e Alentejo) that are different in population and density. Pilot in 5 providers of the NHS (1.004.546 inhabitants)
General description		
Implementation of risk stratification as a basis for identifying needs of population groups, that will allow the adaptation of care models, using information and communication systems, as well as financing and commissioning as facilitators.		

NEXT ADOPTER	Core Features from the Basque practice to be transferred	Sector and scale of the implementation
Serbia - Ministry of Health of Republic of Serbia (MoHRS)	2.2 Integrated care - Deployment of integrated communication and information systems 3.1 Deployment of a School of Health	- Primary Healthcare centres in two Belgrade municipalities pilot project sites: PHC „Zemun“, PHC „Novi Beograd“. - Gerontology Centre „Beograd“ (social care institution in Belgrade with primary healthcare service provision). A total of about 360.000 adults.
General description		
Aging and increase in prevalence of non-communicable diseases lead to a greater need for long-term care and optimization of the entire healthcare system. Introduction of digital communication between healthcare workers at all levels of health care should make the healthcare services more efficient and patients more satisfied. Improvements in coordination between health providers should contribute to continual health care and better quality of patient care. Deployment of relevant web-based health information and access to them can strengthen patients' capacity to recognize disease and manage their own health. Regulation on introduction of new services in the nomenclature of health services financed by state budget, financial resources limitations, organisational issues in healthcare institutions, as well as established patients' access to health care which are difficult to change can influence the implementation and expected outcomes.		

Adoption of Core Features from the Catalan practice

There are 5 NAs interested in transferring Core Features from the sole Catalan good practice (*Catalan Open Innovation Hub on ICT-Supported Integrated Care Services for Chronic Patients*). Two out of three are going to transfer 6 Core Features from the oGP in a small setting which include one hospital and the surrounding territory. Those Core Features are mainly related to:

- Vertical and horizontal integration experiences adopted in Catalonia (block 3 of the oGP);

- and the digital support of integrated care services (block 5 of the oGP).

On the contrary, the third NA will implement only 3 Core Features from the block "Health risk assessment and population-based approach" but to a larger scale (the entire regional population).

NEXT ADOPTER	Core Features from the Catalan practice to be transferred	Sector and scale of the implementation
Italy - Azienda Sanitaria Locale Napoli 2 Nord (ASL NA2)	3.1 Programme for chronic and frail patients. 3.2 Support for complex case management including home hospitalization, transitional care and vertical & horizontal integration supported by digital tools. 3.4 Integrated Care for admission avoidance of subacute and frail patients. 5.1 Regional information exchange platform. 5.2 Primary Care electronic Medical Record and Electronic Prescription. 5.4 ICT tools supporting adaptive case management & collaborative work.	Two District Zone of ASL Napoli 2 Nord
General description		
ASL Napoli 2 Nord (Local Health Authority of North Naples) wants to improve the quality of life and health of the population of North Naples by strengthening vertical integration (within the hospital structures) and horizontal integration (between the different sectors involved in hospital discharge) and improving the management of home care through the use of digital systems. The objective is the definition and implementation of a protocol for the management of patient discharge from the hospital and the consequent taking on of the patient by local structures, with particular focus on frail persons.		

NEXT ADOPTER	Core Features from the Catalan practice to be transferred	Sector and scale of the implementation
Hungary - Jahn Ferenc Dél-pesti Kórház és Rendelőintézet (JFDPK)	1.3 Development of enhanced risk prediction modelling for health policy purposes and/or clinical risk prediction 2.3 Rehabilitation of chronic patients 3.1 Programme for chronic and frail patients 3.2 Support for complex case management including home hospitalization, transitional care and vertical & horizontal integration supported by digital tools 3.4 Integrated Care for admission avoidance of subacute and frail patients 5.4 ICT tools supporting adaptive case management & collaborative work	Multimorbid patients with acute lower limb minor amputation in the care area of the Jahn Ferenc South Pest Hospital (approx. 100 persons/year).
General description		
Jahn Ferenc South-Pest Hospital would like to improve complex care and rehabilitation of multimorbid minor amputees to prevent lower limb loss, providing post-operative, integrated management of patients with lower limb minor amputation to prevent further complications. Aftercare includes reviewing the patients' internal drug therapy, they aim to provide patient education and psychological guidance, ensuring and monitoring the performance of the necessary tests.		

NEXT ADOPTER	Core Features from the Catalan practice to be transferred	Sector and scale of the implementation
Italy - Regione Marche (MARCHE)	1.1 Assessment of transferability, and identification of steps for adoption, according to intellectual property rules of the Catalan population-based risk stratification tool into the ecosystem of the Next Adopter. 1.2 Health data management strategies. 1.3 Development of enhanced risk prediction modelling for health policy purposes and/or clinical risk prediction.	The entire Regional Health System (Marche region: ~1.500.000 citizens).
General description		
The intervention consists of setting up and testing a stratification tool for planning and decision-making purposes in order to improve the efficiency of the Regional Health System and the quality of life of citizens by providing services that meet their needs		

Adoption of Core Features from the OptiMedis practice

Unlike the other NAs, who are only interested in some of the Core Features of the other Good Practices, the 3 NAs interested in the OptiMedis practice (*Population Based Integrated Care Good Practice*) aim to adopt the model almost in its entirety, although they will focus on some areas over the time span of the JADECARE project, mainly:

- savings contract,
- stakeholder engagement,
- patient involvement and empowerment.

Moreover, all three NAs intend to implement the "OptiMedis" model on a large scale (the whole region or province).

NEXT ADOPTER	Core Features from the OptiMedis practice to be transferred	Sector and scale of the implementation
France - Eurometropole de Strasbourg (EUSTRAS)	1.2 Defining data standards and appropriate outcome measures. 1.3 Designing the valued-based payment framework 1.4 Constructing the analytical model to execute the contract. 2.1 Identifying and liaising with stakeholder group 2.2 Creating appropriate governance structures 3.1 Assessing state of current health IT integration and IT tools in use. 3.3 Training with providers to assess incentives for IT deployment and usability assessment. 4.2 Shared-decision making tools and self-management support. 4.3 Comprehensive health checks and health-related goals. 4.4 Providing training on incentives and tools to implement patient centered care. 5.1 Potential analysis tool. 5.2 Performance dashboards. 6.1 Individual treatment plans and care programme. 6.2 Care planning based on Chronic care model. 6.3 Patient coaching.	3 districts in Strasbourg, 46,530 insured persons; local consortium of 20 partners. Implementation will be focused on focus within JADECARE on stakeholder involvement, patient involvement, data-based management and electronic integration.
General description		
Strasbourg has a rich portfolio of initiatives and projects targeting innovations in health care deliver, such as care coordination in multi-professional teams, prevention and physical activity initiatives, medico-social services, and digitisation in health. This is backed-up by national and regional health strategies. The local good practice focuses on transforming a disease based professionally dominated care system towards a territorial population-based, people centred health system in an urban environment in three Strasbourg districts. Its main pillars are to build strong stakeholder networks of multi-professional nature including people and patient representation following a continuity of care logic; develop health programs and a continuity of care approach towards better patient health and self-management; data based decision support including patient information sharing across provider networks, performance measurement, analytical tools for outcome and impact assessment; increase efficiency of health care delivery system, avoid unnecessary hospitalisation and duplication of services, and develop an economic model to sustain patient centred integrated health systems. Increased efficiency and the economic model will guarantee the continuation of activities after the end of the JADECARE project cycle.	

NEXT ADOPTER	Core Features from the OptiMedis practice to be transferred	Sector and scale of the implementation
Slovenia - Health Insurance Institute of Slovenia (ZZZS)	1.1 Identifying current contractual arrangements and assessing possibilities for value-based contracting 1.2 Defining data standards and appropriate outcome measures. 1.3 Designing the valued-based payment framework 1.4 Constructing the analytical model to execute the contract. 2.1 Identifying and liaising with stakeholder group 3.1 Assessing state of current health IT integration and IT tools in use. 3.2 Market assessment on tools adequate to improve IT connectivity of provider. 6.3 Patient coaching.	Implementation focused on stakeholder engagement, patient involvement, prevention, contracting in the chronic kidney disease (CKD); sector in the following sites: At the primary level: - Ljubljana Health Center, family medicine clinic of Primož Štular MD - Sava med, family medicine clinic of Vojislav Ivetić MD - ZD Slovenj Gradec, family medicine clinic of Tina Virtič MD - ZD Nova Gorica, family medicine clinic of Matjaž Divjak MD At the secondary level: - General hospital Slovenj Gradec - University clinical center Ljubljana - General hospital Šempeter pri Gorici - University clinical center Maribor. The number of registered persons in the participating family clinics is: 5,386. For preventive screening, those older than 30 years are eligible: 4,589. Approximately 10% are patients at high risk for CKD.
General description		
The ZZZS long-term goal is to improve the health of the population in the field of CKD, increase the satisfaction and empowerment of patients with CKD, increase the satisfaction of health professionals with new education and prevention options and save money on hospitalizations, drugs and dialysis. The JADECARE implementation is focused mainly on the preparation of starting points for improving communication between the primary and secondary level, for improving preventive activities in the field of CKD, for billing new services (especially educational) in the field of CKD. ZZZS will prepare new educational materials to increase the empowerment of patients.		

NEXT ADOPTER	Core Features from the OptiMedis practice to be transferred	Sector and scale of the implementation
Belgium - Communauté germanophone pour une vie autodéterminée	1.1 Identifying current contractual arrangements and assessing possibilities for value-based contracting 1.2 Defining data standards and appropriate outcome measures. 1.3 Designing the valued-based payment framework 1.4 Constructing the analytical model to execute the contract. 2.1 Identifying and liaising with stakeholder group 2.2 Creating appropriate governance structures 3.1 Assessing state of current health IT integration and IT tools in use. 3.2 Market assessment on tools adequate to improve IT connectivity of provider. 3.3 Training with providers to assess incentives for IT deployment and usability assessment. 3.4 Patient access to their data (Open Notes approach). 5.1 Potential analysis tool. 5.2 Performance dashboards. 5.3 FORTA tool to identify over- and underutilization regarding prescriptions. 6.1 Individual treatment plans and care programme. 6.2 Care planning based on Chronic care model. 6.3 Patient coaching.	The Regional Health System of the German speaking Community (entire population of the region around 78.000 people). Implementation mainly focused on savings contract, stakeholder engagement, patient involvement and empowerment.
General description		
The Dienststelle aims to carry out a Feasibility study on the implementation of integrated care in the German speaking Community. The aim of the feasibility study is to develop a business plan which will guide the implementation of an integrated care in the German speaking Community. This business plan will include recommendations to the development of a model region of integrated care and a financing plan. Based on the results and recommendation of the feasibility study the Dienststelle in cooperation with the local stakeholders and local and national politics will implement the different Core Features from the OptiMedis Model considering the local specificities of the German speaking Community.		

Adoption of Core Features from the South Denmark Region practice

The 6 NAs interested in transferring Core Features from the sole South Denmark Region practice (*Digital roadmap towards an integrated health care sector*), are mainly interested in the block 2 Core Features concerning additional solutions to support complex disease areas including Telemedicine and Digital solutions as Tele-psychiatry, Tele-rehabilitation or Tele-monitoring. Most NAs are interested in implementing two to three Core Features. Only one NA is interested in both, block 1 & 2, Core Features, willing to implement both regulatory framework (as agreements and protocols) as well as digital tools.

Almost all the Next Adopters aim to have an impact at a large scale (population of a province, a region or a country), but directly involving during the pilot project a sample or a little part of the entire population.

NEXT ADOPTER	Core Features from the South Region Denmark practice to be transferred	Sector and scale of the implementation
Italy - Regione Lombardia (LOMBARDIA)	2.2 Tele-psychiatry 2.4 Online physical rehabilitation	Lombardy Region: Local Healthcare Authority ATS Valpadana made up of three health hubs (ASST): Crema, Cremona and Mantua (775.273 inhabitants).
General description		
The project aims bringing psychiatric and rehabilitation services to users who usually can hardly access them due to the physical geographical distance to be covered to reach the closest hospital. The psychiatric service would allow to involve more easily users reluctant to have physical meetings, involving the access to crowded places such as hospitals. The autonomous use of an app involving videos and pain record in rehabilitation domain would allow to relieve crowded Hospitals.		

NEXT ADOPTER	Core Features from the South Region Denmark practice to be transferred	Sector and scale of the implementation
Latvia - Childrens Clinical University Hospital (CCUH)	1.1 Health Agreements 1.2 Messaging Standards 1.3 SAM:BO Agreement 2.1 TeleCOPD 2.2 Telepsychiatry 2.3 My Hospital	Children's University Hospital of Latvia: 359 000 children in Latvia; 70 000 patients annually in Emergency department (CCUH); 17 000 patients are being treated in Inpatient units of CCUH; 700 physicians and 600 of nursing staff in CCUH; 800 paediatricians in Latvia.
General description		
The project aims to equalize the quality of paediatricians services throughout Latvia developing a digital eligible ecosystem for children' s healthcare at national level. The digital eligible innovation ecosystem for children's healthcare will consist of following levels: children's health portal, patient portal, portal for professionals. First, it will develop a strategy on implementation of digital eligible ecosystem, then it will develop a protocol and recommendations on the introduction of telemedicine and digital services in Latvia that contributes to the transition to digitally-enable, integrated, children centred care in national level with special emphasis on sustainability.		

NEXT ADOPTER	Core Features from the South Region Denmark practice to be transferred	Sector and scale of the implementation
Spain - Consejería de Salud y Familias Junta de Andalucía (CSFJA) and Fundación Pública Andaluza Progreso y Salud (FPS)	2.1 TeleCOPD 2.6 The GERI Toolbox	Complex chronic patients in Andalusia (125.000 patients, approx.). A sample of 500 of these patients will be included in the Andalusian pilot. - Andalusian Health Service (SAS) in particular, at primary healthcare level.
General description		
The Andalusian local good practice will be based on the components Tele-COPD (CF1) and Geri-Toolbox (CF6) of the Danish good practice and will be aligned to the "Andalusian Comprehensive Healthcare Plan for Patients with Chronic Diseases", the "Andalusian Integrated Care Process 'Healthcare for Multimorbidity Patients'", the "Andalusian Comprehensive Care Plan" and the "Chronic Patients "Proactive Monitoring" in Primary Healthcare Plan. Thus, to improve the healthcare at home of complex chronic patients, a Centralised System for Proactive Follow-up (SCSP) that will allow to gather information from homecare professionals when attending CCPs at home will be developed and integrated within the corporate IT system (Diraya). The collected data will be uploaded to Diraya/Patient EHR. The platform will be a key element for healthcare professionals in the proactive and remote monitoring of chronic patients, by mean of the early identification of warning signs/signals, the adaptation of prescriptions, the anticipation of health problems, providing support to caregivers, avoiding unplanned inpatient episodes, etc. Besides, the Andalusian teleconsultation platform will also use to facilitate the communication between healthcare professionals (mainly between primary and hospital healthcare professionals) so it will be also included in the assessment. Phone-questionnaires and other elements will be used as a support in the proactive "proactive monitoring" process with a double purpose: - the early identification of information and/or warning signs/signals that need a quick response by the reference healthcare professionals. - To assess the therapeutic patient education to determine patient self-care ability and needs. In summary, the SCSP will facilitate the patient follow-up, will improve the continuity of care by healthcare professionals and improve patient's quality of life.		

NEXT ADOPTER	Core Features from the South Region Denmark practice to be transferred	Sector and scale of the implementation
Spain - Servicio Cántabro de Salud (SCS) and Instituto de Investigación Marqués de Valdecilla (IDIVAL)	2.2 Tele-psychiatry 2.4 Online physical rehabilitation 2.5 Digital Health Centre	All kind of patients living in Cantabria. Mainly • Outpatients with lower limb fractures living in Marques de Valdecilla University hospital health area. • Elderly people in nursing homes in Santander Health Area. Cantabria. Spain
General description		
Regarding each of sub-initiative inside of the Strategy for the digitization of health services in Cantabria; the Cantabria's Online physical rehabilitation programme is a video-directed tele rehabilitation home program for patients with lower limb fractures with the objectives of early mobilization, greater patient participation, better health outcomes and reduction of direct and indirect costs. It involves a paradigm shift and a new form of care that requires training of patients and professionals and integration with electronic medical records, but short-term benefits are expected. Secondly, The Cantabrian School of patients is providing tools to improve the patient empowerment through health promotion and disease prevention. This is e.g. done through workshops, courses, small texts, guidance and counselling on a healthy lifestyle. The focus is on providing tools, motivation and support for self-managing a change of their lifestyle and routines. Cantabrian Patients' School has also created network possibilities for citizens, associations and healthcare professionals, as well as provide knowledge to health organizations in the civil society. A lot of nurses, dieticians, physiotherapists and doctors are collaborating in the Patients' School. The principal activity of the Cantabrian Patients' School is to develop and integrate digital solutions to improve the patient empowerment. Under this vision, several subprojects are unfolded (Responsible Care Workshop, online self-management program in population with chronic disease, Meeting space, Digital skills course, Online space for consultations). Patients can join from home, where they can see pre-recorded information, participate in webinars gain knowledge by reading short texts, and chat with both health care professionals and other patients. Finally, online Tele-psychogeriatric program aimed at the health care of the elderly with cognitive-functional impairment and mental illness institutionalized in nursing homes, with the objectives of facilitating accessibility to specialized hospital programs without the need for travel, with care focused on the patient and their environment in nursing homes, to obtain an improvement in the symptomatic control of psychogeriatric pathologies, better health results and reduction of direct and indirect costs. This modality of online service provision includes a wide range of care services for the elderly with institutionalized mental illness, from evaluation and diagnosis to pharmacological and psychosocial interventions, and monitoring and care in the residence, development of clinical care plans, case management, crisis intervention and severe behavioral disturbances, neuropsychological tests, liaison services for other medical specialties, nursing care, etc. Paradigm shift in the health care system, centered on the patient with chronic psychogeriatric mental illness, based on the development of		

electronic medical records, and the use of new technologies from which short-term benefits are expected.

NEXT ADOPTER	Core Features from the South Region Denmark practice to be transferred	Sector and scale of the implementation
Spain - Gerencia Regional de Salud de Castilla y León (SACYL)	1.1 Improving socio-health coordination and Telehealth care protocols 2.2 Tele-psychiatry (not in the SD) 2.6 Improving communication between levels of care	Regional Health System: from primary care to hospitals: the entire population of the Castilla y León region (2.3 M people) depending on the healthcare need (11 health areas and 249 basic health zones).
General description		
Implement new forms of communication between primary care and hospitals, through the technological modernization of the healthcare system, applicable to the field of dermatology and care of chronic multi-pathological patients, supported by organisational innovation and training, especially in rural areas with the aim to: - reduce the waiting time for dermatology consultations from primary care and avoid unnecessary patient trips to receive hospital specialist care; - implement teleconsultation of pluripathological chronic patients with the continuity of care unit.		

NEXT ADOPTER	Core Features from the South Region Denmark practice to be transferred	Sector and scale of the implementation
Spain - Servicio Murciano de Salud (SMS) and Fundación para la Formación e Investigación sanitarias de la región de Murcia (FFIS)	2.4 Online Physical Rehabilitation 2.5: Digital Health Centre	Rehabilitation Service and Physiotherapy Service of the Morales Messenger Hospital, Murcia, Spain. Patients who come to the Rehabilitation Service for a physiotherapist treatment.
General description		
The project aims to reinforce the rehabilitation treatment of patients who attend the physiotherapy service for post-surgical or post-traumatic rehabilitation through a digital health project with a more flexible approach to rehabilitation, maintaining personal contact with the professional, empowering the patient and maintaining a personalized follow-up. The project will be focused on the rehabilitation treatment with the development of activities at citizens' homes, offering greater flexibility in the rehabilitation process, both for health professionals and for patients by improving collaboration between sectors and achieving greater accessibility of person-cantered comprehensive care data and reports and achieving patient empowerment. As well as		

facilitating the obtaining of information on pro indicators that patients register and that allows to the professional the transparency of the data and the respective monitoring and evaluation accessible to all the actors.

Adoption of Core Features from different practices (Mix and Match)

Four NAs chose a Mix and Match approach, i.e., to adopt Core Features from different good practices: 2 NAs mixed the Basque practice with the South Denmark Region practice; 1 the Basque good practice with the Optimedis practice, while the fourth NA mixed elements of the Catalan practice with the Optimedis practice.

In all four cases the implementation will take place on a large scale: provincial (or country) regional or national.

NEXT ADOPTER	Core Features of oGPs to be transferred into the Region North Denmark practice	Sector and scale of the implementation
Denmark - North Denmark Region (RND)	Basque practice: 1.1: Stratification Data extraction and construction of Dashboards 1.2: Classification of patients 1.3: Stratification in the framework contract OptiMedis practice: 5.1: Potential analysis tool 5.2: Performance dashboards	The North Jutland region has 590,439 inhabitants in 2021. The project will have a special focus on active diabetes patients in the hospital (5,627 active based on the current patient status). The project will be implemented within the regional health system - possibly in collaboration with selected municipalities
General description		
The North Jutland region is already come a long way with their strategic use of data. The reason for joining JADECARE is to be inspired to further develop our own solutions with the mix & match approach. The purpose has therefore not been to implement a complete or parts of IT systems from oGP, but primarily to learn from positive experiences from other EU countries. The first aim is to focus on the diabetic patients (5.627 active patients): to realize Steno Diabetes Center North Jutland's vision; to increase quality of life and life expectancy for citizens with diabetes; to create a coherent diabetes treatment close to the citizen; to slow down the growth of new cases of diabetes. This must include happen based on strategic use of data and data dashboard in the field of diabetes. The second aim, focused on the entire population in North Jutland (590,439 inhabitants, 11 municipalities) is to ensure a new and more data-driven approach to the health field and new knowledge and methods are needed to focus on the entire population group and not only on active patient groups in the hospital.		

NEXT ADOPTER	Core Features of oGPs to be transferred into the Croation Institute of Public Health (CIPH) practice	Sector and scale of the implementation
Croatia - Croatian Institute of Public Health (CIPH)	Basque practice: 2.2 Integrated care - Deployment of integrated communication and information systems 3.1 Patient Empowerment- Deployment of a School of Health 3.2 Patient Empowerment - Empowerment programs for chronic and/or multimorbid patients South Denmark Region practice: 1.3 SAM:BO Agreement 1.1 Health Agreements 1.2 Messaging Standards 2.5 The Digital Health Centre	Patients of the Croatian National Health System with leading chronic non-communicable diseases (COPD, hypertension, diabetes mellitus, multimorbidity).
General description		
The project aims to improve health and quality of life of the patients with leading chronic non-communicable diseases (NCDs) (COPD, hypertension, diabetes mellitus etc) and enhance the health system quality by enabling better communication for patients and their GPs. Target is on digital communication and education by providing user friendly materials, online education and digital communication with healthcare providers and other health professionals included in the care of patients NCDs. The project has to objectives: - The promotion of central e-health platform for both GPs and patients (CEZIH) -"Portal zdravlje" and disease management materials provision; - To enhance input of information regarding NCDs on existing digital platform (digital health centre) and broaden the extent of communication between health care providers and patients.		

NEXT ADOPTER	Core Features of oGPs to be transferred into the Estonia Viljandi Hospital (VH) practice	Sector and scale of the implementation
Estonia - Viljandi Hospital (VH)	Catalan practice: 1.1 Assessment of transferability, and identification of steps for adoption, according to intellectual property rules, of the Catalan population-based risk stratification tool into the ecosystem of the Next Adopter. 1.2 Health data management strategies OptiMedis practice: 1.1 Identifying current contractual arrangements and assessing possibilities for value-based contracting. 1.3. Designing the valued-based payment framework. 1.4 Constructing the analytical model to execute the contract.	Viljandi County (~50 000 inhabitants)
General description		
The project aims to design a contracting and payment framework approach based on OptiMedis that includes Catalonian AMG risk stratification model. Generating predictive model is needed in order to strengthen population health management and provide better-tailored services for risk groups. Contracting and funding models developed are lined with person-centred and integrated services. .The main outcome will be to improve the results of the health and quality of life of the population and increase the efficiency of the healthcare system through better planning and use of resources		

NEXT ADOPTER	Core Features of oGPs to be transferred into the Czech Republic University Hospital Olomouc (UHO) practice	Sector and scale of the implementation
Czech Republic- University Hospital Olomouc (UHO)	Basque practice: 2.3 Coordination of care and communication between health care providers South Denmark Region practice: 2.2 Telepsychiatry	Olomouc region (UHO, ambulances, social care facilities, Jesenik hospital)
General description		
An online tele-psychiatry/psychology program focused on the health care of a select group of patients, designed to facilitate access to specialized care without the need for travel. Through patient-centered care and a patient-centered environment, better symptom control, diagnosis of psychiatric disorders, improved health outcomes, and reduced direct and indirect costs can be achieved. This mode of online service delivery encompasses a wide range of care services, from assessment and diagnosis to pharmacological and psychosocial interventions, follow-up and residential care, and the development of clinical care plans. Sharing documentation will increase collaboration and coordination among health care providers. The outcome sets the stage for the development and expansion of case management, crisis intervention, liaison services for other medical specialties, nursing care, etc. Sharing medical records is also a relief for social service facilities, especially homes for the elderly, for caregivers, reducing the number of trips and paper transfers between patients and physicians. Sharing documentation will facilitate better delivery of health services to patients who are referred to UHOs from other facilities for specialist examinations, or who attend here while receiving outpatient (ambulatory) care.		

The detailed description of the Local Good Practices and the Action Plans are included in the Annex, "JADECARE Local Good Practices and Action Plans".

5. Conclusions

Twenty-one so-called "Next Adopters" from fourteen European countries have decided, as part of the JADECARE Joint Action, to transfer Core Features of 4 original Good Practices related to digital enabled integrated person-centred care to their local sites. The pre-implementation phase of the project, which ended in September 2021, was crucial for the 21 partners to:

1. study the 4 original good practices and the specific Core Features;
2. define the purpose of the implementation in accordance with the Next Adopters' strategies, needs, expectations and level of maturity;
3. analyse the local site situation, highlighting strengths, weaknesses, risks and opportunities (SWOT analysis);
4. design the local good practice (to be) and consequently, set SMART goals for each of the defined useful actions to be taken, the resources and time required and the key performance indicators relevant for monitoring and evaluating the status of the implementation.

Specifically, this last part, called "Local Good Practice and Action Plan" was supported both by a specific, structured methodology to be carried out by the Next Adopters, and by periodic meetings between the Next Adopters and the experts of the 4 original Good Practices, who provided a real "tailored advice and guidance" service to each Next Adopter Working Group.

The methodology carried out by the Next Adopters and the tailored support provided, included the following steps:

- to identify local policies, strategies and interventions;
- to define the target population and the setting(s) for the LGP implementation;
- to specify the general aim to be achieved, that motivates the LGP;
- to list the expected outcomes, the local Core Features (LCF) and their components as well as the inputs to the local good practice;
- to ensure the logic sequence of the process (first the input, then the LCFs and consequently the outcomes);
- to describe the LGP and summarize it in one sentence.

After this exercise, the Next Adopters defined the Local Action Plan (LAP) with the following methodology:

- set a SMART objective for each of the LCFs described in the LGP;
- to describe the specific activities to be implemented (What);
- to define the actors that will (Who) be involved in each activity;
- to define the resources needed;
- to define the setting(s) where the activities will be implemented (where);
- to define the timeframe for the actions;
- to specify the Key Performance Indicators (measure) to assess the experience, process, outputs and outcomes during the implementation

The transfer strategy of JADECARE allowed Next Adopters to adopt a "one-to-one approach", where each Next Adopter targets only one oGP and tries to implement all or some of its CFs, or a "Mix and Match approach", where the Next Adopters chooses CFs from different oGPs and try to match them in a single local good practice.

17 out of 21 Next Adopters chose the "one-to-one approach" while the other 4 chose a Mix and Match approach. Each of them is going to implement an average of five CFs from the oGPs:

- In the Basque practice, the most selected block by Next Adopters is the one of "Risk Stratification".

- In the Catalan practice, the highest interest of Next Adopters is on “Health risk assessment: population-based approach”.
- In the OptiMedis practice, the Next Adopters are more interested in the “Shared savings contract with reimbursement/commissioning organizations”.
- In the South Denmark Region practice, the highest interest of Next Adopters is on “Cross sectorial digital communication: additional solutions to support complex disease areas”.

Despite the support received and the methodology provided, Next Adopters faced some difficulties and barriers during the pre-implementation phase: the most outstanding one is related to the Covid19 pandemic restrictions, not allowing face-to-face meetings and local site visits. Other difficulties reported were found regarding the recruiting and staffing of the Next Adopter Working group (NAWG), the reluctance to change and lack of time and resources to be dedicated to the project implementation. Further reported barriers from Next Adopters were related to legal and regulatory framework, the existence of gaps in the skills of the health workforce and patients/citizens, the possible lack of integration between JADECARE local objectives and institutional local strategies and, in some cases, the not easy or lack of information exchange between oGPs and NAs.

Nevertheless, some of those aspects could be considered, in a different way, namely, as facilitating factors: for example, the Covid-19 pandemic has also been an opportunity to speed up the change and break some reluctances, especially on using digital tools among the patients and health professionals. Other reported facilitators by the NAs, regarding the NAWGs were the good relationship among the participants, the fruitful communication and working environment, the enthusiasm for change and the multidisciplinarity of the group. Furthermore, most of the NAs highlighted the key role played by the pre-existing and favourable conditions in their sites that enabled to put the seed for innovation, as well as the high commitment from the management.

Finally, all the NAs acknowledged the added value and the facilitating role played by the support, advice and suggestions provided by the oGPs leaders and experts and the pre-implementation methodology provided by the JADECARE team.

As a conclusion JADECARE is considered as a booster of digital innovation at the local level throughout Europe.

Annex. Local Good Practices and Action Plans

Local Good Practices and Action Plans derived from the Basque practice

***Name of the Next Adopter*: ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP (ACSS)**

LOCAL GOOD PRACTICE ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP (ACSS)

Title of the Local Good Practice: Implementation of population risk stratification in Portugal and improvement of continuity of care.

Target population: Pilot in 5 providers (1.004.546 inhabitants).

Setting(s): National Health Service. In three regions of the country (Norte, Centro e Alentejo) that are different in population and density.

Main aim: Improve citizens' quality of life, continuity of care and system efficiency, based on risk stratification.

Outcomes: Population groups and their needs identified and risk stratified; Communication among professionals facilitated; Timely and adequate provision of care, according to the needs; Adjusting financing and commissioning to the population needs; Health system sustainability.

Local Core Features and their Components:

To develop a population approach based on risk stratification

- Training on risk stratification;
- Implementation of the risk stratification instrument;
- Data extraction and processing mechanisms;
- Classification and stratification of the population;
- Identification of needs;
- Dashboards for data visualization and analysis;
- Explore other possible uses for the stratification outputs that could come up after the implementation of the risk stratification and that are not known at the moment.

Propose changes to commissioning and financing risk adjusted

- Local health Units Risk adjusted financing;
- Indicators to include in the commissioning.

Develop instruments that facilitate the coordination of care and communication among professionals

- Shared individual care plan for patients with multimorbidity;
- New Care pathways for the main chronic diseases (multimorbidity, COPD, CHF, diabetes);
- Programs targeted at different risk strata (case manager, expansion of the discharge management teams, reference internist).

Integrate Information System in the electronic health record:

- Shared electronic health record as central point of the clinical process;
- Integration of the individual plan of care in the electronic health record;
- Integration of the care pathways in the electronic health record;
- Area for the management of the chronic prescription.

Inputs: Human resources (health and Information Systems, local managers); Local leaders; Investment; Information systems; Stratification instrument; Training; Citizens; Decision makers

General description: Implementation of risk stratification as a basis for identifying needs by population groups that will allow the adaptation of care models, using information and communication systems, as well as financing and commissioning as facilitators.

Local Core Feature 1: Develop a population approach based on risk stratification.

Local Core Feature 2: Propose changes to the commissioning and financing based on population risk stratification.

Local Core Feature 3: Develop instruments that facilitate the coordination of care and communication among professionals.

Local Core Feature 4: Integrate the Information Systems in the Electronic Health Record.

ACTION PLAN ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP (ACSS)

Related original Good Practices and their Core Feature (s): Basque oGP CF 1.1, 1.2, 1.3, 2.2 and 2.3

Local Core Feature 1: Develop a population risk stratification approach.

- *SMART objective*: By the end of JADECARE (December 2022), ACSS will have defined a national approach for population risk stratification that will contribute to a more people-centred system, supporting clinical and management decision-making, with an impact on the sustainability of the NHS.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Training of healthcare professionals on risk stratification	National School of Public Health (ENSP); 3M or IASIST or ACSS	Professors Specialists on the dashboards of the chosen instrument Study Visits to the Basque Country oGP	The National School of Public Health, ACSS and/or IASIST or 3M will train professionals from the 5 pilots	2 months Starting in December 2021	Nº of training sessions Nº and profile of the trained professionals
Decide the risk stratification instrument to be implemented	ACSS	ACSS	The instrument will be implemented in the 5 pilots	1 month Starting in November 2021	
Configure data extraction and processing mechanisms	ACSS; 3M or IASIST or ACSS	ACSS experts	This will be done at the central level (ACSS)	6 months Starting in February 2022	Database creation (Y/N) % of technical execution completed % of functional execution completed

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Classify and stratify the population	ACSS Pilots	ACSS experts	Pilot project Local health unit Litoral Alentejano (ULSLA) and Local health unit Alto Minho (ULSAM)	1 month Starting in November 2022	Nº of criteria used in stratification Population stratified (Y/N)
Design and adapt the dashboards	ACSS Pilots ENSP	ACSS experts Primary care and hospital doctors Primary care and hospital nurses Managers Other professionals	Pilot project Local health unit Litoral Alentejano (ULSLA) and Local health unit Alto Minho (ULSAM)	3 months Strating in March 2022	% completeness
Explore other purposes for which stratification can be used	ACSS; Pilots; ENSP; SPMS		Pilot project at Local health unit Litoral Alentejano (ULSLA) and Local health unit Alto Minho (ULSAM)	12 months Starting in November 2021	List of other purposes for which stratification can be used

Local Core Feature 2: Propose changes to the commissioning and financing risk adjusted.

- *SMART objective*: By the end of JADECARE (December 2022), ACSS will have defined a proposal to risk adjust financing and commissioning.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Test several scenarios for the risk adjusted financing in the Local health units	ACSS; Local health units	Professionals from ACSS Risk stratification instrument	Pilot project Local health unit Litoral Alentejano	6 months Starting in March 2022	Proposal for the Local health units risk adjusted financing (Y/N)
Create a group to define measurable indicators for risk adjusted performance assessment, to promote integration of care	ACSS; ENSP; Managers from primary care and hospitals	Several professionals	Pilot project Local health unit Litoral Alentejano	1 month Starting December 2022	Nº and profile of the professionals involved
Define measurable indicators for risk adjusted performance assessment, to promote integration of care	ACSS; ENSP; Managers from primary care and hospitals	Several professionals	Pilot project Local health unit Litoral Alentejano	9 months Starting in January 2022	Nº of measurable indicators for risk adjusted performance assessment, to promote integration of care

Local Core Feature 3: Develop instruments that facilitate the coordination of care and communication among professionals.

- *SMART objective*: By the end of JADECARE (December 2022), the group will have designed a set of instruments to facilitate the coordination of care and communication among professionals, contributing to more integrated and patient-centred care.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create a group to design the digital shared Individual Care Plan (PIC) for patients with multi-morbidity	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS; Patients	Primary care and hospital doctors Primary care and hospital nurses Professionals from the social sector Shared services of the Ministry of Health (SPMS) Patients Input from the Basque oGP	Pilot project ACeS Porto Oriental, Hospital da Figueira da Foz (HDFF) and Local Health Unit Litoral Alentejano (ULSLA)	1 month Starting in November 2021	Nº and profile of the healthcare professionals involved in the design of the individual care plan
Design the digital shared individual care plan for patients with multimorbidity	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS; Patients	Professionals from the different levels of care Study visits to Basque Country oGP	Pilot project ACeS Porto Oriental, Hospital da Figueira da Foz (HDFF) and Local Health Unit Litoral Alentejano (ULSLA)	3 months Starting in January 2022	Proposal for the individual care plan (Y/N) % of technical completeness
Create groups to define care pathways for each chronic disease – multimorbidity, CHF, Diabetes, COPD	Primary care and hospital doctors; Primary care and hospital nurses;	Professionals from the different levels of care	Pilot project ACeS Póvoa Varzim/Vila do Conde (Diabetes)	1 month Starting in November 2021	Nº and profile of the professionals involved in the design of the multimorbidity care pathway

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
	Professionals from the social sector; SPMS; Patients; DGS	Basque Country oGP clinical pathways	Pilot project ACeS Porto Oriental Pilot project Hospital da Figueira da Foz (HDFF) (COPD and CHF) Pilot project Local Health Unit Litoral Alentejano (ULSLA) (multimorbidity and CHF)		Nº and profile of the professionals involved in the design of the CHF care pathway Nº and profile of the professionals involved in the design of the diabetes care pathway Nº and profile of the professionals involved in the design of the COPD care pathway
Define care pathways for each chronic disease – multimorbidity, CHF, Diabetes, COPD	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS; Patients; DGS	Professionals from the different levels of care Basque Country oGP clinical pathways	Pilot project ACeS Póvoa Varzim/Vila do Conde (Diabetes) Pilot project ACeS Porto Oriental Pilot project Hospital da Figueira da Foz (HDFF) (COPD and CHF) Pilot project Local Health Unit Litoral Alentejano (ULSLA) (multimorbidity and CHF)	9 months Starting in December 2021	Proposal for multimorbidity care pathway (Y/N) Proposal for the CHF care pathway (Y/N) Proposal for the diabetes care pathway (Y/N) Proposal for the COPD care pathway (Y/N)
Create groups to define programs for the different risk strata (case manager, expansion of discharge	Primary care and hospital doctors; Primary care and hospital nurses;	Professionals from the different levels of care	Pilot project ACeS Porto Oriental	1 month Starting in November 2021	Nº and profile of the professionals involved in the design of the case management program

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
management teams role, reference internist)	Professionals from the social sector; SPMS		Pilot project Local Health Unit Litoral Alentejano (ULSLA)		Nº and profile of the professionals involved in the design of the expansion of the discharge management teams roles Nº and profile of the professionals involved in the design of the role of the reference internist
Define programs for the different risk strata (case manager, expansion of discharge management teams role, reference internist)	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS	Professionals from the different levels of care Basque Country oGP study visits Session of liason nurse from the Basque Country	Pilot project ACeS Porto Oriental Pilot project Local Health Unit Litoral Alentejano (ULSLA)	12 months Starting in December 2021	Nº of criteria for admission in each program Programs final proposal (Y/N)

Local Core Feature 4: Integrate the information systems in the electronic health record.

- *SMART objective*: By the end of JADECARE (December 2022), the ACSS will have defined an action plan, to be implemented by the SPMS, for the remodelling of the single shared electronic health record, including the integration of the designed instruments, which will facilitate the coordination of care and communication among professionals, with an impact on the continuity of care and sustainability of the health system.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create a group to define the set of additional information to be shared in the electronic health record (for example, prescriptions, assessment scales, medical tests)	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; Shared Services of the Ministry of Health (SPMS) – Tech professionals	Information System experts Professionals of the different levels of care	Pilot project ACeS Baixo mondego Pilot Project Hospital da Figueira da Foz (HDFF) Pilot project Local Health Unit Litoral Alentejano (ULSLA)	1 month Starting in November 2021	Nº and profile of the professionals involved in the definition of the set of information to be shared in the electronic health record
Define the set of additional information to be shared in the electronic health record (for example, prescriptions, assessment scales, medical tests)	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS	Information System experts Professionals of the different levels of care Basque Country oGP study visit	Pilot project ACeS Baixo Mondego Pilot Project Hospital da Figueira da Foz (HDFF) Pilot project Local Health Unit Litoral Alentejano (ULSLA)	4 months Starting in December 2021	Nº of items to be shared in the electronic health record (Y/N)
Create a group to design an area for the management of chronic medicines based on the dosage guide	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS	Information System experts	Pilot project ACeS Baixo Mondego	1 month Starting in November 2021	Nº and profile of the professionals involved

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
		Professionals from different levels of care			
Design an electronic chart for the management of chronic medicines based on the dosage guide	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS	Information System experts Professionals from different levels of care	Pilot project ACeS Baixo Mondego	4 months Starting in December 2021	Proposal for an area for the management of chronic medicines (Y/N)
Define the Plan for the implementation of the electronic health record as the core of the patient process, including the instruments designed in the LCF3	Primary care and hospital doctors; Primary care and hospital nurses; Professionals from the social sector; SPMS	Information System experts Professionals from the different levels of care Basque Country oGP study visit	Pilot project ACeS Baixo Mondego Pilot project Local Health Unit Litoral Alentejano (ULSLA)	6 months Starting in December 2021	Implementation Plan (Y/N) Nº of goals covered by the plan

***Name of the Next Adopter*: AGENZIA REGIONALE DI SANITÀ (TOSCANA)**

LOCAL GOOD PRACTICE AGENZIA REGIONALE DI SANITÀ (TOSCANA)

Title of the Local Good Practice: "Piana di Lucca" District Zone's approach to taking care of complex patients by integrating hospital and primary care.

Target population: Complex patients with multi-chronicity and management difficulties (6.000 people).

Setting(s): "Piana di Lucca" District Zone.

Main aim: Identifying the population of complex patients and improving their care through enhanced integration and proactivity of primary and hospital care.

Outcomes: Identification of the complex patient population; Enabling communication among healthcare professionals; Providing timely and integrated care to the population of complex patients; Guaranteeing the continuity of complex patients' care.

Local Core Features and their Components:

Developing a population risk stratification process (LCF1)

- Identification of criteria for local stratification model.
- Training for health personnel who will perform and benefit from the results of population stratification.
- Identification by GPs of complex patients utilizing the identified criteria.
- Utilization of ACG system to support the stratification process providing provided that the local privacy issue is resolved.

Enhancing proactivity and integration of care pathways for complex patients with multi-chronicity and management difficulties (LCF2).

- Developing new roles of primary and hospital care professionals in an integrated care perspective.
- Fostering communication and shared decision-making within multi-disciplinary team through sharing of Personalized Care Plan.
- Adaptation of existing ICT tools to promote integrated care.
- Enrolment of the identified complex patients and acquisition of informed consent.

Inputs: Funding; Time needed; Willingness of primary and hospital care professionals to participate; Availability of enabling rules for population stratification; Technical assistance for integration of ICT systems.

General description: "Piana di Lucca" District Zone's approach proposes a variety of interventions promoting enhanced integration and proactivity of care for complex patients. These interventions include identifying chronic patients through a stratification process and fostering communication and sharing of care plans among health professionals. Our strategy takes place in a context where

the increasing number of patients with multi-chronicity and management difficulties has become a public health priority, and, because of this, our approach is aligned with the National Chronicity Plan and the Health Care Initiative Model. The practice represents an opportunity to integrate and coordinate the efforts for providing timely and integrated care and it is built on the "Basque health strategy in ageing and chronicity: integrated care". Factors that might have a negative impact on our objectives are non-participation of clinical professionals in the process, impediments due to privacy issues and difficulties in tackling communication obstacles.

Local Core Feature 1: Developing a population stratification process

Local Core Feature 2: Enhancing proactivity and integration of care pathways for complex patients with multi-chronicity and management difficulties

ACTION PLAN AGENZIA REGIONALE DI SANITÀ (TOSCANA)

Related original Good Practices and their Core Feature (s): Basque oGP; CF 1.1, 1.2 and 2.3.

Local Core Feature 1: Developing a population stratification process.

- *SMART objective*: "Piana di Lucca" District Zone will develop a local stratification system to support identification of complex patients.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create, within the NAWG, a Specific Working Group (SWG) for the local stratification model	Members of the NAWG: 2 GPs-AFT Coordinators (Functional Territorial Aggregation); 1 Coordinator of Internal Medicine Unit; 1 Coordinator of Primary Care Unit; 1 Coordinator of Territorial Nursing Care; 1 Director of "Piana di Lucca" District; 1 GP and ARS Tuscany consultant; 1 Coordinator of Citizen Participation Committee; 1 Project Scientific Coordinator; 1 Project Manager.	Experts	Tuscany Region	1-15 November 2021 (fortnight)	SWG formed (Y/N) N° and profile of the members
Literature review for identifying complex patients criteria	ARS Tuscany "Documentation Center"	Time	ARS Tuscany	1-15 November 2021 (fortnight)	N° of articles collected N° of articles selected N° of databases consulted

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Establish criteria and methods for GPs to identify complex patients using the outpatient EHR	SWG	Time Stratification criteria used in the ACG System Available literature	"Piana di Lucca" District Zone	15 November -15 December 2021 (1 month)	N° of SWG meetings N° and type of criteria to be used List of criteria available (Y/N) Type of identification method selected
GPs identification, aiming at at least 10 GPs identified	Members of the NAWG: 2 GPs-AFT Coordinators; Director of "Piana di Lucca" District	Time	"Piana di Lucca" District Zone	1 November–15 December 2021 (1 and a half months)	N° of GPs identified N° of GPs identified for each AFT
Establish procedures and provide the assistants to the GPs	Members of the NAWG: 2 GPs-AFT Coordinators Director of "Piana di Lucca" District 2 administrative officers for legal and financial affairs	Assistants of the GPs available Financial resources	"Piana di Lucca" District Zone	1 November–15 December 2021 (for definition: 1 and a half months) 1 January-15 December 2022 (for delivery: 11 and a half months)	N° of assistants Descriptive document about the incentive system (Y/N) Incentive system implemented (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Train all identified GPs on the methods to be used to identify complex patients	SWG	Time	"Piana di Lucca" District Zone	15 December-31 December 2021 (fortnight)	N° of trainings performed N° hours spent for training N° of identified GPs trained
Identify at least 100 complex patients and include them in the "ICP (Individual Care Plan) Folder" of the outpatient EHR	Identified GPs	Time	"Piana di Lucca" District Zone	1 January-28 February 2022 (2 months)	N° of patients identified N° of patient lists completed
Support and monitoring activities	Members of the NAWG: Project Scientific Coordinator Project Manager	Time	"Piana di Lucca" District Zone	1 November 2021-31 December 2022 (14 months)	Types of support and monitoring activities performed Level of perceived satisfaction with support activities Report about support and monitoring activities available (Y/N)
Use the ACG System to support the local stratification process	SWG	Availability of privacy policies that allow ACG to be used for clinical purposes	Tuscany Region	1 July-15 December 2022 (5 and a half months)	Use of the ACG System to support data acquired with the local stratification model (Y/N) N° of cases where it is used and % of agreement

Local Core Feature 2: Enhancing proactivity and integration of care pathways for complex patients with multi-chronicity and management difficulties.

- *SMART objective*: "Piana di Lucca" District Zone will foster communication among healthcare providers and promote the sharing of individual care plans tailored to the needs of complex patients.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Define modalities for nurse involvement to encourage adherence to the project	Members of the NAWG: 1 Coordinator of Territorial Nursing Care; Coordinators of Nursing Units	Time	"Piana di Lucca" District Zone	1 November–15 December 2021 (1 and a half months)	N° and type of selected modalities Descriptive document about modalities available (Y/N)
Define modalities for specialists involvement to encourage adherence to the project	Members of the NAWG: 1Coordinator of Internal Medicine Unit; 1 Coordinator of Primary Care Unit; 1 Coordinator of specialists-AFT; 1 Coordinators of Medical Specialist Units (Hospital and Outpatient specialists).	Time	"Piana di Lucca" District Zone	1 November–15 December 2021 (1 and a half months)	N° and type of selected modalities Descriptive document about modalities available (Y/N)
Define the roles and functioning of the integrated clinical network	All members of the NAWG	Time	"Piana di Lucca" District Zone	1 November–15 December 2021 (1 and a half months)	Descriptive document about roles and functioning available (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Define the multidimensional assessment system for complex patients and follow-up tools	Members of the NAWG: 1 Coordinator of Territorial Nursing Care; 1 Coordinator of Citizen Participation Committee; 1 GP-AFT Coordinator; Coordinator of Primary Care Unit	Assessment scales Follow-up questionnaires available Time	ARS Tuscany	1 November–15 December 2021 (1 and a half months)	N° and type of assessment tools N° and type of follow up tools
Identification of the professionals within integrated and structured clinical network including GPs, Family and Community nurses, Specialists.	Members of the NAWG: 2 GPs-AFT Coordinators, 1 Coordinator of Territorial Nursing Care, 1Coordinator of Internal Medicine Unit, 1Coordinator of specialists-AFT.	Willingness of professionals	"Piana di Lucca" District Zone	15 December 2021-31 January 2022 (1 and a half months)	Document describing the composition of the integrated clinical network reporting N° of GPs N° of Family and Community Nurses ° and type of Specialists
Conduction of Consensus Conference upon the roles and functioning of the integrated clinical network to multiprofessional teams	Members of the NAWG: 2 GPs-AFT Coordinators; 1 Coordinator of Territorial Nursing Care; 1 Coordinator of Internal Medicine Unit; 1 Coordinator of specialists-AFT.	Time Multiprofessional teams identified	"Piana di Lucca" District Zone	15 December 2021–31 January 2022 (1 and a half months)	N° of meetings performed N° of hours spent for meetings N° of professionals attended

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Adaptation of outpatient EHR for ICP management and teleconsultation platform use	ICT Experts Specific companies	Time Availability of tools for ICP management Availability of the regional teleconsultation platform	"Piana di Lucca" District Zone	1 November–31 December 2021 (for ICP management: 2 months) 1 November 2021-31 Jan 2022 (for teleconsultation platform: 3 months)	ICP tool activated in the outpatient EHR (Y/N) Regional teleconsultation platform linked to the outpatient EHR (Y/N)
Definition of informed consent for enrolment of complex patients	Experts administrative officers for legal affairs	Time	ARS Tuscany	1-15 November 2021 (fortnight)	Informed consent defined (Y/N)
Enrolment of at least 100 complex patients previously identified by GPs and signing of informed consent	Identified GPs	Time GPs assistants available Informed consent defined	"Piana di Lucca" District Zone	1 February–31 March 2022 (2 months)	N° of complex patients enrolled N° of informed consents signed

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Multidimensional assessment of enrolled complex patients	Identified GPs Identified Family and Community nurses	Time Multidimensional assessment scales defined	"Piana di Lucca" District Zone	1 February-30 April 2022 (3 months)	N° of complete multidimensional assessments performed
Definition of a "medical ICP" and "nursing ICP" and sharing with multiprofessional teams	Multiprofessional team (GPs, nurses, specialists)	ICT tools Time	"Piana di Lucca" District Zone	1 February-30 April 2022 (3 months)	N° of ICPs defined and shared
Development of an integrated software for the management of medical and nursing ICPs	ICT experts Specific companies	ICT tools Time Financial resources	"Piana di Lucca" District Zone	1 July-15 December 2022 (5 and a half months)	Unified software for the management of medical and nursing ICPs implemented (Y/N)
Periodic telephone, outpatient and/or home-based follow-up for complex patients	Identified Family and Community nurses	Time Follow-up questionnaires defined	"Piana di Lucca" District Zone	1 April-15 December 2022 (8 and a half months)	N° of follow-up activities performed for each patient Monitoring of the "Care intensity coefficient" (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Periodic sharing and review of ICPs	Multiprofessional team (GPs, nurses, specialists)	Time ICT tools	"Piana di Lucca" District Zone	1 April-15 December 2022 (8 and a half months)	N° of ICPs reviewed N° of times each ICP has been adjusted
Support and monitoring activities	Members of the NAWG: 1 Project Scientific Coordinator; 1 Project Manager	Time	"Piana di Lucca" District Zone	1 November 2021-31 December 2022 (14 months)	Types of support and monitoring activities performed Level of perceived satisfaction with support activities Report about support and monitoring activities available (Y/N)

***Name of the Next Adopter*: ARISTOTELIO PANEPISTIMIO THESSALONIKIS (AUTH)**

LOCAL GOOD PRACTICE ARISTOTELIO PANEPISTIMIO THESSALONIKIS (AUTH)

Title of the Local Good Practice: Greece's approach on patient classification and patient empowerment.

Target population: 2000,

Setting(s): Hippokration General Hospital; AHEPA General University Hospital, Thessaloniki,

Main aim: Empower the population in order to improve their quality of life and prevent avoidable emergency room visits reducing unnecessary costs. Advance patients' classification through ACG system in order to increase the quality and effectiveness of the healthcare system. A digitally enabled integrated care approach will facilitate patient classification and increase patient and caregiver empowerment. The approach focuses on classification of patients, empowerment of patients and caregivers and digitally enabled integrated care.

Outcomes: Provide timely and appropriate care to the population based on their care needs; Empower patients and caregivers in chronic care and promote symptoms self-management; Enable communication among healthcare professionals and with patients; Inform patients on the available care pathways; Enhance empathy of medical professionals; Inform patients and medical professionals on their rights and obligations in health delivery.

Local Core Features and their Components:

Classify a large part of general population based on their medical data (LCF)

- Criteria for local classification model
- Data extraction and processing mechanisms

Empower patients and caregivers in chronic care (LCF)

- Create a web application along with a mobile app which, through interactive scenarios, will inform patients and caregivers about chronic conditions, symptoms management and medical education
- Inform the population on the available care pathways, promote inclusion in the health system and inform them about their rights and obligations

Enhance empathy on medical professionals (LCF)

- Use virtual reality equipment to create scenarios promoting empathy
- Inform medical professionals on patients' rights and obligations in healthcare

Inputs: Funding; IT Staff; Program managers; Decision makers; Alignment of policy makers; Training and technical assistance; IT systems; Health professionals; Patients' data; Patients; Caregivers.

General description: Greece will implement a LGP based on the local needs and capacities of the health system. In Greece, the MHR Medical Health Records – Personal Health Records has not been

widely used, leading in a shortage of digitally available medical data. Nevertheless, hospitals have their own digital database, providing the NAWG with a large amount of data available for the performance of classification. At the same time, patient empowerment has gained ground during the last few years, offering great opportunities and getting medical professionals accommodated with the idea of managing their patients based on their own needs. For that purpose, the empowerment of the patients will be implemented in two different levels. The patients' level and the medical professionals' level. On the patients' level, they will be offered with a large variety of different digital tools, which they can use to educate/inform themselves on how to manage their symptoms, increase health literacy, as well as expand their knowledge regarding their rights and obligations, decision making on issues that affect them (treatment plan etc.). On the medical professionals' level, they will be trained in empathy with the use of virtual reality, a skill that is missing from the curricula of the medical schools but is necessary when interacting with patients. Furthermore, medical professionals will also be informed on the patients' and their own rights and obligations when it comes to healthcare.

Local Core Feature 1: Classify a large number of patients based on their medical data.

Local Core Feature 2: Empower patients and caregivers in chronic care (LCF).

Local Core Feature 3: Enhance empathy on medical professionals.

ACTION PLAN ARISTOTELIO PANEPISTIMIO THESSALONIKIS (AUTH)

Related original Good Practices and their Core Feature (s): The Basque Health Strategy in Ageing and Chronicity: Integrated Care original Good Practice.

Local Core Feature 1: Classify a large number of chronic patients based on their medical data.

- *SMART objective*: By the end of JADECARE (September 2022), the NAWG of Greece will adopt a classification approach based on ACG grouper that contributes to the transition to digitally enabled, integrated, person-centred care, with a special emphasis on sustainability.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Design criteria for the local classification model	Regional health authorities; Hospitals; Developers; Researchers	Hospital database PHR IT staff Researchers Decision makers Johns Hopkins ACG grouper's academic license	Hippokration General Hospital Ahepa General University Hospital	8 months	List of criteria used for the classification (Y/N) Adopt the definition of the classification approach
Develop a data extraction process and processing mechanisms	IT staff; Researchers; Public health experts; hospital staff	Hospital database PHR IT staff Researchers Decision makers Johns Hopkins ACG grouper's academic license	Hippokration General Hospital Ahepa General University Hospital	12 months	Data extraction processes designed No. of patients classified/total number of patients targeted

Local Core Feature 2: Empower patients and caregivers in chronic care.

- *SMART objective*: By the end of JADECARE (September 2022), the NAWG of Greece and all the stakeholders involved will have defined a digitalized approach for empowering patients and caregivers. This approach is dedicated to improving chronic conditions, health care and effectiveness, increasing knowledge and empowering service users and transforming them from passive recipients to active agents in the health system.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creation of a mobile app and a web application which will inform patients and caregivers about chronic diseases	General population	Professors IT staff Program managers IT systems Health professionals Decision makers	Hippokration General Hospital Ahepa General University Hospital	8 Months	Patient Reported Experience Measures (PREMs) No. of training sessions No. of participants in training No. of downloads
Inform patients on the available care/clinical pathways in order to improve health systems and notify them about their rights and obligations through digital means	General population	Professors IT staff Program managers IT systems Health professionals Decision makers	Hippokration General Hospital Ahepa General University Hospital	12 months	System usability in pilot phase User experience Patient Reported Experience Measures (PREMs) No. of downloads No. of clicks per topic Creation of an online platform

Local Core Feature 3: Enhance empathy on medical professionals.

- *SMART objective*: By the end of JADECARE (September 2022), the NAWG of Greece will have implemented a Virtual Reality platform for promoting empathy in health professionals. Medical professionals will increase their skills, knowledge and capacities on the updated human rights charter and contemporary evidence-based treatment, and enhance empathy by engaging in interactive communication and actions in order to strengthen connections with their patients.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creation of scenarios promoting empathy, using virtual reality equipment	Health professionals	IT staff Program managers IT systems Psychologists	Hippokration General Hospital Ahepa General University Hospital	10 months	Virtual reality application developed No. of training programs
Inform medical professionals on patients' rights and obligations in order to improve the health status via prevention, diagnosis, treatment and recovery	Health professionals	IT staff Program managers IT systems	Hippokration General Hospital Ahepa General University Hospital	12 months	System usability User experience No. of participants in training No. of training programs No of downloads

***Name of the Next Adopter*: MINISTARSTVO ZDRAVLJE (MoHRS)**

LOCAL GOOD PRACTICE MINISTARSTVO ZDRAVLJE (MoHRS)

Title of the Local Good Practice: Improvement in integration of health information system; and patient empowerment.

Target population: 360,000 adults.

Setting(s): Primary Healthcare centres in two Belgrade municipalities pilot project sites: PHC "Zemun", PHC "Novi Beograd"; Gerontology Centre "Beograd"(social care institution in Belgrade with primary healthcare service provision).

Main aim: Improving health care in order to provide affordable, efficient, quality services with a sustainable continuity in their provision in the area of prevention and treatment of persons suffering from chronic diseases, and in accordance with their needs.

Outcomes: Providing more efficient healthcare services; Providing health services through the accomplishment of communication between GPs and specialists; Contributing to the process for achieving sustainable continuity of healthcare providing for persons suffering from chronic diseases; Improvement of E-health portal with access to information relevant for health care.

Local Core Features and their Components:

Improvement in integration of health information system

- Developed E-health record
- Ensure the conditions for establishing communication channels between health professionals on primary and hospital/clinical level

Patient empowerment through E-health portal upgrade

- E-health portal put in place
- Ensure the setting for personalized access

Inputs: Funding; Working team; IT staff; Decision makers; Training and technical assistance; IT infrastructure; IT vendor.

General description: Aging and increase in prevalence of non-communicable diseases lead to a greater need for long-term care and optimization of the entire healthcare system. Introduction of digital communication between healthcare workers at all levels of healthcare should make the healthcare services more efficient and patients more satisfied. Improvements in coordination between health providers should contribute to continual health care and better quality of patient care. Deployment of relevant web-based health information and access to them can strengthen patients' capacity to recognize disease and manage their own health.

Regulation on introduction of new services in the nomenclature of health services financed by state budget, financial resources limitations, organisational issues in healthcare institutions, as well as established patients access to healthcare which are difficult to change can influence the implementation and expected outcomes.

Local Core Feature 1: Improvement in integration of health information system.

Local Core Feature 2: Patient empowerment through E-health portal upgrade which will be used for patients' access to information relevant for health management.

ACTION PLAN MINISTARSTVO ZDRAVLJE (MoHRS)

Related original Good Practices and their Core Feature (s): Basque oGPs: CF2.2, CF3.1

Local Core Feature 1: Improvement in integration of health information system.

- *SMART objective*: (By December 2022) the Ministry of Health will introduce e-health record in state social care institutions in Belgrade and e-consultation service between GPs and specialists.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Integration of the module of E-health record with local information system	Healthcare workers; IT vendors; IT staff; Patients	Funds 10.000 EUR IT infrastructure	Social care institution GC "Beograd"	3 months, starting from March 2022	Integration completed (Yes/ No) Completeness (%)
Training of the health staff on access and use of E-health record	Healthcare workers; IT vendors; IT staff	IT infrastructure IT professionals	Social care Institution GC "Beograd"	2 months, starting from May 2022	Number of sites where the trainings were carried out % of trained staff
Amend the Rulebook on Nomenclature of Healthcare Services on Introduction of E-consultation through E-Health portal	Ministry of Health staff; Ministry of Finance staff; National Health Insurance Fund staff; GPs from NA sites	Professionals in the field of health insurance, IT, healthcare, finance	Ministry of Health	3 months, starting from December 2021	Amendment of the Rulebook adopted: Yes/No Rulebook enters into force: date
Integration of the module for e-consultations with local information system	Healthcare workers; IT vendors; IT staff	Funds 10.000 EUR IT infrastructure	PHC "Zemun" PHC "Novi Beograd"	3 months, starting from March 2022	Number of sites where the integration was completed

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Training of users	Healthcare workers; IT vendors; IT staff	IT infrastructure IT professionals	PHC "Zemun" PHC "Novi Beograd"	3 months, starting from September 2022	Number of sites where the training was carried out Number of trained staff
Application of non-face to face consultation trough E Health portal service	Healthcare workers; Patients	IT infrastructure Health professionals	PHC "Zemun" PHC "Novi Beograd"	Starting from November 2022 (excluding postponed application of regulation)	Number of performed consultations, monthly report

Local Core Feature 2: Patient empowerment through E-health portal upgrade which will be used for patients' access to information relevant for health management.

- *SMART objective*: (By December 2022) the Ministry of Health will introduce patients' access to E-portal where patients can be informed about illnesses in terms of gaining a better understanding of certain diseases and treatment.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Risk assessment regarding personal data protection	Staff of the Institute for Public Health of Serbia	IT professionals	Institute for Public Health of Serbia	3 months, starting from December 2021	Approved: Yes/No
Releasing mobile application E-health (Google Play, iOS)	IT staff	IT infrastructure	E-administration	2 months, starting from April 2022	Completed: Yes/No

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Promotion	Media professionals; Health professionals; IT staff	Funds 5000 EUR Professionals	Institute for Public Health Healthcare institutions E-administration Media	4 months, starting from June 2022	Number of different sources the promotion was performed through Completeness of promotion plans (%)
Issuing the authentication for personalized access to E-health portal	Staff of the Post of Serbia	IT Infrastructure Postal staff	Public Company Post of Serbia	Starting from June 2022	Number of issued authentications, quarterly report
Setting up the working team for the development of contents through the E-health portal relevant for patient empowerment	Ministry of Health staff; Health professionals; IT staff; Patient associations	Health professionals IT professionals Patients	Ministry of Health Institute for Public Health Medical Chamber	2 months, starting from January 2022	Working team established: Yes/ No
E-Health portal extension with introduction of relevant medical contents made by health professionals, publicly available	Health professionals; IT staff	IT infrastructure Health professionals	Institute for Public Health of Serbia E-administration	10 months, starting from March 2022	Information system upgrade set up: Yes/ No Number of contents publicly available: two months reporting Number of logins: two months reporting

***Name of the Next Adopter*: AZIENDA UNITÀ SANITARIA LOCALE UMBRIA 1 (UMBRIA)**

LOCAL GOOD PRACTICE AZIENDA UNITÀ SANITARIA LOCALE UMBRIA 1 (UMBRIA)

Title of the Local Good Practice: Integrated management of heart failure patients in the "Media Valle del Tevere" district.

Target population: Patients who are carriers of known structural heart disease at high risk of evolution towards Heart Failure (HF) or who are already suffering from HF.

Setting(s): Perugia Hospital; “Media Valle del Tevere” Hospital; Specialist cardiological clinics of the hospital of Perugia; Outpatient clinics of the GPs of the “Media Valle del Tevere” District.

Main aim: Implementing the integrated treatment/assistance pathway for patients with known structural heart disease at high risk of evolution towards HF or who already suffering from Heart Failure, according to the provisions of the Integrated Care Pathway (ICP) on heart failure, using the ICT tools, also by means of promoting patient compliance, through telemedicine systems.

Outcomes: Ensuring continuity of care for the patient; enabling multidisciplinary tele-collaboration between healthcare professionals; Improving the activity of the territorial Operations Centres.

Local Core Features and their Components:

Improve interoperability between existing software applications

- Implementing an integration between the telemedicine software and the patient management software used by General Medicine
- Implementing an integration between the Electronic Hospital Medical Record software and the Territorial Medical Record
- Implementing an integration between telemedicine software and the Territorial Medical Record
- Implementing check-up booking agendas at the Perugia Hospital for patients suffering from heart failure that must be followed by local structures of the USL Umbria 1 company in the “Media Valle del Tevere” District
- Implementing an integration between EHR Repository and telemedicine software

Coordination of care and communication between operators (GPs, hospital and outpatient specialists, family nurses) and with the patient and the caregiver in patients that are carriers of known structural heart disease at high risk of evolution towards HF or who are already suffer from HF

- Application of the ICP by the actors involved in the path

To achieve a structured and standard corporate program for the individual empowerment of the patient with Heart Failure (HF) and / or caregiver, based on the model of the KronikON program

Definition of structured and standard company program for individual empowerment of the patient with heart disadvantage

- Development of online information materials (adaptation of Basque materials)
- Training of the staff of the interested services

Inputs: IT staff USL Umbria 1; Communications staff USL Umbria 1; District staff USL Umbria 1; Cardiology staff of Media Valle del Tevere Hospital; JADECARE funding; Internal budget; Telemedicine software provider; Electronic medical record software provider; Territorial Folder software provider; General medicine software provider; CUP (Single Bookings Centre) software provider; Interoperability middleware software provider; HF ICP project; Communication provider.

General description: It is estimated that in Italy there are 1.2 million people affected by heart failure, with a prevalence of 2% in the general population; the prevalence significantly increases in subjects >65 years of age, becoming 10%. The prevalence of asymptomatic left ventricular dysfunction is also high and similar to that of clinical decompensation: 1.5% of the general population.

The project aims to integrate the care of HF patients through the integration of existing software, the application of the HF ICP and, then, the patient empowerment pathways.

Local Core Feature 1: Improve interoperability processes between hospital and territorial healthcare applications software *(With reference to the Basque oGP B2 - CF2 - Development of integrated information and communication systems)*

Local Core Feature 2: Coordination of care and communication between operators (GPs, hospital and outpatient specialists, family nurses) and with the patient and the caregiver in patients that are carriers of known structural heart disease at high risk of evolution towards HF or who already suffer from HF *(With reference to the Basque OGP B2 - CF3 - Coordination of care and communication between care providers)*

Local Core Feature 3: To achieve a structured and standard corporate program for the individual empowerment of the patient with Heart Failure (HF) and / or caregiver, based on the model of the KronikON program *(With reference to Basque oGP B3 - CF2 - Self-care and empowerment programs for chronic and / or multimorbidity patients)*

ACTION PLAN AZIENDA UNITÀ SANITARIA LOCALE UMBRIA 1 (UMBRIA)

Related original Good Practices and their Core Feature (s): Basque oGP B2 - CF2, B2 – CF3, B3 – CF2

Local Core Feature 1: Improve interoperability processes between hospital and territorial healthcare applications software.

- *SMART objective*: By the end of JADECARE (January 2023), USL Umbria 1 will integrate an HL7 channel for the interoperability of the GALILEO CCE and ATLANTE software. GALILEO CCE will send, through the channel, the information set relating to the nursing history that is also present in ATLANTE.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
GALILEO EHR > ATLANTE HER integration	IT staff USL Umbria 1; Studio Vega srl staff; Dedalus spa staff	IT staff USL Umbria 1 Subcontractor for technical development Galileo software Atlante software Picasso software	Health information system USL Umbria 1	September 2023	Development of integration channels Testing
HEALTH-MEETING > ATLANTE integration	IT staff USL Umbria 1; Studio Vega srl staff; Wezen srl staff; Dedalus spa staff	IT staff USL Umbria 1 Subcontractor for technical development Health-meeting software Atlante software Picasso software	Health information system USL Umbria 1	September 2023	

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
HEALTH-MEETING > ECWMED integration	IT staff USL Umbria 1; System Technology srl staff; Wezen srl staff; Dedalus spa staff	IT staff USL Umbria 1 Subcontractor for technical development Health-meeting software ECWMED software Picasso software	Health information system USL Umbria 1	September 2023	Development of integration channels Testing
FSE > HEALTH-MEETING integration	IT staff USL Umbria 1; Umbria Digitale staff; Wezen srl staff; Dedalus spa staff	IT staff USL Umbria 1 Subcontractor for technical development FSE software Health-meeting software Picasso software	Health information system USL Umbria 1	September 2023	Development of integration channels Testing

Local Core Feature 2: Coordination of care and communication between operators (GPs, hospital and outpatient specialists, family nurses) and with the patient and the caregiver in patients that are carriers of known structural heart disease at high risk of evolution towards Heart Failure (HF) or who already suffer from HF.

- *SMART objective*: Implement the integrated treatment/assistance pathway for patients with known structural heart disease at high risk of evolution towards HF or who are already suffering from HF, according to the provisions of the ICP on heart failure referred to in DDG (Director-General's Decision) using the ICT tools referred to in LCP2, also by promoting patient compliance, through telemedicine systems.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creation of 2nd level CUP (Single Bookings Centre) agendas at the Cardiology Unit of the Perugia Hospital to allow the booking of follow-up visits for patients suffering from heart failure that are already in hospital discharge	IT staff USL Umbria 1; Umbria Salute Staff; Personnel of the Cardiology Unit of the Perugia Hospital; Staff of the Cardiology Unit of the Media Valle del Tevere Hospital	ISES Web software	UO Cardiology Hospital of Perugia UO Cardiology Media Valle del Tevere Hospital	September 2022	Development agendas Activate the ICP Activate multidisciplinary groups
Activation of multidisciplinary groups through the HM software between the aggregations of general practitioners, specialists and hospital doctors to allow collaboration between professionals from different care settings	Health-meeting software; IT staff USL Umbria 1; GP; Staff of the Cardiology Unit of the Media Valle del Tevere Hospital	Health-meeting software	GPs UO Cardiology Media Valle del Tevere Hospital	December 2022	
Implementation of the Heart Failure ICP	Management of USL Umbria 1; Management of the Hospital of Perugia	HF ICP document	COT (Territorial Operations Centre) GPs Hospital of Perugia	May 2023	

Local Core Feature 3: To achieve a structured and standard corporate program for the individual empowerment of the patient with Heart Failure (HF) and/or caregiver, based on the model of the KronikON program.

- *SMART objective*: Help target patients and their caregivers to become more active and more literate about their health by improving their ability to adopt appropriate lifestyles, compliance with self-monitoring and treatments, as well as overall capacity to make decisions and consciously manage their disease.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Definition of structured and standard company program for individual empowerment of the patient with heart failure (four sessions, one session per week and one reminder session every 2 months, each session will last 20-30 minutes, developed once a week for four consecutive weeks at the health centre or at the patient's home)	JADECARE USL Umbria 1 working group	JADECARE USL Umbria 1 working group	UO Cardiology Media Valle del Tevere Hospital	May 2023	Number of patients trained
Development of online information materials. Production of printable information materials and online publication on schedule, adapting those foreseen in the oGP of the Basque countries to the local reality	JADECARE USL Umbria 1 working group Communication provider	USL Umbria 1 website Communication provider	UO Cardiology Media Valle del Tevere Hospital	May 2023	

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Training of the staff of the interested services. Design and implementation of a training course on the engagement of patients with known structural heart disease at high risk of evolution towards HF or already suffering from HF	JADECARE USL Umbria 1 working group Cardiology USL Umbria 1 staff	JADECARE USL Umbria 1 working group	UO Cardiology Media Valle del Tevere Hospital	May 2023	

Local Good Practices and Action Plans derived from the Catalan practice

***Name of the Next Adopter*: MARCHE REGION**

LOCAL GOOD PRACTICE MARCHE REGION

Title of the Local Good Practice: A stratification tool for an effective management of chronic diseases in the Marche region

Target population: The entire population of Marche region (~1.500.000 persons)

Setting(s): The Regional Health System

Main aim: To apply a population stratification tool in order to improve the efficiency of the Regional Health System and the quality of life of citizens by providing services that meet their needs.

Outcomes: Providing an in-depth analysis of the health status of the Marche population; Guaranteeing continuity of care throughout the region; Reorganising services on the basis of the health needs of people suffering from chronic diseases; Assessing the economic impact of the reorganisation of services for chronic diseases

Local Core Features and their Components:

Implement a risk stratification tool based on adjusted morbidity groups (LCF1)

- criteria for local stratification model
- data extraction and processing mechanisms
- definition of care programs for each of the strata

Build a map/dashboard of citizens' health/risk and available services (LCF2)

- City/village/district indicators based on the GMA and/or chronic diseases
- Map available services in each area
- dashboard for data visualization

Inputs: Staff; IT system; Funding; Decision-makers; Technical assistance.

General description: The intervention consists of setting up and testing a stratification tool for planning and decision-making purposes.

Local Core Feature 1: Component 1 is represented by the Catalan GMA population stratification algorithm, suitably adapted to the regional context and available health data. This tool will focus on chronic diseases and will make it possible to assess the population of the Marche Region placed in the higher sections of the Kaiser pyramid.

Local Core Feature 2: Component 2 envisages displaying on Marche region map the aggregated data from the stratification (and other indicators related to chronic diseases) as well as the available services to facilitate analysis and planning activities.

ACTION PLAN MARCHE REGION

Related original Good Practices and their Core Feature (s): Catalan Open Innovation Hub on ICT, B1 – CF 1-2-3

Local Core Feature 1: Implement a risk stratification tool based on adjusted morbidity groups (GMA)

- *SMART objective*: In the framework of JADECARE, Marche Region will set up a risk stratification tool based on GMA, which will support healthcare services programming, with a focus on chronic diseases.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Identify criteria for local stratification model	Healthcare professionals IT experts Data scientists	Catalan GMA	Marche Region/Regional Health Agency	3 months (December 2021-February 2022)	List of criteria (Y/N)
Implement data extraction and processing mechanisms	Healthcare professionals IT experts Data scientists	Health data IT infrastructure Software	Marche Region/Regional Health Agency	6 months (March-August 2022)	Database with required health data (Y/N) Availability of IT infrastructure (Y/N) % of data processed
Define care programs and services for each of the strata	Healthcare professionals Marche/ARS staff		Marche Region/Regional Health Agency	4 months (July-September 2022	Short report on care programs and services

Local Core Feature 2: Build a map/dashboard of citizens' health/risk and available services

- *SMART objective*: In the framework of JADECARE, Marche Region will develop a map/dashboard allowing in-depth analysis of stratification data and available services for policy- and decision-making processes.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Definition of indicators on stratification and/or chronic diseases	Healthcare professionals IT experts Data scientists Marche/ARS staff		Marche Region/Regional Health Agency	2 months (September-October 2022)	List of indicators (Y/N)
Mapping of available services for chronic diseases in Marche Region	Healthcare professionals Marche/ARS staff	Data on available services	Marche Region/Regional Health Agency	2 months (September-October 2022)	List of services (Y/N)
Set up of the dashboard for data visualization	Healthcare professionals IT experts Data scientists Marche/ARS staff	Subcontract for the dashboard	Marche Region/Regional Health Agency	6 months (June-November 2022)	Availability of the dashboard (Y/N)
Identification of policies and interventions at regional level to support implementation and sustainability of the LGP	Project manager Marche/ARS staff Regional policy representatives		Marche Region/Regional Health Agency	2022-2023	List of policies and interventions (Y/N)

***Name of the Next Adopter*: Jahn Ferenc Dél-pesti Kórház és Rendelőintézet (JFDPK)**

LOCAL GOOD PRACTICE Jahn Ferenc Dél-pesti Kórház és Rendelőintézet (JFDPK)

Title of the Local Good Practice: Complex care and rehabilitation of multimorbid type 2 diabetes patients with risk of minor amputation to prevent major amputations and loss of lower limb

Target population: Multimorbid type 2 diabetes patients with the risk of lower limb minor amputation in the care area of the Jahn Ferenc South Pest Hospital (approx. 100 persons/year)

Setting(s): Jahn Ferenc South-Pest Hospital and Clinic

Main aim: To provide complex, integrated care and aftercare for multimorbid type 2 diabetes patients with the risk of lower limb minor amputation to prevent further complications. Aftercare includes reviewing the patients' internal drug therapy, providing patient education, lifestyle changing activities and psychological guidance, and ensuring and monitoring the performance of the necessary tests and check-ups.

Outcomes: Transparent and more simple patient pathways; Development of off-site investigation pathways; Increased effectiveness of patient education; Improved collaboration and information sharing between different care providers; Improved aftercare for multimorbid type 2 diabetes patients; Effective risk assessment algorithm for type II diabetes complications; Developed and tested methods to measure the needs of the patients with type II diabetes; Defined risk factors for risk stratification; Developed and tested health literacy assessment tools; Assessed feasibility of complex, integrated care and aftercare for multimorbid type 2 diabetes patients .

Local Core Features and their Components:

Development a risk assessment algorithm and prediction model for type II diabetes complications and a further risk stratification method for health policy purposes including prevention

- Risk assessment algorithm
- Identification of relevant risk factors for risk stratification

Complex acute care for multimorbid type 2 diabetes patients with risk of minor amputation

- Integrated, complex preoperative diabetology protocol
- Integrated, complex post-operative protocol
- Standardised system for requesting examinations with the use of a digital patient pathway management system

Complex rehabilitation program for multimorbid type 2 diabetes patients with minor amputation

- Complex and integrated aftercare for multimorbid type 2 diabetes patients with minor amputation
- Standardized (digital) health literacy assessment method
- Complex post-operative diabetic and dietetic education system tailored for patients with different health literacy level supported by ICT tools

Long term aftercare for multimorbid type 2 diabetes patients to minimalize quality of life loss and complications

- Long-term aftercare health plan based on individual needs and the available capacities
- Lifestyle change programmes for type II diabetes patients
- Assessment of the effectiveness of the complex and integrated care with a dashboard of indicators

Inputs: Alignment of policy makers; Training and technical assistance for healthcare providers; Identification of relevant care providers to formulate the optimal patient pathway; IT systems to help the patient pathway management; Type II diabetes care protocols

General description: Type II diabetes is one the most common non-communicable disease in Hungary. The neglected or the inadequate care and services could lead to major complications for example minor toe amputations or more extended, major lower limb amputations. (Toe or other smaller amputations usually precedes limb amputation) Unfortunately, Hungary is leading in the number of major amputations worldwide (41.1 manor amputations per 100,000 people); a big part of these amputations can be prevented by proper and continuous diabetes care. In our local good practices, we try to formulate and test an integrated complex diabetes care approach to prevent major amputations. The care process includes the acute care, the rehabilitation, the long term aftercare and the tertiary prevention services. This complex and integrated care plan will be supported by digital solutions and tools in the field of risk assessment, patient pathway planning, health literacy assessment, patient education.

Local Core Feature 1: Development a risk assessment algorithm and prediction model for type II diabetes complications and a further risk stratification method for health policy purposes including prevention

Local Core Feature 2: Complex acute care for multimorbid type 2 diabetes patients with risk of minor amputation

Local Core Feature 3: Complex rehabilitation program for multimorbid type 2 diabetes patients with minor amputation

Local Core Feature 4: Long term aftercare for multimorbid type 2 diabetes patients to minimalize quality of life loss and complications

ACTION PLAN Jahn Ferenc Dél-pesti Kórház és Rendelőintézet (JFDPK)

Related original Good Practices and their Core Feature (s): Catalan Center for Open Innovation on ICT-supported integrated care services for chronic patients:

Core Feature 1.3: Development of enhanced risk prediction modelling for health policy purposes and/or clinical risk prediction

Core Feature 2.3: Rehabilitation of chronic patients

Core Feature 3.1: Programme for acute and frail patients

Core Feature 3.2: Support for complex case management including home hospitalization, transitional care and vertical & horizontal integration supported by digital tools

Core Feature 3.4: Integrated Care for admission avoidance of subacute and frail patients

Core Feature 5.4: ICT tools supporting adaptive case management & collaborative work

Local Core Feature 1: Development of a risk assessment algorithm and prediction model for type II diabetes complications and a further risk stratification method for health policy purposes including prevention.

- *SMART objective*: In the framework of JADECARE, we will identify the risk factors involved with a severe diabetic foot gangrene among multimorbid patients with type 2 diabetes so that providing a basis to define adjusted morbidity groups, which will support healthcare services strategic planning later in the future. Our main objective is to formulate the risk assessment algorithm and test it with at least 15 patients.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Development a risk assessment algorithm for type II diabetes complication	Medical Staff	Current Guidelines for Diabetes Care	Hospital	Oct/Nov 2021	Risk factors included in the risk assessment algorithm (target: at least 3)
Implement risk assessment, risk classification for multimorbid type 2 diabetes patients	Medical Staff	Clinical data of medical records + Structured interview of each patient	Hospital	Continuously - During the hospital stay of each patient	Number of patients who participated in the risk assessment (target: 15 patients with type II diabetes)
Identification of key Medical History Elements	Medical Staff	Clinical data of medical records + Structured interview of each patient	Hospital	Continuously - During the hospital stay of each patient	Number of patients who take part in the Identification of key Medical History Elements (target: 10 patients with type II diabetes)
Identification of relevant risk factors for risk stratification such as neglected treatment and care needs and factors or patient and provider compliance	Medical Staff	Clinical data of medical records + Structured interview of each patient	Hospital	Continuously - During the hospital stay of each patient	Identified relevant risk factors for type II diabetes complication for risk stratification purpose (target: at least 3 relevant risk factors for type II diabetes complications)

Local Core Feature 2: Complex acute care for multimorbid type 2 diabetes patients with risk of minor amputation

- *SMART objective*: In the framework of JADECARE, we will provide preoperative and postoperative management for the patient who has undergone minor amputation for a diabetic foot. Our main objective is to develop and then use the complex preoperative and postoperative protocols with at least 10 patients.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Develop and introduce a preoperative diabetology protocol to ensure consistent and safe patient treatment and care	Members of Diabetology Department	Current Guidelines of Medical Care	Hospital	Oct/Nov 2021	Number of developed complex diabetology protocols (target: 2, at least one preoperative and one postoperative protocol)
Introduction of a preoperative integrated (diabetology-angiology-etc) protocol (professional guideline) (bottom-up approach, generalising individualised patient pathways)	Medical Staff	Current Guidelines of Surgical and Medical Care	Hospital	Oct/Nov 2021	Number of health care providers with different speciality included in the formulation of the complex diabetology protocols (target: 4)
Formulation and implementation of a post-operative integrated protocol (professional guideline) (bottom-up approach, generalising individualised patient pathways)	Medical Staff	Current Guidelines of Surgical and Medical Care	Hospital and Outpatient Clinics	Formulation: Oct/Nov 2021 Implementation: During the whole program	Number of patients that got their patient pathway according to the new protocols (target: 10 patient with type II diabetes) Level of patient satisfaction with pathway management
Strengthening (building and linking missing links, tuning) + shortening individualised patient pathways, formulate complex case management methods	Medical Staff and Hospital Leadership	Current Guidelines of Surgical and Medical Care	Hospital and Outpatient Clinics	Oct/Nov 2021	Level of patient satisfaction with pathway management system (target: at least 7 on a scale from 1-10)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Use of a standardised protocol for requesting examinations with the use of digital patient pathway management system	Medical Staff IT Staff	Current Guidelines of Surgical and Medical Care + Medical IT System	Hospital	During the whole program	

Local Core Feature 3: Complex rehabilitation program for multimorbid type 2 diabetes patients with minor amputation

- *SMART objective*: We will we develop a new integrated and holistic approach to provide complex rehabilitation programs for multimorbid type 2 diabetes patients with minor amputation. Our objective is to involve at least 10 patients in the complex rehabilitation programs

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Provide complex and integrated aftercare for multimorbid type 2 diabetes patients with minor amputation	Medical Staff Physiotherapist Dietician Home care nurse Primary Doctor Family Member Social Worker Staff of Health Promotion Office	Electronic Health Data	Outpatient Clinics HPO Primary Care Home hospitalisation Telehealth visits	Continuously: Regular follow-up visits scheduled depending on the specialty and the individual needs	Number of patients involved in the complex rehabilitation program (target: at least 10 multimorbid type 2 diabetes patients with minor amputation)
Development of area-specific physiotherapy groups	Physiotherapist Leader of HPO	HPO?	Health Promotion Office	Oct/Nov 2021	Number of available services (e. g. physiotherapy, mental health services, etc.) (target: at least 4)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Produce and test a standardized (digital) health literacy assessment method	Medical Staff Staff of HPO	Guidelines of the topic	Hospital Health Promotion Office Telehealth visits	Oct/Nov 2021	Number of patient that have their health literacy level assessed with the new health literacy assessment method (target: at least 10 multimorbid type 2 diabetes patients with minor amputation
Implement a post-operative complex diabetic and dietetic education system tailored for patients with different health literacy level supported by ICT tools (written + audio-visual)	Medical Staff Diabetology Nurse Dietician Staff of HPO	Electronic Health Data	Hospital Diabetology Outpatient Clinic Health Promotion Office Telehealth visits	Continuously – Started during the hospital stay and continued within 1 week after minor amputation and hospital discharge	Level of patient satisfaction with complex diabetic and dietetic education (target: at least 6 on a scale from 1-10)
Develop and introduce a Patient Education Effectiveness Feedback System	Medical Staff Diabetology Nurse Staff of Health Promotion Office	Formerly collected educational data	Diabetology and Surgery Outpatient Clinic Health Promotion Office Telehealth visits	Oct/Nov 2021	

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Provide mental health support as part of the rehabilitation system	Psychologist	HPO?	Health Promotion Office Telehealth visits	Continuously – Started within 1 week after minor amputation and hospital discharge	

Local Core Feature 4: Long term aftercare for multimorbid type 2 diabetes patients to minimalize quality of life loss and complications

- *SMART objective*: In the framework of JADECARE, we will formulate a long-term aftercare method for multimorbid type 2 diabetes patient with minor amputation after complete wound healing to minimalize the chance of further complications. Our objective is to make personalised long term aftercare plan for at least 5 patients.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Formulate longt-erm aftercare healthplan based on the individual needs and the available capacities	Medical Staff Primary Doctor Family Member Social Worker Physiotherapist Psychologist Staff of Health Promotion Office	Medical Guidelines	Outpatient Clinics Primary Care Home hospitalisation Health Promotion Office	Oct/Nov 2021	Number life-style change programmes (e. g. patient education, patient clubs etc.) (target: at least 3)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Involving patients in aftercare and lifestyle change programmes (patient education, patient clubs, physiotherapy, psychologist, health education) using digital tools	Medical Staff Primary Doctor Family Member Social Worker Physiotherapist Psychologist Staff of Health Promotion Office	Capacities of HPO?	Outpatient Clinics Primary Care Home hospitalisation Health Promotion Office	Continuously – Within 1 months after minor amputation and thereafter on a regular basis	Number of individual personalised long term aftercare plans (target: at least 5)
Create a dashboard of measurable and achievable indicators to assess the effectiveness of the complex and integrated care.	Project Manager Data scientists Medical Staff Primary Doctor Family Member Social Worker Physiotherapist Psychologist Staff of Health Promotion Office	Electronic Health Care Data	Hospital	Oct/Nov 2021	Number of indicators that are developed to to measure the effectiveness of the whole complex and integrated care process (target: at least 10 indicators)

***Name of the Next Adopter*: ASL NAPOLI 2 NORD**

LOCAL GOOD PRACTICE ASL NAPOLI 2 NORD

Title of the Local Good Practice: ASL NAPOLI2 NORD'S approach to social and health integration (vertical and horizontal integration) and the use of digital technology to improve home care services

Target population: n. 2 Health Districts of ASL Napoli 2 Nord

Setting(s): Asl Napoli 2 Nord

Main aim: Improving the quality of life and health of the ASL Napoli 2 Nord population by strengthening the Vertical and the Horizontal integration and improving the management of home care through the use of digital systems.

Outcomes: Improving the communication between social and health services (Municipalities and ASL); Improving the communication between the different intra-health facilities settings (Hospitals and Territory); Ensuring the continuity of care for the patient; Providing an appropriate home care on the simple and complex needs of patients; Managing home care through the use of digital Telemonitoring and Telemedicine platforms; Training social and health network operators in the correct use of available technology.

Local Core Features and their Components:

Implementation of the latest version of the operative protocol for fragile and / or home care patients

- Formalization of the operational protocol for the management of protected hospital-territory discharges of frail people
- Implementation of the operational protocol for the management of protected discharges
- Monitoring and verification of the implementation of new protocol

Integration / Development of Digital Platforms to support the management of home care

- Integration of the ddPAST platform for the access of social service operators of the municipalities belonging to the Napoli2 Nord ASL
- Integration of the ddPAST platform for the access of hospital operators
- Creation of the ddPAGeF Platform of Fragility
- Implementation of interoperability among platforms (ddPAST, ddPAGeF, HOMECARE)
- Implementation of training courses for the use of platforms and the training of care givers

Inputs: Funding; Program managers; IT Staff; IT System; Training and technical assistance

General description: -

Local Core Feature 1: Implementation of the latest version of the operative protocol for fragile and/or home care patients

Local Core Feature 2: Integration/Development of Digital Platforms to support the management of home care

ACTION PLAN ASL NAPOLI 2 NORD

Related original Good Practices and their Core Feature (s): Catalan oGP CF 3.1, 3.2, 3.4, 5.1, 5.2, 5.4

Local Core Feature 1: Implementation of the latest version of the operating protocol for frail patients and/or in home care

- *SMART objective*: The expected goal is the formalization of the operational protocol for the management of protected hospital-territory discharges of frail people and the setting up of the planned path, also starting from the new operational protocol for home care

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Formalization of the operational protocol for the management of protected hospital-territory discharges of frail people	Strategic Direction of the ASL UOC Home Care UOC Social and Health Integration	An operator from each actor identified for the preparation of the final document and the deliberative act	ASL Napoli 2 Nord Subsequently, the Municipalities of the ASL	4 months	Deliberative act of formalization of the new protocol Document sharing the protocol with the municipalities of the ASL
Implementation of the operational protocol for the management of protected discharges	Health facilities of the ASL Napoli 2 Nord Health Districts of the ASL Napoli 2 Nord Municipalities of the ASL	For Hospitals: Health Department, 1 contact person for the protected discharge of the various Departments and the Emergency Department, the hospital social service For Health Districts: The District Director, 1 PUA / UVI / Social-Health contact person, 1 Home care contact person, 1 Rehabilitation care contact person For Municipalities: Social Services Manager, 1 Social Secretariat / Social Service Contact	ASL Napoli 2 Nord the Municipalities of the ASL any RSAs, Rehabilitation Centers, etc., accredited private individuals		Number of reports of protected discharges managed according to the protocol / total reporting of protected discharges - expected 30% in the first year and + 10% for each subsequent year

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Monitoring and verification of the implementation of new protocol	Strategic Direction of the ASL UOC Home Care UOC Social and Health Integration UOC Information Technologies Health Districts Hospitals of the ASL Municipalities of the ASL	N. 1 contact person for each actor involved	ASL Napoli 2 Nord		Definition of the system and monitoring tools Document sharing the monitoring system with all the actors involved Semiannual report processing

Local Core Feature 2: Integration/Development of Digital Platforms to support the management of home care

- *SMART objective*: Integration of the ddPAST platform for the access of social service operators of the municipalities belonging to the Napoli2 Nord ASL (to facilitate the connection between Districts and Social Services, both for the multidimensional assessment of the need and for the social-health care)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creating a working group to define the activities to be performed on the ddPAST platform for the access of Social Workers	Director of UOC Social Health Integration and Home Care Social Workers of the ASL Municipalities Information Technology Director; Executive Analyst; IT Staff	Professionalism of the various figures involved	ASL Napoli 2 Nord Municipalities of the ASL	6 months	Number and type of profiles of the professionals identified Formalization of the document of analysis
Development of modules according to the specifications of the document of analysis	IT Staff	SQL Server DB Visual Studio "Serenity" development platform Programming languages: C #, JavaScript, CSS, HTML	ASL Napoli 2 Nord	10 months	DB creation / integration (Y / N) % completeness of the technical project % completeness of the functional project

Trial / Test	IT Staff	DdPAST platform	ASL Napoli 2 Nord	4 months	% of new profiles created for the social services of the municipalities % of access to the system by the social services of the municipalities % assistance requests

- *SMART objective*: Integration of the ddPAST corporate platform for the access of hospital operators (to facilitate protected discharges)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creating a working group to define the activity to be performed on the ddPAST platform for the access of hospital operators.	Director of UOC Social Health Integration and Home Care Health directors of the PP.OO. Information Technology Director Executive Analyst IT Staff	Professionalism of the various figures involved	ASL Napoli 2 Nord	6 months	Number and type of profiles of the professionals identified Formalization of the functional document of analysis

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Development of modules according to the specifications of the document of analysis	IT Staff	SQL Server Visual Studio "Serenity" development platform Programming languages: C #, JavaScript, CSS, HTML	ASL Napoli 2 Nord	10 months	DB creation /integration (Y / N) % Completeness of the technical project % Completeness of the functional project
Trial / Test	IT Staff	DdPAST platform	ASL Napoli 2 Nord	4 months	% of new profiles created for hospital operators % of access to the System by hospital operators % assistance requests

- *SMART objective*: Creation of the ddPAGeF Platform of Fragility

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creating a working group to define the specifications of the ddPAGeF Platform to be created	Director of UOC "Social Health Integration and Home Care" Director of UOSD Elderly and Dementia of the Territorial Care Department Information Technology Director Executive Analyst IT Staff	Professionalism of the various figures involved	ASL Napoli 2 Nord MMG	6 months	Number and type of profiles of the professionals identified Formalization of the functional document of analysis
Development of the Platform and the modules according to the specifications of the document of analysis	IT Staff	SQL Server Visual Studio "Serenity" development platform Programming languages: C #, JavaScript, CSS, HTML	ASL Napoli 2 Nord	10 months	DB creation / integration (Y / N) % completeness of the technical project % completeness of the functional project
Trial / Test	IT Staff	DdPAGeF platform	ASL Napoli 2 Nord	4 months	% of new profiles created for operators % of access to the System by operators % Assistance requests

- *SMART objective*: Implementation of interoperability among platforms (ddPAST, ddPAGeF, HOMECARE)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creating a working group to define the specifications of the interoperability integrations	Information Technology Director Executive Analyst IT Staff	Professionalism of the various figures involved	ASL Napoli 2 Nord	6 months	Number and type of profiles of the professionals identified Formalization of the functional document of analysis
Development of interoperability integration procedures and modules	Information Technology Director Executive Analyst IT Staff	SQL Server Visual Studio "Serenity" development platform Programming languages: C #, JavaScript, CSS, HTML	ASL Napoli 2 Nord	10 months	Database creation (Y / N) % completeness of the technical project % completeness of the functional project
Trial / Test	IT Staff	DdPAGeF platform	ASL Napoli 2 Nord	4 months	% of new profiles created for operators % of access to the System by operators % assistance requests

- *SMART objective:* Implementation of training courses for the use of platforms and the training of care givers

Sintetic objective					
Implementation of training courses for the use of platforms and the training of care givers					
Activities	**Actors**	**Resources**	**Setting(s)**	**Timeline**	**Key Performance Indicators**
Creating a working group to define the programme of the courses and identifying the dedicated spaces	Information Technology Director Executive Analyst IT Staff	Professionalism of the various figures involved	ASL Napoli 2 Nord	2 months	Number and type of profiles of the professionals identified Calendar of courses which have to be delivered
Providing training courses to all operators and caregivers	IT Staff	Professionalism of the various figures involved materials for the course	ASL Napoli 2 Nord	12 months	Number and type of profiles of the professionals identified % course delivery

Local Good Practices and Action Plans derived from the Optimedis practice

***Name of the Next Adopter*: DIENSTSTELLE DER DEUTSCHPRACHIGEN GEMEINSCHAFT FUR SELBSTBESTIMMTES LEBEN (SELBM)**

LOCAL GOOD PRACTICE DIENSTSTELLE DER DEUTSCHPRACHIGEN GEMEINSCHAFT FUR SELBSTBESTIMMTES LEBEN (SELBM)

Title of the Local Good Practice: Establish a population-based regional integrated care system in the German speaking Community of Belgium based on the OptiMedis model.

Target population: The entire population of the region, around 78.000 people.

Setting(s): The Regional Health System of the German speaking Community.

Main aim: Establish a population-based regional integrated care system in the German speaking Community of Belgium based on the OptiMedis model and the Quadruple AIM and consider the regional specificities of the German speaking Community.

Outcomes: Improve the health situation of the entire population and the quality of care; Improved resource efficiency; Improve patient satisfaction; Improve satisfaction of the healthcare providers.

Local Core Features and their Components:

Feasibility study on the implementation of integrated care in the German speaking Community

- Analysis of Secondary Data (Statistics of the region and health indicators).
- Analysis of Primary Data (Survey from healthcare providers in the region).
- Exchanges with stakeholders and regional and national political actors to develop a business case based on the evidence gathered.
- Development of a business plan on how can the region become a model region for integrated care. The business case consists of the different components and recommendation to achieve it and a financing plan.

Establish a shared savings contract model with reimbursement/commissioning organizations

- Develop an appropriate shared savings contract model with reimbursement/commissioning organizations. Identifying current contractual arrangements and assessing possibilities for value-based contracting.
- Defining data standards and appropriate outcome measures.
- Designing the valued-based payment framework.
- Constructing the analytical model to execute the contract.

Establish a strong and inclusive governance structure to manage the implementation of the integrated care in the German speaking Community.

Inputs: Funding; IT staff; Access to statistical data; Program managers; Decision-makers; Alignment of local and national policymakers and local stakeholders; Training and technical assistance; IT systems.

General description: In cooperation with the original Good Practice, OptiMedis, the Dienststelle aims to carry out a Feasibility study on the implementation of integrated care in the German speaking Community. The aim of the feasibility study is to develop a business plan which will guide the implementation of integrated care in the German speaking Community. This business plan will include recommendations for the development of a model region of integrated care and a financing plan. Based on the results and recommendations of the feasibility study, the Dienststelle, in cooperation with the local stakeholders and local and national politics, will implement the different Core Features from the OptiMedis Model, considering the local specificities of the German speaking Community.

Local Core Feature 1: Feasibility study on the implementation of integrated care in the German speaking Community

Local Core Feature 2: Establish a shared savings contract model with the National Institute for Health and Disability Insurance

Local Core Feature 3: Establish a strong and inclusive governance structure to manage the implementation of integrated care in the German speaking Community

Local Core Feature 4: Implementation of care programs.

ACTION PLAN DIENSTSTELLE DER DEUTSCHPRACHIGEN GEMEINSCHAFT FUR SELBSTBESTIMMTES LEBEN (SELBM)

Related original Good Practices and their Core Feature (s): Optimedis oGP: CF 1.1, 1.2, 1.3, 1.4, 2.1, 2.2., 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 4.3, 4.4, 5.1, 5.2, 5.3, 6.1, 6.2 and 6.3

Local Core Feature 1: Feasibility study on the implementation of integrated care in the German speaking Community.

- *SMART objective*: By the beginning of 2022, the Dienststelle, in cooperation with OptiMedis, will have performed a Feasibility study on the implementation of integrated care in the German speaking Community. The timeline for the feasibility study is from July to December 2021.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Mission and goal clarification	Experts from the Dienststelle; Experts from Optimedis	Experts attending the meeting	The Regional Health System of the German speaking Community	1 Kick-Off Meeting and, if needed, meetings to update the mission and goals	Mission and goals of the study clearly defined Roles and expectations of the different actors clearly defined
Secondary data analysis	Project Manager; Health Data analyst; Sickness funds	Access to statistical data from the insurance companies Eventually financial resources to get access to the statistical data Access to Health studies about the region already performed	The Regional Health System of the German speaking Community	In the framework of the study, which is expected to last 6 months	The statistical data will be analysed and, on this basis, the current situation of the region and the potential efficiency gains and optimalisation in the quality of care will be analysed.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Primary data analysis	Project Manager; Health Data analyst; GP and nursing; Hospital staff; Pharmacists; National Institute for Health and Disability Insurance; Political stakeholders; Other stakeholders from the NAWG	Perform interviews of stakeholders Travel expenses and human resources to perform the interviews	The Regional Health System of the German speaking Community	In the framework of the study, which is expected to last 6 months	Assess the situation of the healthcare structures and sector and the willingness to invest in the integrated care initiatives
Organisation of Regional Health Conference	Project Manager; Experts from OptiMedis and the Dienststelle; GPs and nursing; Hospital Staff; Sickness insurances; Patient representatives or patients interest groups; Local authorities and politics; Other local stakeholders that might be relevant	Expenses to organise a meeting e.g. room rent	The Regional Health System of the German speaking Community	One or, if needed, several meetings with the different stakeholders in the region within the timeframe of the study	Discussion and presentation of the results of the first analysis with the regional stakeholders
Development of a business plan	Project Manager; OptiMedis; Dienststelle; Local politics; Other regional stakeholders	The development of the business plan and the feasibility study will cost around 85,000€	The Regional Health System of the German speaking Community	In the framework of the study, which is expected to last 6 months	A business plan including a financing plan has been developed

Local Core Feature 2: Establish a shared savings contract model with the National Institute for Health and Disability Insurance.

- *SMART objective*: By the end of 2022, a shared savings contract model has been negotiated with National Institute for Health and Disability insurance and the legal basis has been laid down to implement this model. The timeline for this action is January to December 2022.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Develop a shared savings contract model which fits in the Belgium regulatory context and also meets the international best practices requirements of shared-savings contract models	Dienststelle; National Institute for Health and Disability Insurance; Sickness funds; National Health Minister and Ministry; Regional Health Minister; Law specialist; Health data analyst; Statistics experts	Financial resources to allow to implement the shared savings model Access to health data to analyse and evaluate the shared savings model	The Regional Health System of the German speaking Community	From the beginning till the end of 2022: based on the findings of the feasibility study, the Dienststelle will undergo discussion with the National Institute for Health and Disability Insurance and the Regional and Federal Political level to establish a shared savings model	A legal and regulatory framework has been established. This framework meets the international best practices requirements of shared savings contract models

Local Core Feature 3: Establish a strong and inclusive governance structure to manage the implementation of the integrated care in the German speaking Community.

- *SMART objective*: By the end of 2022, a strong and inclusive governance structure to manage the implementation of the integrated care in the German speaking Community will be established. The timeline for this action goes from February to December 2022. But it is dependent on the negotiation concerning the establishment of the shared savings contract model.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Establish a strong efficient and coherent Governance structure	All stakeholders of the NAWG; Legal specialist; Local authorities and politics	Stakeholder meetings Legal framework to establish the Governance structure Financial retribution of the participants for participating in the stakeholder meetings	The Regional Health System of the German speaking Community	By the end of 2022, based on the findings and the recommendations of the Feasibility study, a Governance structure that is efficient and consistent with the regional stakeholder structure is established	A Governance structure with a clear legal framework has been established and the role of every partner is clearly defined

Local Core Feature 4: Implementation of test care program.

- *SMART objective*: By the end of 2022, a first care program will be tested with a limited number of patients and limited number of actors. Before such a care program can be implemented, Core Features 2 and 3 must fulfilled. End of 2022, November- December 2022; earliest timeline possible.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Implement a first test care program on the basis of the findings of the feasibility study	All stakeholders of the NAWG; Especially GPs and hospitals; Legal specialist	Stakeholder meetings Define the content of care program Financial retribution of the participants for participating in the stakeholder meetings	The Regional Health System of the German speaking Community Limited number of patients to be defined with the stakeholders	By the end of 2022, based on the findings and the recommendations of the Feasibility study, a first test care program with a limited range and limited group of patients can be implemented to test an integrated care program	A care program could be tested and delivered to collect first evidence and best practices that enable the NAWG to implement structurally the integrated care model and programs in the German speaking Community

***Name of the Next Adopter*: EUROMETROPOLE DE STRASBOURG (EUSTRAS)**

LOCAL GOOD PRACTICE EUROMETROPOLE DE STRASBOURG (EUSTRAS)

Title of the Local Good Practice: Establish a population based integrated care system for three Strasbourg districts based on the OptiMedis model

Target population: 3 districts in Strasbourg, N= 46.530 insured persons.

Setting(s): High level of socio-economic precarity; limited collaboration of local stakeholders; existing initiatives in multi-professional teams and physical activity for health; Supportive environment for population based integrated care through national, regional and city programs; support for populations with high level of precarity.

Main aim: Develop a population based local integrated care system in three districts of Strasbourg based on the OptiMedis model and the Quadruple AIM to the local specificities of the Strasbourg Community.

Outcomes: Strong and motivated health services provider networks; Coordination, cooperation, and data (information) sharing between health and medico-social services; Strengthening continuity of care between care levels (inter/intra level); Establish an economic model based on health and economic data.

Local Core Features and their Components:

Strong and motivated health services provider networks

- Unite the stakeholders and decision-makers around a population-based local integrated care system
- Co-construct the Core Features for a proof of concept for an integrated care system

Coordination, cooperation, and data (information) sharing between health and medico-social services

Strengthening continuity of care between care levels (inter/intra level)

- Develop and monitor patient-centred health programs at the interface between prevention, ambulatory and hospital care for different risk strata and strengthen patient self-management

Establish an economic model based on health and economic data

- Develop an economic model to sustain population-based integrated care by evaluating the efficiency of health care delivery

Inputs:

Strong and motivated health services provider networks

- Coordination Staff

- Liaise with key players
- Decision makers
- Healthcare and social professionals

Coordination, cooperation, and data (information) sharing between health and medico-social services

- Coordination staff
- Liaise with key players
- Decision makers
- Healthcare and social professionals

Strengthening continuity of care between care levels (inter/intra level)

- Experts and patient representatives for case management and patient pathways
- Hospital experts
- Health education specialists
- Experts in community medicine, mediation, and health coaching
- Marketing/communication experts (health programs, health information)

Establish an economic model based on health and economic data

- Experts in health economy, insurance medicine, study design and data analysis

General description: Strasbourg has a rich portfolio of initiatives and projects targeting innovations in health care delivery, such as care coordination in multi-professional teams, prevention and physical activity initiatives, medico-social services, and digitisation in health. This is backed-up by national and regional health strategies. The local good practice (LGP) focuses on transforming a disease-based professionally dominated care system towards a territorial population-based, people-centred health system in an urban environment in three Strasbourg districts. Its main pillars are to build strong stakeholder networks of multi-professional nature including people and patient representation following a continuity of care logic; develop health programs and a continuity of care approach towards better patient health and self-management; data based decision support including patient information sharing across provider networks, performance measurement, analytical tools for outcome and impact assessment; increase efficiency of health care delivery system, avoid unnecessary hospitalisation and duplication of services, and develop an economic model to sustain patient-centred integrated health systems. Increased efficiency and the economic model will guarantee the continuation of activities after the end of the JADECARE project cycle.

Local Core Feature 1: In-depth analysis of the existing situation to fully understand the field network

- Include the OptiMedis approach in the local strategy (CLS)
- Validate a CLS action sheet
- List of health professionals in the three selected districts
- List of adopted physical activity unit partners

- The sport and health prescription pathway from A to Z (data, information system, patients, doctors, other health professionals)
- Analysis of the patient base of each MUS and each neighbourhood (list of routine and preventive activities)
- Identify key partners and barriers
- Map local, regional, national and international experience and support mechanisms for the planned initiatives

Local Core Feature 2: Creating the network and developing the elements for a successful proof of concept

- Launching a call for external service provider to lead workshops on the needs of the MUS
- Launching a human resource hiring for the prevention and care pathway component
- Launching a call for external service provider on IS (shared patient file) and data (access to SNDS data)

Local Core Feature 3: Co-construct the Core Features for a proof of concept for an integrated care system

- Identify potential efficiency gaps for the prevention and management of NCDs
- Develop an analytic model to show population-based effects of integrated people-centred health services using the Triple Aims of the Value Based Care (VBC) framework and define indicators

Local Core Feature 4: Implement shared patient information system within healthcare and social professionals in the 3 districts

- Agree on the core characteristics for shared patient information at the urban district level and review currently used systems
- IT integration following national e-health strategy (Ségur numérique, masanté2022)

Local Core Feature 5: Develop and monitor patient centred health programs at the interface between prevention, ambulatory and hospital care for different risk strata and strengthen patient self-management

- Conduct a population segmentation exercise by disease group and identify needs for each population strata
- Develop and implement patient pathways and case management systems for specific NCDs
- Strengthen secondary and tertiary prevention programs for NCDs
- Develop communication and marketing strategies to increase patient subscription to preventive care programs
- Develop and implement programs for strengthening patient self-management programs
- Integrate and share innovations

Local Core Feature 6: Develop an economic model to sustain population-based integrated care by evaluating the efficiency of health care delivery and re-invest generated savings in patient empowerment and preventive services

- Identify current funding mechanisms for integrated care and their elements
- Describe and analyse economic benefits of integrated care within the defined implementation area.
- Develop a business plan for a Strasbourg district based integrated care model

ACTION PLAN EUROMETROPOLE DE STRASBOURG (EUSTRAS)

Related original Good Practices and their Core Feature (s): Optimedis oGP: CF 1.2, 1.3, 1.4, 2.1, 2.2., 3.1, 3.3, 4.2, 4.3, 4.4, 5.1, 5.2, 6.1, 6.2 and 6.3

Local Core Feature 1: In-depth analysis of the existing situation to fully understand the field network.

- *SMART objective*: Full mapping of two existing key systems in the territories.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Include the OptiMedis approach in the local strategy (CLS)	Institutional; OptiMedis; LGP working group	Expert staff time LGP working group coordination OptiMedis	Strasbourg districts, EUSTRAS	Q4 2021	Number of preparatory meetings
Validate a CLS action sheet	Institutional; Ville de Strasbourg	Expert staff time LGP working group coordination	EUSTRAS	Q1 2022	CLS Signature
List all health professionals in the 3 selected districts	Institutional; OptiMedis; LGP working group	Expert staff time LGP working group coordination	Selected Strasbourg districts	Q4 2021	List, map, visualisations Analysis of relationships
List all Adapted physical activity unit partners	GIP MS; OptiMedis; LGP working group	Expert staff time LGP working group coordination	EUSTRAS Selected Strasbourg districts	Q4 2021	List, map, visuals

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
The sport and health prescription pathway from A to Z (data, information system, patients, doctors, other health professionals)	GIP MS; OptiMedis; LGP working group; existing professional networks	Expert staff time Network partners LGP working group coordination	EUSTRAS Selected Strasbourg districts	Q4 2021	Summary of the journey and recommendations on gaps/needs
Analysis of the patient base of each MUS and each neighbourhood (list of routine and preventive activities)	Network partners; OptiMedis; LGP working group	Expert staff time; LGP working group coordination	Strasbourg districts	Q1 2022	Synthesis reports
Identify key partners and barriers	Network partners; OptiMedis; LGP working group	Expert staff time LGP working group coordination OptiMedis	EUSTRAS Selected Strasbourg districts	Q1 2022	List of convinced adopters List of challenges
Map local, regional, national and international experience and support mechanisms for the planned initiatives	Network partners; OptIMedis; LGP working group	Expert staff time	Strasbourg districts	Q1 2022	Synthesis report

Local Core Feature 2: Creating the network and developing the elements for a successful proof of concept.

- *SMART objective*: Developing the resources needed to run the network.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Launching a call for external service provider to lead workshops on the needs of the MUS	OptiMedis; EUSTRAS	External service provider	Regional Strasbourg city	Q4 2021	Number of applications, provider selection
Launching a human resource hiring for the prevention and care pathway component	OptiMedis; EUSTRAS	External service provider	Strasbourg	Q4 2022	Concept paper and/or analytic model
Launching a call for external service provider on IS (shared patient file) and data (access to SNDS data)	OptiMedis; EUSTRAS	External service provider		Q4 2021	Number of applications Provider selection

Local Core Feature 3: Co-construct the Core Features for a proof of concept for an integrated care system.

- *SMART objective*: Define prototypes of key pillars of the integrated care concept at neighbourhood level.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Identify potential efficiency gaps for the prevention and management of NCDs	Health professionals; medico-social care experts; Patient representatives; Sport-Santé; OptiMedis; EUSTRAS	Various reports of existing studies Expert staff time LGP working group coordination	Regional Strasbourg city Strasbourg districts	Q2 2022	List of areas for improvement

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Develop an analytic model to show population-based effects of integrated people centred health services using the Triple Aims of the Value Based Care (VBC) framework and define indicators	Health analysts; Health professionals; Epidemiologists and survey staff; CPAM and ARS; Sport-Santé; OptiMedis; EUSTRAS	Expert staff time Agreements for utilisation of health data LGP working group coordination	Strasbourg	Q4 2022	Concept paper and/or analytic model

Local Core Feature 4: Support the implementation of a shared patient information system among healthcare professionals in the 3 districts.

- *SMART objective*: Patient data is shared with all actors participating in patient care pathways.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Agree on the core characteristics for shared patient information at the urban district level and review currently used systems	Health professionals; CPTS, MUS staff; Other TSD projects; Actors national e-health strategy; OptiMedis; EUSTRAS	Expert staff time	Strasbourg Grand-Est region	Q1 2022	Agreed list of features for district patient information
IT integration following national e-health strategy (ségur numérique, masanté2022)	TSD projects; CPTS, MUS; Pulsy; IT experts; Health professionals; OptiMedis; EUSTRAS	Expert staff time	Strasbourg districts	Q4 2022	Remaining gaps

Local Core Feature 5: Develop and monitor patient-centred health programs at the interface between prevention, outpatient and inpatient care for different risk strata and strengthen patient self-management.

- *SMART objective*: At least xx patients (to be defined) are recruited in patient programs and apply patient self-management.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Conduct a population segmentation exercise by disease group and identify needs for each population strata	Health professionals; Hospital based NCD experts; District network participants; Representatives of successful pilot projects (FHF?); OptiMedis; EUSTRAS	Expert time National and international examples of respective tools	Strasbourg districts Strasbourg hospitals	Q1 2022	Define risk strata for at least 2 disease groups
Develop and implement patient pathways and case management systems for specific NCDs	Health professionals; Hospital-based NCD experts; District network participants; OptiMedis; EUSTRAS	Expert time	Strasbourg ARS Grand-Est	Q2 2022	Patient pathways and patient programs for at least 2 disease groups
Strengthen secondary, and tertiary prevention programs for NCDs	Health professionals; Hospital based NCD experts; District network participants; GIP-MS and Associations; Patient reps; Mediators/coaches; OptiMedis; EUSTRAS	Expert time	Strasbourg city Strasbourg districts	Q3 2022	Defined prevention actions for each patient program
Develop communication and marketing strategies to increase patient subscription to preventive care programs	Marketing experts; District network participants; GIP-MS; Health service; OptiMedis; EUSTRAS	Communication experts Communication platform	Strasbourg districts	December 2022	Communication material

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Develop and implement programs for strengthening patient self-management programs	Health education specialists; District network participants; Patient reps; OptiMedis; EUSTRAS	Health education courses Health mediators/coaches program	Strasbourg districts	Q4 2022	Designed training course and coaching program for patient self-management
Integrate and share innovations	District network participants; OptiMedis; EUSTRAS	Funds Expert time	Strasbourg	Q4 2022	At least two meetings/conferences were organised to share Strasbourg Integrated Care experience

Local Core Feature 6: Develop an economic model to sustain population based integrated care by evaluating the efficiency of health care delivery and re-invest generated savings in patient empowerment and preventive services.

- *SMART objective*: A business model for a neighbourhood based integrated care program.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Identify current funding mechanisms for integrated care and its elements	Health professionals; EMS Strasbourg; CPAM; ARS; OptiMedis; EUSTRAS	Expert time	District City Region Grand Est National	Q1 2022	List of support initiatives and funding sources
Describe and analyse economic benefits of integrated care within the defined implementation area.	CPAM, ARS; Sport Santé; OptiMedis; EUSTRAS	Expert time; Funding; Previous reports and studies	Strasbourg	Q4 2022	Report
Develop a business plan for a Strasbourg district based integrated care model	District network participants; CPAM; OptiMedis; EUSTRAS	Expert time	Strasbourg	December 2022	Business plan for district/Strasbourg integrated care unit

***Name of the Next Adopter*: ZAVOD ZA ZDRAVSTVENO ZAVAROVANJE SLOVENIJE THE HEALTH INSURANCE INSTITUTE OF SLOVENIA (ZZZS)**

LOCAL GOOD PRACTICE ZAVOD ZA ZDRAVSTVENO ZAVAROVANJE SLOVENIJE THE HEALTH INSURANCE INSTITUTE OF SLOVENIA (ZZZS)

Title of the Local Good Practice: Integrated care in nephrology.

Target population: The number of registered people in the participating family clinics is approximately 1500 / family clinics. For preventive screening, those older than 50 years are eligible. Approximately 10% are patients at high risk for CKD (Chronic Kidney Disease).

Setting(s):

At the primary level (these are healthcare providers scattered throughout the country):

- 4 family medicine clinics with a reference clinic

At the secondary level (these are healthcare providers scattered throughout the country):

- General hospital Slovenj Gradec
- University clinical center Ljubljana
- General hospital Šempeter pri Gorici
- University clinical center Maribor

Health insurance institute of Slovenia

Due to the limitations ZZZS has in paying for the services provided by the participating healthcare providers, the target population is the one that is tied to the individual participating healthcare provider (and does not represent the entire population of a certain territory).

Main aim: Improving the health of the population (preventive activities and disease prevention, prolonging the quality of life of patients with CKD (QALY - quality-adjusted life-year), maintaining work capacity and social inclusion, slowing down the progression of CKD); Well-empowered patients; Long-term savings (in hospitalizations (less and shorter), in the use of erythropoietin, in delayed dialysis).

Outcomes: Comprehensive patient information is available across the entire provider network; Case management and quality standards are agreed and monitored across provider network; Patients actively participate in managing their disease (reducing risk factors, etc.); An analytic framework for monitoring patient outcomes and healthcare cost is in place.

Local Core Features and their Components:

New model of communication between healthcare providers at different levels (LCF 1)

- Definition of criteria for the transition of patients from the primary to the secondary level
- Patient data exchange tools (e-medical record, e-consultations)

Population screening (LCF 2)

- Clinical pathway for early detection of CKD
- Analysis of past experiences in screening

Patient coaching (LCF 3)

- Educational materials for patients
- Educational materials for educators

Payment model (LCF 4)

- Review of existing contracts
- Review of existing services
- Preparation of a proposal for a new payment model
- Proposal for the charging for educational services

Inputs: Experts in nephrology and family medicine and graduate nurses; Financial resources to pay for these experts; Financial resources for educational materials; Experts in the field of payment models; Financial resources for laboratory tests.

General description: Our long-term quadruple goal is: to improve the health of the population in the field of CKD, increase the satisfaction and empowerment of patients with CKD, increase the satisfaction of health professionals with new education and prevention options and save money on hospitalizations, drugs and dialysis. These are the goals we are striving for in the next few years. However, as time within JA JADECARE is limited, we will focus mainly on the preparation of starting points for improving communication between the primary and secondary level, for improving preventive activities in the field of CKD, for billing new services (especially educational) in the field of CKD. We will prepare new educational materials and review the existing ones to increase the empowerment of patients. To ensure the success of our activities, we have included all interested parties in the NAWG (family physicians, nephrology specialists, payment model experts, nephrology patients' association). We will also invite experts from the field of family medicine reference clinics and e-Medical record from the Public health institute to participate in the planned activities to ensuring sustainability in the use of the proposed solutions.

Local Core Feature 1: New model of communication between health care providers at different levels.

Local Core Feature 2: Population screening.

Local Core Feature 3: Patient coaching.

Local Core Feature 4: Payment model.

ACTION PLAN ZAVOD ZA ZDRAVSTVENO ZAVAROVANJE SLOVENIJE THE HEALTH INSURANCE INSTITUTE OF SLOVENIA (ZZZS)

Related original Good Practices and their Core Feature (s): OptiMedis, CF1.1, CF1.2, CF1.3, CF1.4, CF2.1, CF3.1, CF3.2, CF6.3

Local Core Feature 1: New model of communication between health care providers at different levels (LCF 1).

- *SMART objective*: By October 2022, the NAWG will define the criteria for the transition of patients from the primary to the secondary level, review existing tools for the exchange of patient data and prepare a proposal for their more efficient use.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Meetings with NAWG (initial meeting to agree on implementation of activities, follow-up control meetings)	NAWG; Project management	Human resources	MS Teams	October 2021 and every 2 months thereafter	Minutes of meetings
Determining criteria for the transition of patients between primary and secondary level (including a population segmentation exercise to group people in disease stages, define specific cut-off points for each stage and develop specific interventions for each stage, for example: promotion and health education for patients without diagnosis, hypertension or diabetes control for patients at risk and so forth)	Nephrologists and family physicians from NAWG; Nephrological Society	Human resources	Nephrological Society or MS Teams	October 2021 - April 2022	Document with developed criteria
Review of existing tools for the exchange of patient data	Nephrologists and family physicians; Representatives of ZZZS from NAWG; Public health institute	Human resources eHealth Platform	MS Teams	October 2021 – March 2022	List of existing tools

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Preparation of a proposal for a more efficient use and upgrading of tools for the exchange of patient data and proposal for complementary services in information sharing	Nephrologists and family physicians from NAWG	Human resources eHealth platform	Nephrological society or MS Teams	April 2022 – September 2022	Document with prepared proposal
Presentation of the proposal to ZZZS (administrator of payment models) and Public health institute (administrator of eHealth) to ensure the sustainable use of the proposed solutions	NAWG	Human resources	ZZZS or MS Teams	October 2022	Minutes of the meeting

Local Core Feature 2: Population screening (LCF 2).

- *SMART objective*: In 6 months, nephrologists from NAWG will determine the parameters for CKD screening, and colleagues from ZZZS will examine the financial possibilities for this. Participating family medicine clinics will review past screening experiences and, by November 2022, invite 200 patients to the screening program.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Meetings with NAWG (initial meeting to agree on implementation of activities, follow-up control meetings)	NAWG; Project management	Human resources	MS Teams	October 2021 and every 2 months thereafter	Minutes of meetings
Determination of criteria for CKD screening (clinical pathway for early detection of CKD) - population segmentation, risk strata for CKD and the specific set of interventions per strata	Nephrolog ists and family physicians from NAWG; Nephrological Society	Human resources	Nephrological Society or MS Teams	October 2021 – March 2022	Document with determined criteria
Past experience with CKD screening	Nephrologists and family physicians from NAWG; Nephrological Society	Human resources	Nephrological Society or MS Teams	October 2021 – March 2022	Report on past experiences
Agreement on payment for additional services (lab tests)	ZZZS; Participating family medicine clinics	Human resources	ZZZS	October 2021 - March 2022	Agreement reached

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Carrying out screening in selected family medicine clinics (this activity largely depends on the course of the epidemic in 2022 in the country, as nurses from reference clinics are currently engaged in population vaccination and testing)	Family medicine clinics	Human resources Laboratory - funds for additional tests	Family medicine clinics	April 2022 – November 2022	Number of preventive examinations and tests performed
Presentation of results and proposal to the Public health institute regarding the inclusion of additional tests in the program of family medicine reference clinics, to ensure sustainable implementation of screening	NAWG; Public health institute	Human resources	ZZZS or MS Teams	December 2022	Minutes of the meeting and agreement on the inclusion of new tests in the family medicine reference clinics program

Local Core Feature 3: Patient coaching (LCF 3).

- *SMART objective*: By August 2022, the NAWG, in collaboration with the Nephrology Society, the Patients' Association and the nursing staff from reference clinics, will prepare educational materials for patients and educators.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Meetings with NAWG (initial meeting to agree on implementation of activities, follow-up control meetings)	NAWG; Project management	Human resources	MS Teams	October 2021 and every 2 months thereafter	Minutes of meetings
Review of existing patient materials	Nephrologists from NAWG; Patient Representative from NAWG; Nurses from reference clinics	Human resources	Patients Association Internet	November 2021 – January 2022	List of existing materials
Update of materials / preparation of new materials for patients	Nephrologists from NAWG; Patient Representative from NAWG	Human resources Financial resources for the preparation of materials	Patients Association Nephrological Society	February 2022 – June 2022	Prepared materials
Preparation of materials for educators (including how to help patients define their health goals and motivate them to actively participate in health programs linked to preventive care (blood sugar	Nephrologists from NAWG; Nephrological Society	Human resources Financial resources for the preparation of materials	Nephrological Society	November 2021 – June 2022	Prepared materials

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
and hypertension control, weight loss, etc))					
Publishing materials for patients online and printing	Nephrology Society; Patient Association	Human resources Financial resources for the preparation of materials	Patients' Association Internet	July 2022 – August 2022	Published materials

Local Core Feature 4: Payment model (LCF 4).

- *SMART objective*: By the end of 2022, NAWG billing model experts will review existing service payment contracts, as well as a list of existing services, and together with the nephrology profession prepare a proposal for new services (especially educational) and billing options, or if the need arises, prepare a proposal for funding additional teams for prevention activities.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Meetings with NAWG (initial meeting to agree on implementation of activities, follow-up control meetings)	NAWG; Project management	Human resources	MS Teams	October 2021 and every 2 months thereafter	Minutes of meetings
Review of existing contracts	Experts for payment models at ZZZS	Human resources	ZZZS	November 2021 – February 2022	Document with a report on existing contracts
Review of existing services paid by ZZZS to health care providers	Experts for payment models at ZZZS	Human resources	ZZZS	November 2021 – February 2022	Document with a report on existing services
Preparation of a proposal for new services and a proposal for their billing including an analysis of cost savings potentials to define opportunities for financing complementary services where needed	Experts for payment models at ZZZS; Nephrologists from NAWG	Human resources	ZZZS	March 2022 – September 2022	Document with the proposal

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Preparation of a proposal for the General Agreement, as the inclusion of new services in the General Agreement ensures their sustainable use	Experts for payment models at ZZZS	Human resources	ZZZS	October 2022 – December 2022	Prepared proposal for the General Agreement

Local Good Practices and Action Plans derived from the South Denmark Region practice

Name of the Next Adopters: **LOMBARDY REGION**

LOCAL GOOD PRACTICE

Title of the Local Good Practice: Lombardy Digital Roadmap towards an Integrated Health Care Sector

Target population: 775.273 inhabitants

Setting(s): Lombardy Region – DG Welfare, Local Healthcare Authority ATS Valpadana made up of three health hubs (ASST): Crema, Cremona and Mantua

Main aim: Improving the quality of healthcare services addressing territories, users and mild needs still uncovered. Improving the digital transition of the regional healthcare system, handling accessibility issues

Outcomes:

- Integrated communications among various healthcare actors: GPs, specialists, hospitals, caregivers etc…
- Patients' empowerment
- Improved digital skills for professionals and patients, especially elders. Reduction of the digital divide.
- Decrease hospitals' crowding
- Improved quality of home healthcare
- Increase the number of patients treated, improving the efficiency

Local Core Features and their Components:

- Telepsychiatry [LCF1]
- Digital platform and app(s) for mobile devices (Component 1)
- Design of a video consultation feature complementary to physical consultations (Component 2)
- Integrated and coordinated communication among different actors (Component 3)
- Video consultation among professionals feature to exchange good practices (Component 4)
- Online Physical Rehabilitation [LCF2]
- Exercise videos to recover from surgical intervention (Component 1)
- Prevention exercise videos: to promote a healthy lifestyle (Component 2)
- Pain and progress questionnaires (Component 3)

- Digital platform and app(s) for devices to provide the videos and questionnaires (Component 4)

Inputs:

- Funding
- IT experts' and Healthcare professionals' inputs to design a working integrated service
- Existing app/platform adaptation
- Professionals and patients training and technical assistance
- Patient assessment on the 1st prototype

General description: The project aims bringing psychiatric and rehabilitation services to users who usually can hardly access them due to the physical geographical distance to be covered to reach the closest hospital. The psychiatric service would allow to involve more easily users reluctant to have physical meetings, involving the access to crowded places such as hospitals. The autonomous use of an app involving videos and pain record in rehabilitation domain would allow to relieve crowded Hospitals.

Local Core Feature 1: Telepsychiatry

Local Core Feature 2: Online Physical Rehabilitation

ACTION PLAN LOMBARDY REGION

Related original Good Practices and their Core Feature (s): Digital Roadmap towards an Integrated Health Care Sector (Region of South Denmark) B2-CF2: Tele-psychiatry B2-CF4: Online physical rehabilitation

Local Core Feature 1: Telepsychiatry

SMART objective: By the end of the project, the three ASST would be able to use a common platform, integrated with the regional healthcare IT system. Such a platform would allow a direct online consultation between patient and Psychiatrist as a complementary tool for physical visits. Moreover, it would allow video-consultation between professionals, in order to coordinate their action.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Determination of the app features (video consultation + …)	ATS DG Welfare ARIA 3 ASST	IT professionals Healthcare professionals	3 ASST	November 2021 – January 2022	Features chosen to be developed
Scouting of existing platform and adaptability Development of guidelines and requirements for developing a new platform	ARIA 3 ASST	IT professionals	3 ASST	December 2021 – June 2022	App availability / integration of existing platforms
Questionnaires to measure and record progresses to be used during testing	3 ASST	Healthcare professionals	3 ASST	December 2021 – June 2022	Number of questionnaires elaborated

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Training of professionals	ARIA Professionals involved in the testing phase	Psychiatrists	3 ASST	June 2022 – July 2022	Number of professionals trained
Testing	Professionals Patients DG Welfare ATS – 3 ASST	Psychiatrists Patients	3 ASST	August 2022 – December 2022	Number of patients involved Patients and professionals feedbacks

Local Core Feature 2: Online Physical Rehabilitation

SMART objective: By the end of the project the three ASST will have a platform with recorded video tutorial for both postsurgical patients and for prevention activities. Such a platform would be integrated with the regional healthcare IT system. The videos will be accessible to the patient on a web platform or an app to be consulted as many times as necessary.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Establishment of a professional working team to decide which domain has to be covered and target group definition	ATS DG Welfare 3 ASST	IT professionals Physiotherapists	3 ASST	November 2021 – January 2022	Number of people involved and profiles covered

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Determination of excercises to be recorded / questionnaires for pain record + progress achieved	Professional working team ATS DG Welfare	IT professionals Physiotherapists	3 ASST	December 2021 – January 2022	Number of exercises chosen / questionnaires elaborated
Questionnaires to measure and record progresses to be used during testing	3 ASST	Healthcare professionals	3 ASST	December 2021 – June 2022	Number of questionnaires elaborated
Video recording	ARIA Professional working team	IT professionals Physiotherapists Funding for videorecorder and videomaker	3 ASST	January 2022 – March 2022	Videos recorded
Scouting of existing platform and adaptability Development of guidelines and requirements for developing a new platform	ARIA 3 ASST	IT professionals	3 ASST	December 2021 – June 2022	App availability / integration of existing platforms
Training of professionals	ARIA Professionals involved in the testing phase	Physiotherapists	3 ASST	June 2022 – July 2022	Number of professionals trained
Testing	Professionals Patients DG Welfare ATS – 3 ASST	Physiotherapists Patients	3 ASST	August 2022 – December 2022	Number of patient involved Patients and professionals feedbacks

Name of the Next Adopters: **CHILDREN'S CLINICAL UNIVERSITY HOSPITAL (CCUH), NATIONAL HEALTH SERVICE OF LATVIA**

LOCAL GOOD PRACTICE

Title of the Local Good Practice: Development of digital eligible ecosystem for children' s healthcare as national level pilot project

Target population: 359 000 children in Latvia; 70 000 patients annually in Emergency department (CCUH); 17 000 patients are being treated in Inpatient units of CCUH; 700 physicians and 600 of nursing staff in CCUH; 800 paediatricians in Latvia

Setting(s): Children's University Hospital of Latvia

Main aim: To equalize the quality of paediatricians' services throughout Latvia

Outcomes:

- One evidence-based channel for parents, children and adolescents, as well as children's health professionals
- Coordinated approach in children's healthcare using innovative methods
- Effective usage of medical stuff within Children's hospital and healthcare in General
- More accurate and trustable source of information and services
- Cheaper for patients and families as they don't need to travel to Hospital in case it's not emergency
- Improved availability of services inside and outside the hospital
- Reduce waiting time for Hospital services
- Empowered citizens for active participation in healthcare decision making

Local Core Features and their Components:

- Develop a strategy on implementation of digital eligible ecosystem
  - acquaintance with good practice abroad
  - the Telemedicine strategy
  - The Conceptual Design document
  - Digital solution implementation plan and structure in CCUH, development of system integration plan
- Build the digital eligible innovation ecosystem for children' s healthcare
  - Collaboration Agreements and standards on cross-sectorial integrated care and continuity of care
  - Communication and promotion plan on promoting citizen involvement and increasing the use of digital solutions
  - Promotion plan on raising the competence of medical staff in working with telemedicine systems and equipment

- Promotion plan on raising the competence of medical staff in working with telemedicine systems and equipment
- Solution providers
- Succession plan for updating and updating the content and solutions
- Training with providers to assess incentives for IT deployment and usability assessment
- Monitoring plan to evaluate the efficiency the pilot project and indicate possible improvements;

protocol and recommendations on the introduction of telemedicine and digital services in Latvia

Inputs:

- Funding
- IT staff
- Program managers
- Healthcare professionals
- Patients/parents
- Decision makers
- Alignment of policy makers
- Training and technical assistance
- IT systems

General description: The digital eligible innovation ecosystem for children's healthcare consist of following levels: children's health portal, patient portal, portal for professionals

Local Core Feature 1: Develop a strategy of digital eligible ecosystem

Local Core Feature 2: Build the digital eligible innovation ecosystem for children' s healthcare

ACTION PLAN CHILDREN'S CLINICAL UNIVERSITY HOSPITAL (CCUH),

Related original Good Practices and their Core Feature (s): Digital Roadmap Denmark oGP, CF B1.1, B1.2., B1.3, B2.1, B2.2., B2.3, B2.4, B2.5, B2.6

Local Core Feature 1: Develop a strategy of digital eligible ecosystem

SMART objective By the end of February 2022 CCUH will develop a strategy on implementation of digital eligible ecosystem that contributes to the transition to digitally-enable, integrated, person centred care with special emphasis un sustainability.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create a core group to develop strategy on implementation of digital eligible ecosystem	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH	CCUH	1 week from October 25	Number and profile of professionals engaged
To get acquainted with examples of good practice and identify possible models to be adapted for the introduction of telemedicine and digital solutions	Project manager, Healthcare professionals, hospital, IT experts	Jadecare, network with children's hospital abroad	CCUH, web based (emails, meetings)	1 month from November 1	Evaluation matrix of good practice approved (Y/N)
Development of the Telemedicine strategy	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH	CCUH	1 months from December 1	Telemedicine strategy approved (Y/N)
Development of The Conceptual Design document	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH	CCUH	1 months from January 3	The Conceptual Design document approved (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Coordinated development of digital solution implementation plan and structure in CCUH, development of system integration plan	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH	CCUH	1 month from January 28	Digital solution implementation plan and structure approved (Y/N)

Local Core Feature 2: Develop a strategy of digital eligible ecosystem

SMART objective: By the end of Jadecare (dec2022) CCUH will develop a protocol and recommendations on the introduction of telemedicine and digital services in Latvia that contributes to the transition to digitally-enable, integrated, person centred care in national level with special emphasis un sustainability.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creation of a general framework for cooperation in the provision / delivery of digital services at national level - integration with national e-health system to avoid of fragmentation of service tools	Project manager, Healthcare professionals, hospital, IT experts, public health staff	Professionals from CCUH Public health institutions	CCUH, national health care providers	3 months from March 1	General framework for cooperation – templates of agreements, standards available (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Creation of sustainable integration between primary, secondary and tertiary care in the implementation of telemedicine solutions (considering that primary care providers could be inflexible in the implementation of new solutions)	Project manager, Healthcare professionals, hospital, IT experts, public health staff, GPs	Professionals from CCUH Public health institutions	CCUH, national health care providers	3 months from March 1	Templates of agreements, standards drafted/approved/available (Y/N)
Promoting citizen involvement and increasing the use of digital solutions (reducing face-to-face attendance) - developing a communication and promotion plan	Project manager, Healthcare professionals, hospital, IT experts, public health staff, GPs, patients	Professionals from CCUH Public health institutions	CCUH, national health care providers	3 months from June 1	Number of citizens involved in promotion
Evaluate possible solution providers	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH ..	CCUH	4 months from April 1	Evaluation matrix of solution providers drafted (Y/N)
Development of a succession plan for updating the content and solutions	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH	CCUH	3 months from August 1	Succession plan for updating the content and solutions approved (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
To develop and perform monitoring plan to evaluate the efficiency the pilot project and indicate possible improvements;	Project manager, Healthcare professionals, hospital, IT experts	Professionals from CCUH	CCUH	3 months from August 1	Monitoring plan of project performance approved (Y/N)
To develop a protocol and recommendations on the introduction of telemedicine and digital services in Latvia, Including such aspects as identification of the patient, recording of the provided health care services, storage of the records, organisational aspects of the remote consultation, etc	Project manager, Healthcare professionals, hospital, IT experts, public health staff, GPs, patients	Professionals from CCUH Public health institutions	CCUH, national health care providers	4 months from September 1	protocol and recommendations on the introduction of telemedicine and digital services in Latvia available (Y/N)

Name of the Next Adopters: **GERENCIA REGIONAL DE SALUD DE CASTILLA Y LEÓN –SACYL (SPAIN)**

LOCAL GOOD PRACTICE

Title of the Local Good Practice: Improving communication between levels of care and Digitally facilitated healthcare

Target population: The entire population of the Castilla y León region (2.3 M people) depending on the healthcare need

Setting(s): The Regional Health System: from primary care to hospitals

Main aim: Facilitate communication between healthcare levels and integrated healthcare through digital and technological support, and support and the definition of efficient and decisive healthcare pathways.

Outcomes:

- Use of new digital communication channels for teleconsultation and resolution between Primary Care and Hospital Care professionals (Dermatology and Continuity of Care Unit).
- Assessment of the interconsultation by the hospital specialist and response in a short time with the consequent reduction of the patient's waiting time for inpatient care.
- Avoid unnecessary patient trips to the hospital by improving the accessibility of the healthcare system.
- Incorporation of devices to guide diagnosis.

Local Core Features and their Components:

- Non-face-to-face consultation (Nonpresential consultation)
- Teledermatology e teleconsultation with Continuity of Care Unit (CCU)
- Referral protocols
- Healthcare pathways
  - *Patients at home*
  - *Patients in socio health center*

Inputs:

- Technological resources and materials: Smartphones and dermatoscopes, videoconferencing system, electronic medical record system, and other devices.
- Human resources: personnel from the Regional Health Service, project managers from the peripheral Health Departments (technical and functional), health care professionals from the public health system of Castilla y León and healthcare professionals from the sociohealthcare residential centers.
- Economic resources: SACYL ´s own budget allocation for technological equipment.

- Organisational resources: Definition of the care pathway, work agendas to establish synchronous communication between professionals from different healthcare centers and levels of care.
- Training resources for professionals and patients.

General description: Implement new forms of communication between primary care and hospitals, through the technological modernization of the healthcare system, applicable to the field of dermatology and care of chronic multi-pathological patients, supported by organisational innovation and training, especially in rural areas.

Local Core Feature 1: Teledermatology

Local Core Feature 2: Teleconsultation of pluripathological chronic patients with the continuity of care unit.

ACTION PLAN GERENCIA REGIONAL DE SALUD DE CASTILLA Y LEÓN –SACYL (SPAIN)

Related original Good Practices and their Core Feature (s): Danish oGP; CF1.1, CF 2.2 and 2.6

Local Core Feature 1: Teledermatology

SMART objective: To reduce the waiting time for dermatology consultations from primary care and avoid unnecessary patient trips to receive hospital specialist care.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Define protocols for referral, photographic and dermatoscopic acquisition.	Family doctor and dermatologist	Institutional Communication platform	Web based	October-november 2021	Defined protocols : yes/no
Purchase of the necessary technology Smartphone and dermatocospio	General Directorate of Infrastructures and Information Technology (GDIAIT) Health	Own budgets	primary care health centers	November 2021-	Percentage of health centers with devices purchased. Provided by GDIAIT.
Define registration protocols in EHR	Health Information Systems Service	Institutional Communication platform	Web based	October-november 2021	Defined protocols: yes/no

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Select and train program representatives at each health center.	Healthcare professionals	Institutional Communication platform	Select and train program representatives at each health center.	Healthcare professionals	Institutional Communication platform Total hours of training completed per professional, taken from the professional training registry application.
Implement in each health area : **1.Preparation: Select technical and assistance manager in coordination with the IT service of each hospital.** **2. Upstart: testing the service and Tecnical support** **Webinar and video tutorial** **3. Operation: Tecnical support**	Health Information Systems Service IT department of each hospital Head of dermatology service	Institutional Communication platform and mail On-site training	In each hospital /dermatology serviceWeb based Hotline technical suppport	June 21 - february 2022	Percentage of dermatology services in the community using teledermotology taken from the service portfolio. Number of tutorials created Reduction in average waiting time for dermatology consultation from health information systems Percentage of resolution in teleconsult

Local Core Feature 2 Teleconsultation of pluripathological chronic patients with the continuity of care unit.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Define implementation centers	Central and Peripheral managements	Institutional Communication platform and mail Health Information Systems	managements	October- November 2021	List of selected centers
Installation of telepresence equipment	General Directorate of Infrastructures and Information Technology (GDIAIT) Peripheral managements	Own budgets	primary health care centers and hospitals	January -march 2022	Number and percentage of connected health care centers
Connection tests	General Directorate of Infrastructures and Information Technology (GDIAIT) Peripheral managements	Own personnel	Primary Care-Hospital	January-june 2022	Correct technical communication criteria
Pilot test of connection with social services Management	General Directorate of Infrastructures and Information Technology (GDIAIT) Peripheral managements IT of Social Services Management	Own personnel and Social Services Management	Pilot center and selected hospital	January-June 2022	Correct technical communication criteria

Name of the Next Adopters: **SERVICIO CÁNTABRO DE SALUD (SCS) AND INSTITUTO DE INVESTIGACIÓN MARQUÉS DE VALDECILLA (IDIVAL)**

Title of the Local Good Practice: Strategy for the digitization of health services in Cantabria

Target population: All kind of patients living in Cantabria. Mainly

- Outpatients with lower limb fractures living in Marques de Valdecilla University hospital health area.
- Elderly people in nursing homes in Santander Health Area. Cantabria. Spain.

Setting(s):

- Cantabria Health Service & Regional Ministry of Health of Cantabria
- Marqués de Valdecilla University Hospital. Rehabilitation Service.
- Online Portal hosted by the Cantabrian Health Service (SCS).

Main aim: The main aim of the Strategy for the digitization of health services in Cantabria is to improve and develop new ways to continue caring for patients with digital and technological tools

Specific, the Cantabria's Online physical rehabilitation programme has as main objective to Improve results in rehabilitation in outpatients after suffering a lower limb fracture, the patient satisfaction and reduce direct and indirect costs. Improve the active participation of the patient and therapeutic compliance in the rehabilitation program from hospital discharge and throughout the process.

On the other hand, the main aim of the Cantabrian Patients' schools, is to provide health promotion and disease prevention to the citizens. The focus is on providing tools, motivation and support for self-managing a change of their lifestyle and routines. Patients' School also create network possibilities for citizens, as well as provide knowledge to health organizations in the civil society. One of the objectives of the Cantabrian School of Patients is to develop and integrated digital solution to empower the patients. The use of this digital solution should result in: flexibility, motivation and resource optimization.

Lastly, Support program in tele-psychogeriatric for nursing homes in Cantabria aims to improve the quality of health care for the elderly with mental illness and cognitive impairment, institutionalized in nursing homes.

Outcomes:

- Patients empowerment
- Motivation, flexibility and resources optimization
- Improve patients' knowledge in healthy lifestyle
- Improve communication between patients and medical staff
- Decrease the need to visit the doctor
- Meeting point between patients

- Early start of the active mobilization program at home after hospital discharge or surgery.
- Improve therapeutic compliance with the rehabilitation program by the patient at home.
- Improve knowledge of the process by the patient and caregiver.
- Improve communication between the rehabilitation team and the patient.
- Decrease the need to travel to perform physiotherapy programs in the hospital
- Facilitate accessibility to a comprehensive bio-psycho-social and functional psychogeriatric evaluation, in this population according to their care needs
- Develop a tele-psychogeriatric program through IT aimed at the elderly admitted to nursing homes in the health area
- Increase care focused on institutionalized patients with mental illness and cognitive-functional impairment, guaranteeing continuity of care
- To improve the knowledge of the processes of cognitive-functional deterioration and mental illness among the socio-sanitary professionals of the nursing homes
- Improve communication between the Psychogeriatric Team of the Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital, the elderly, their families and caregivers and the professional teams of socio-sanitary work in the nursing homes
- Reduce travel from nursing homes to hospital health care facilities for regular consultations.
- Facilitate various bureaucratic and administrative tasks online for the elderly, families, caregivers and socio-health professionals of the nursing homes

Local Core Features and their Components:

Information and training program for video-directed exercises:

- Exercise programs recorded on video aimed at different processes (fractures) and evolutionary moments

Synchronous and asynchronous online communication channels between patient and therapist and between patients and medical specialists

- Application Web for tele-rehabilitation in electronic medical record.
- App for mobile devices
- Online questionnaires to evaluate progress.
- Teleconsultations

Patients' School

- Application Web with content about health, courses and contact details
- Responsible Care Workshop
- Online self-management program in population with chronic disease
- Meeting space patient - patient, patient-associations and patient - healthcare professional

- Digital skills course.
- Online space for consultations by patients and answers from experts

Geriatric Tele-Psychiatry Online

Online management of the psychological and behavioral disorders of the elderly with dementia institutionalized in nursing homes

- Contact with the socio-sanitary professionals of the nursing homes to provide information on the program and the various technological aspects used
- Psychogeriatric program adapted to the different evolutionary moments of mental illnesses and the functional cognitive situation of the elderly
- Fundamentally synchronous online communication channels between the elderly, family members, socio-health professionals of the nursing homes and the Psychogeriatric Team
- Development of web applications for tele-psychogeriatric in electronic medical records of the Cantabrian Health Service
- Development of the Application for mobile devices
- Online questionnaires to assess progress
- Online Tele-psychogeriatric consultations

Inputs:

- Funding
- Health IT expert
- IT system: application web in electronic medical record.
- Medical Staff time to develop the action plans
- Rehabilitation staff time to design the programme, development and commissioning.
- Video recording and video edition system
- Training and technical assistance.
- Computer system: improvement of web applications in electronic medical records.
- Hardware for the development of the program

General description:

Regarding each of sub-initiative inside of the Strategy for the digitization of health services in Cantabria;

the Cantabria's Online physical rehabilitation programme is a video-directed tele rehabilitation home program for patients with lower limb fractures with the objectives of early mobilization, greater patient participation, better health outcomes and reduction of direct and indirect costs.

It involves a paradigm shift and a new form of care that requires training of patients and professionals and integration with electronic medical records, but short-term benefits are expected.

Secondly, The Cantabrian School of patients is providing tools to improve the patient empowerment through health promotion and disease prevention. This is e.g. done through workshops, courses, small texts, guidance and counselling on a healthy lifestyle. The focus is on providing tools, motivation and support for self-managing a change of their lifestyle and routines. Cantabrian Patients' School has also created network possibilities for citizens, associations and healthcare professionals, as well as provide knowledge to health organizations in the civil society. A lot of nurses, dieticians, physiotherapists and doctors are collaborating in the Patients' School.

The principal activity of the Cantabrian Patients' School is to develop and integrate digital solutions to improve the patient empowerment. Under this vision, several subprojects are unfolded (Responsible Care Workshop, online self-management program in population with chronic disease, Meeting space, Digital skills course, Online space for consultations). Patients can join from home, where they can see pre-recorded information, participate in webinars gain knowledge by reading short texts, and chat with both health care professionals and other patients.

Finally, online Tele-psychogeriatric program aimed at the health care of the elderly with cognitive-functional impairment and mental illness institutionalized in nursing homes, with the objectives of facilitating accessibility to specialized hospital programs without the need for travel, with care focused on the patient and their environment in nursing homes, to obtain an improvement in the symptomatic control of psychogeriatric pathologies, better health results and reduction of direct and indirect costs. This modality of online service provision includes a wide range of care services for the elderly with institutionalized mental illness, from evaluation and diagnosis to pharmacological and psychosocial interventions, and monitoring and care in the residence, development of clinical care plans, case management, crisis intervention and severe behavioral disturbances, neuropsychological tests, liaison services for other medical specialties, nursing care, etc. Paradigm shift in the health care system, centered on the patient with chronic psychogeriatric mental illness, based on the development of electronic medical records, and the use of new technologies from which short-term benefits are expected.

Local Core Feature 1: Synchronous and asynchronous online communication channels between patient and therapist and between patients and medical specialists

Local Core Feature 2: Information and training program for video-directed exercises

Local Core Feature 3: Patients' School

Local Core Feature 4: Geriatric Tele-Psychiatry Online

Local Core Feature 5: Online management of the psychological and behavioral disorders of the elderly with dementia institutionalized in nursing homes

ACTION PLAN SERVICIO CÁNTABRO DE SALUD (SCS) AND INSTITUTO DE INVESTIGACIÓN MARQUÉS DE VALDECILLA (IDIVAL) – Spain

Related original Good Practices and their Core Feature (s): South Denmark B2-CF2: Tele-psychiatry, B2-CF4: Online physical rehabilitation, B2-CF5: Digital Health Centre

Local Core Feature 1: Information and training program for video-directed exercises

SMART objective: By the end of 2022, the Rehabilitation service of the Marques de Valdecilla University Hospital will have designed and recorded on video tutorial exercise programs for the most frequent processes: Ankle fracture, Tibial plateau fracture and fractures of the proximal end of the femur in different evolutionary stages. The videos will be accessible to the patient on a web platform to be consulted as many times as necessary.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create professional work teams for each process / fracture	Head of Rehabilitation service	Physical Therapist and PM & rehabilitation specialists	Marques de Valdecilla hospital Rehabilitation Service	1 month	Profile of professionals engaged and teams composition members.
Create exercise program protocols for each fracture and evolutionary moment.	Professional work teams: Physical Therapist and PM & rehabilitation specialists	Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	3 months	Number of protocols approved and published by each working group

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Video - recording and video-editing of exercise programs	Video Professionals Professional work teams: Physical Therapist and PM & rehabilitation specialists	Funding – subcontractor for profesionals Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	2 months	Number of finished video programs Comprehensibility analysis test of videos
Inclusion of the programs in the web system and electronic heath records	Health IT expert IT Hospital department Head of Rehabilitation service	Funding – subcontractor for profesionals Specific time in working agenda	Marques de Valdecilla hospital IT Heath Service	2 months	Number of programs included in electronics medical record by the end of the timeline.
Training for Rehabilitation and Traumatology professionals	Head of Rehabilitation service Professional work teams: Physical Therapist and PM & rehabilitation specialists	Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	1 month	• % physical therapist completing the training. Evaluation by professionals of the rehabilitation service

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Start-up of a pilot project and evaluation of the results of the trial period	Head of Rehabilitation service Professional work teams: Physical Therapist and PM & rehabilitation specialists Marques de Valdecilla Hospital Quality service	Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	4 months	Number of patient users of each program. Number of views of each video-program. Patient satisfaction survey results. Percentage of patients in each group who did not require inclusion in a physical therapy program after the tele-rehabilitation program.

Local Core Feature 2: Synchronous and asynchronous online communication channels between patient and therapist and between patients and medical specialists

SMART objective: By the end of JADECARE (Sep 2023), the Rehabilitation service of the Marques de Valdecilla University Hospital will have designed synchronous and asynchronous online communication channels between patient and therapist and between patients and medical specialists including:

- Application Web for tele-rehabilitation in electronic medical record.
- App for mobile devices
- Online questionnaires to evaluate progress.
- Teleconsultations

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Design of Application web for tele-rehabilitation and App for mobile devices	Health IT expert IT Hospital department Head of Rehabilitation service	Funding – subcontractor for profesionals Specific time in working agenda	Marques de Valdecilla hospital IT Heath Service	4 months	App availability
Create Online questionnaires to evaluate progress of patients	Professional work teams: Physical Therapist and PM & rehabilitation specialists Selected Expert patient	Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	3 months	Number of questionnaires. Comprehensibility analysis test of questionnaires.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create online tele-consultations	Health IT expert IT Hospital department Head of Rehabilitation service Professional work teams: Physical Therapist and PM & rehabilitation specialists Selected Expert patient	Funding – subcontractor for professionals Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	3 months	Availability of teleconsultation
Training for Rehabilitation professionals	Health IT expert Head of Rehabilitation service Professional work teams: Physical Therapist and PM & rehabilitation specialists	Funding – subcontractor for profesionals Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	1 month	% Physical therapist and physicians completing the training. Evaluation by professionals of the rehabilitation service

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Start-up of a pilot project and evaluation of the results of the trial period	Head of Rehabilitation service Professional work teams: Physical Therapist and PM & rehabilitation specialists Marques de Valdecilla Hospital Quality service	Specific time in working agenda	Marques de Valdecilla hospital Rehabilitation Service	4 months	Number of patient users of each program. Patient satisfaction survey results. Professional satisfaction survey results Percentage of patients in each group who did not require inclusion in a physical therapy program after the tele-rehabilitation program.

Local Core Feature 3: Patients' School

SMART objective: By the end of 2022, the Cantabrian School of Health will have improved the content and organization of the patients' school and appointed the team that will work on it. This will be possible if we fulfill the following activities: Create a professional work team, design and record webinars and courses to promote healthy lifestyle, update the online platform with new content, create a new online space to solve the most common questions of patients... All this content will be available on a web platform to be consulted as many times as necessary.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create professional work team	Responsible of Cantabrian School of health	Nurses, doctors, patients that would be interested in participate as voluntaries	Online Portal – Patients' School	1 month	Profile of professionals engaged and teams composition members.
Create the annual program/agenda for the Patients' school.	Professional work teams: nurses, doctors, patients, associations…	Specific time in working agenda	Cantabrian School of Health (SCS)	3 months	Number of activities planned
Creating Material (slides, small text) Video - recording and video-editing of webinars	• Video Professionals Professional work teams: nurses, doctors, patients associations…	• Funding – subcontractor for professionals Specific time in working agenda	Cantabrian School of Health (SCS) Online Portal – Patients' School	3 months	Number of finished video courses / webinars

Upload the courses / webinars in the online portal	Health IT expert Professional team	Funding – subcontractor for professionals Specific time in working agenda	Online Portal – Patients' School	2 months	Number of courses included in the web portal
Training for Patients to learn how to use the online platform	Patients Professional work teams: nurses, doctors, patients, associations…	Specific time in working agenda	Cantabrian School of Health (SCS) Online Portal – Patients' School	1 month	Number of patients completing the training.
Start-up of a pilot and evaluation of the results	Professional work teams: nurses, doctors, patients, associations… Patients Marqués de Valdecilla Hospital Quality Service	Specific time in working agenda	Cantabrian School of Health (SCS) Online Portal – Patients' School	4 months	Number of patient users of Patients' School Platform. Number of views of each course/webinar. Patient satisfaction survey results.

Local Core Feature 4: Geriatric Tele-psychiatry Online

SMART objective: By the end of the project, the Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital will have designed and launched the Psychogeriatric Program for online case management and crisis intervention with demented elderly institutionalized in nursing homes with severe psychological and behavioral disturbances that seriously affect daily activities in the nursing home by establishing a direct online consultation between the Psychogeriatric Team of the Long Term Care Unit of the Psychiatry Service of the Valdecilla University Hospital and the professional teams of socio-sanitary work in the nursing homes

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create professional work teams for psychogeriatric care	Psychogeriatric team (Psychiatry, Geriatrics, Clinical Psychology and Nursing) of the Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital	Professionals of Psychiatry, Geriatrics, Clinical Psychology and Nursing	Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital.	2 months	App availability Teleconsultation availability Profile of the professionals involved and composition of the online psychogeriatric care teams for nursing homes. Number of protocols approved and published by the work team Number of elderly users of each program Number of first and subsequent consultations made
Create protocols for care programs for various chronic psychogeriatric pathologies with special attention to depression and cognitive and functional impairment.	Professional socio-sanitary work teams in nursing homes	Specific time in work schedule agenda	Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital.	2 months	

Development of online strategies and programs for institutionalized elderly with chronic mental illness and cognitive and functional impairment	Department for Digital Transformation and Relations with Health Users of the Regional Ministry of health of Cantabria	Financing - subcontractor for professionals	Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital.	6 months	Number of elderly registered in the program. Number of consultations with other Hospital Services and Primary Health Care Teams Number of programs included in the electronic medical record at the end of the schedule. Results of the satisfaction survey of the elderly users of the Program. Results of the satisfaction survey of the social health professionals of the nursing homes. Results of the satisfaction survey of the professionals of the Psychogeriatric Team.
Evaluation of the results of the trial period to the actors involved. patients and relatives, and social-health work teams in nursing homes	Quality Service	Computer, informatics and IT and quality Service of the Valdecilla University Hospital	Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital.	2 months	

Local Core Feature 5: Online management of the psychological and behavioral disorders of the elderly with dementia institutionalized in nursing homes.

SMART objective: By the end of the project, the Long Term Care Unit of the Psychiatry Service of Valdecilla University Hospital will have designed and launched the Psychogeriatric Program for online case management and crisis intervention with demented elderly institutionalized in nursing homes with severe psychological and behavioral disturbances that seriously affect daily activities in the nursing home by establishing a direct online consultation between the Psychogeriatric Team of the Long Term Care Unit of the Psychiatry Service of the Valdecilla University Hospital and the professional teams of socio-sanitary work in the nursing homes.

Name of the Next Adopters: **Consejería de Salud y Familias, Junta de Andalucía (CSFJA) and Fundación Pública Andaluza Progreso y Salud (FPS)**

Title of the Local Good Practice: Improving healthcare at home for complex chronic patients (CCPs), including proactive follow-up, in Andalusia

Target population: Complex chronic patients in Andalusia (125.000 patients, approx.). A sample of 500 of these patients will be included in the Andalusian pilot

Setting(s): Andalusian Health Service (SAS) (in particular, at primary healthcare level).

Main aim: Improve health status and quality of life of CCPs by enhancing home healthcare proactive follow-up and its evaluation.

Outcomes:

- Provide timely and appropriate care to CCPs at their home based on their care needs.
- Allow CCP proactive interventions and follow-up.
- Enable communication among healthcare professionals and with patients.

Local Core Features and their Components:

- Development of a Centralised System for Proactive Follow-up (SCSP) of chronic patients.
  - Tendering of the SCSP implementation
  - SCSP design.
  - SCSP development.
- Deployment of "proactive follow-up" in primary healthcare centres.
  - Definition and selection of participating healthcare centres and teams.
  - Training of healthcare professionals.
  - Patient selection
- Monitor the corporate system for improving healthcare at home (SCSP+Teleconsultation).
  - Definition of KPI.
  - Data gathering.
  - Data assessment.

Inputs:

- Decision makers.
- Alignment of policy makers.
- Funding.
- Reference documents/guidelines and procedures
- IT systems.
- IT Staff / Technical assistance.

- Program managers.
- Training.
- SAS Managers.
- Healthcare professionals.

General description: The Andalusian local good practice will be based on the components Tele-COPD (CF1) and Geri-Toolbox (CF6) of the Danish good practice and will be aligned to the "Andalusian Comprehensive Healthcare Plan for Patients with Chronic Diseases", the "Andalusian Integrated Care Process 'Healthcare for Multimorbidity Patients'", the "Andalusian Comprehensive Care Plan" and the "Chronic Patients "Proactive Monitoring" in Primary Healthcare Plan.

Thus, to improve the healthcare at home of complex chronic patients, a Centralised System for Proactive Follow-up (SCSP) that will allow to gather information from homecare professionals when attending CCPs at home will be developed and integrated within the corporate IT system (Diraya). The collected data will be uploaded to Diraya/Patient EHR. The platform will be a key element for healthcare professionals in the proactive and remote monitoring of chronic patients, by mean of the early identification of warning signs/signals, the adaptation of prescriptions, the anticipation of health problems, providing support to caregivers, avoiding unplanned inpatient episodes, etc. Besides, the Andalusian teleconsultation platform will also use to facilitate the communication between healthcare professionals (mainly between primary and hospital healthcare professionals) so it will be also included in the assessment.

Phone-questionnaires and other elements will be used as a support in the proactive "proactive monitoring" process with a double purpose:

the early identification of information and/or warning signs/signals that need a quick response by the reference healthcare professionals.

Assess the therapeutic patient education to determine patient self-care ability and needs.

In summary, the SCSP will facilitate the patient follow-up, will improve the continuity of care by healthcare professionals and improve patient's quality of life.

Local Core Feature 1: Tele-COPD (CF1)

Local Core Feature 2: Geri-Toolbox (CF6)

ACTION PLAN Consejería de Salud y Familias, Junta de Andalucía (CSFJA) and Fundación Pública Andaluza Progreso y Salud (FPS)

Related original Good Practices and their Core Feature (s): Digital Roadmap Towards an Integrated Health Care Sector (Region of South Denmark); B2-CF1 (Tele-COPD) and B2-CF6 (Geri Toolbox)

Local Core Feature 1: Development of a Centralised System for Proactive Follow-up (SCSP) of chronic patients.

SMART objective: By the end of 2022, a Centralised System for Proactive Follow-up (SCSP) of chronic patients that will allow gathering information from homecare healthcare professionals will be implemented (and which will also allow the connection with home/mobile health devices in the future).

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Tendering of the SCSP implementation.	Information and communication technology service (STIC). General Directorate of Healthcare (DGAS). Management unit.	Professionals from different settings	SAS	Process started in July 2021 (expected to be finalised by the end of 2021)	Process started in July 2021 (expected to be finalised by the end of 2021)
SCSP design.	SAS staff, Healthcare professionals, IT experts.	Professionals from different settings	SAS	3 months	Work plan accepted by SAS (Y/N). Report on the technological environment drafted (Y/N). Report on the functional analysis drafted (Y/N). Training plan drafted (Y/N). Knowledge transfer plan drafted (Y/N).

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
SCSP development.	IT professionals. Project researchers, Project Manager, Healthcare professionals.	Professionals from different settings, IT infrastructure	SAS	6 months	Supply and installation in the SAS corporate system of the starting components of the SCSP (Y/N). Testing SCSP components (Y/N). Solving the problems identified during the tests and adjustment of SCSP (Y/N).

Related original Good Practices and their Core Feature (s): Digital Roadmap Towards an Integrated Health Care Sector (Region of South Denmark); B2-CF1 (Tele-COPD) and B2-CF6 (Geri Toolbox)

Local Core Feature 2: Deployment of "proactive follow-up" in primary healthcare centres.

SMART objective: By the end of 2022, JADECARE Joint Action and expected outcomes among healthcare professionals will be carried out to promote data gathering and project development.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Definition and selection of participating healthcare centres and teams.	General Directorate of Healthcare (DGAS). Management unit. PHC professionals, Project researchers, Project manager.	Professionals from different settings	SAS	1 month	Selection of participating healthcare centres (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Training of healthcare professionals.	PHC professionals, Project researchers, Project manager.	Professionals from different settings. SAS infrastructure. Observatory of Innovative Practices for Complex Chronic Disease Management (OPIMEC) infrastructure	SAS	3 months	N of awareness-raising sessions, N of attendees to the awareness-raising sessions. N of training sessions, N of PHC professionals trained.
Patient selection	PHC professionals, Project researchers, Project manager.	Professionals from different settings, IT infrastructure	SAS	1 month	N of cases selected ≥ 500 (Y/N)

Name of the Next Adopters: **Servicio Murciano de Salud (SMS) and Fundación para la Formación e Investigación sanitarias de la región de Murcia (FFIS)**

Title of the Local Good Practice: Developing a tele-rehabilitation service in Murcia

Target population: Patients who come to the Rehabilitation Service for a physiotherapist treatment

Setting(s): Rehabilitation Service and Physiotherapy Service of the Morales Messenger Hospital, Murcia, Spain.

Main aim: Reinforce the rehabilitation treatment of patients who attend the physiotherapy service for post-surgical or post-traumatic rehabilitation through a digital health project with a more flexible approach to rehabilitation, maintaining personal contact with the professional, empowering the patient and maintaining a personalized follow-up.

Outcomes:

- An online application available for various groups of patients(x nº).
- The user can take responsibility for their own rehabilitation and training recommended by the therapist based on his/her needs.
- Program flexibility can increase compliance.
- The user reports on his/her compliance and the experienced level of pain development.
- Rehabilitation professionals can carry out personalized follow-up.
- Web administration, where physical therapists, primary care physicians and other healthcare professionals can monitor progress and create individualized training programs.

Local Core Features and their Components:

- Develop an online rehabilitation program that allows offering treatments to patients with greater flexibility to perform them.
- Elaborate short videos with rehabilitation exercises according to the pathology of the patients.
- Develop a combined treatment plan between face-to-face and online consultation, which can be supervised by professionals in Rehabilitation and Physiotherapy.
- Define pain measurement criteria to evaluate recovery and progress.
- Have an online platform where videos of rehabilitation exercises can be available.
- Have an application for a smart mobile phone or tablet where patients can record their pain parameters and activities and where professionals can monitor patients.

Inputs:

- Financing
- Technological Professionals (1 SGTI-SMS -1 Hospital)
- Project managements (2-3)
- Professionals in Rehabilitation(x nª)
- Physiotherapists(x nª)

- Support professionals in Design and Communication (1)
- Trainers and technical assistants (1 SMS - 1 Hospital)
- Directors and Support Managers (Medical Director - Deputy Director and Head of Rehabilitation and Physiotherapy Services).
- Material resources such as smartphones, tablets, web access. (x nº of phones, tablets)
- Selected patients.

General description: The implementation of Rehab / DK is a project that aims to obtain higher quality and better support in the rehabilitation treatment with the development of activities at citizens' homes, offering greater flexibility in the rehabilitation process, both for health professionals and for patients by improving collaboration between sectors and achieving greater accessibility of person-cantered comprehensive care data and reports and achieving patient empowerment. As well as facilitating the obtaining of information on pro indicators that patients register and that allows to the professional the transparency of the data and the respective monitoring and evaluation accessible to all the actors.

Local Core Feature 1: Develop an online rehabilitation program that allows offering treatments to patients with greater flexibility to perform them.

Local Core Feature 2: Prepare short videos with rehabilitation exercises according to the pathology of the patients)

Local Core Feature 3: Develop a combined treatment plan between face-to-face and online consultation, which can be supervised by professionals in Rehabilitation and Physiotherapy

Local Core Feature 4: Define pain measurement criteria to evaluate recovery and progress.

Local Core Feature 5: Have an online platform where videos of rehabilitation exercises can be available

Local Core Feature 6: Have an application for a smart mobile phone or tablet where patients can record their pain parameters and activities and where professionals can monitor patients

ACTION PLAN Servicio Murciano de Salud (SMS) and Fundación para la Formación e Investigación sanitarias de la región de Murcia (FFIS)

Related original Good Practices and their Core Feature (s): Digital Roadmap towards an integrated Healthcare sector/Region Southern Denmark/ DK. B2- CF4 Online Physical Rehabilitation

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Develop an online rehabilitation program that allows offering treatments to patients with greater flexibility to perform them..	Project managements (1 SMS-1 FFIS-1 hospital). Physiotherapists And Doctors in Rehabilitation (2).of Healthcare (DGAS). Primary care family physicians (2)	Time of the professionals dedicated to the elaboration of the program.	Central SMS Services. Rehabilitation Service of the Morales Messenger Hospital. La Flota Primary Health Center .	4 weeks from the start (October).	Hours dedicated to the development of the program or activity. Degree of progress of the activity according to the programmed time divided from 1-5.
Elaborate short videos with rehabilitation exercises according to the pathology of the patients.	Support professionals in Design and Communication (FFIS). Project managements (1 SMS-1 FFIS-1 hospital). Physiotherapists (2) And Doctors in Rehabilitation (2). Patients for video recording (4).	Availability of equipment for video recording. Material that must be on stage for filming both in the physiotherapy clinic and in the patients' homes.	Stage availability at the Morales Messenger Hospital physiotherapy clinic. Stage availability in patients' homes	4 months (12 weeks). 12 videos are planned: 6 knee videos 6 shoulder videos (1 video per week from November).	To define

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Develop a combined treatment plan between face-to-face and online consultation, which can be supervised by professionals in Rehabilitation and Physiotherapy.	2 professionals from the rehabilitation service of the Morales Messenger Hospital. 2 professionals from the physiotherapist service of the Morales Messenger Hospital 2 Project managements (1 SMS-1 FFIS-1). 2 technological professionals (1SGTI-SMS/1 Hospital). Primary care Family Physicians (La Flota Primary Health Center).	Time dedicated to developing the treatment plan for: -Rehabilitator -Physiotherapist -Manager -IT Technician of General Services (SGTI). -IT technicians from Hospital Morales Messenger - Family Physicians	Rehabilitation service of the Morales Messenger Hospital. Physiotherapist service of Hospital Morales Messenger. Central services of SMS La Flota Primary Health Center	3 weeks development of the treatment plan by a Rehabilitator and a Physiotherapist. 1 week for plan review by all participating physicians and physical therapists. 1 semana para revisión de los gestores del proyecto en SMS y FFIS.	To define
Define pain measurement criteria to evaluate recovery and progress.	Doctors in Rehabilitation. Physiotherapists. Family Physicians	Have various pain evaluation guides available.	Rehabilitation service of the Morales Messenger Hospital. Physiotherapist service of Hospital Morales Messenger.	1 week	To define

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Have an online platform where videos of rehabilitation exercises can be available.	2 technological professionals. (1 SGTI-1 Hospital) 2 Project Managers	General Management SGTI-SMS. Computer service of FFIS. (Health School)	SGTI (SMS) hosted on SMS servers	3 months	To define
Have an application for a smart mobile phone or tablet where patients can record their pain parameters and activities and where professionals can monitor patients.	Company that develops the App. 2 Project managements (1 SMS-1 FFIS-1). 2 technological professionals(1SGTI-SMS/1 Hospital) Physiotherapists And Doctors in Rehabilitation.	Developer SME General Management SGTI-SMS. Time dedicated to developing the treatment plan for: -Rehabilitator -Physiotherapist -Manager -IT Technician from SGTI. -IT technicians from Hospital Morales Messenger	SGTI (SMS)	3 months	To define

LGPs and Action Plans mixing and matching different good practices

***Name of the Next Adopter*: HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO (CIPH)**

LOCAL GOOD PRACTICE HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO (CIPH)

Title of the Local Good Practice: Croatian approach on an Integrated Healthcare Sector (New media use in GP-patient communication and disease management materials with the Digital Health Centre).

Target population: Patients with leading chronic non-communicable diseases (NCDs) (COPD, hypertension, diabetes mellitus, multimorbidity), with special emphasis on patients with diabetes mellitus.

Setting(s): Croatian National Health System.

Main aim: Improve health and quality of life of the patients with leading chronic noncommunicable diseases (NCDs) (COPD, hypertension, diabetes mellitus, etc). Enhance the health system quality by enabling better communication for patients and their GPs. Target is on digital communication and education, by providing user-friendly materials.

Outcomes: Provide timely and more appropriate personalized care for NCDs patients based on their care needs; Enable better and more efficient communication among healthcare professionals and patients with focus on digital communication; Patient empowerment by providing user-friendly educational materials, in both digital and paper form; Improve the time dedicated to each patient, by providing ready-made materials and resources for patients.

Local Core Features and their Components:

Promotion of central e-health digital platform (CEZIH) -"Portal zdravlje" use

- Encourage GPs to introduce their patients to central e-health portal
- Encourage the use of central e-health portal for both GPs and patients

Disease management materials

- Recommendations on diet, physical activity, stress management, sleep hygiene, smoking cessation and alcohol intake reduction, etc
- Pharmacotherapy schedule/calendar templates

Digital Health Centre

- Identification of healthcare professionals connected on digital platform (e-health)
- Identification of diabetes mellitus patients that are users of digital platform (e-health)
- Communication channel through digital platform (e-health)
- Web page creation
- E-learning about diabetes mellitus for patients

Inputs: IT staff; IT systems; Program managers; Healthcare providers.

General description: Improvement of health, disease management and quality of life for patients with NCDs through online education and digital communication with healthcare providers and other health professionals dealing with care of NCDs patients.

Local Core Feature 1: Promotion of central e-health digital platform (CEZIH) - "Portal zdravlje" use and disease management materials provision (Promote the use of central e-health platform for both GPs and patients; Enhance input of information regarding NCDs on existing website and improve efficiency of GP-patient contact/visit)

Local Core Feature 2: Digital Health Centre (enhance input of information regarding diabetes mellitus on existing digital platform and broaden the extent of communication between healthcare providers and patients).

ACTION PLAN HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO (CIPH)

Related original Good Practices and their Core Feature (s): Basque Health strategy; CF2.2., CF3.1; CF3.2

Denmark oGP; CF B1-CF3, B1-CF1, B1-CF2, B2-CF5

Local Core Feature 1: Promotion of central e-health digital platform CEZIH, Portal zdravlje use and disease management materials provision.

- *SMART objective*: By the end of JADECARE (December 2022) Croatian Institute of Public Health will:
  - Conduct a questionnaire for GPs on the use of the central e-health portal app (e-health portal is an application for communication between the doctor and the patient that allows faster, timely and complete care of the patient)
  - Promote the use of central e-health platform (CEZIH) - "Portal zdravlje" among the GPs (education, encouragement)
  - Establish a sustainable web page with relevant disease management materials on NCDs, and disseminate print-friendly materials to GPs.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Questionnaire conduction use of central e-health platform (CEZIH) - "Portal zdravlje"	IT experts; Project manager; GPs	MoH CHIF CIPH	CHIF	January 1 - February 15, 2022	N° of questionnaires sent N° of questionnaires received
Central e-health platform (CEZIH) - "Portal zdravlje" promotion	Project manager; GPs	MoH CHIF CIPH	CHIF	February 15 - December 31, 2022	% of GPs using the app No. of patients using the app
Web page creation	IT experts; Project manager	CIPH www.hzjz.hr	CIPH	January 1 - February 15, 2022	Web page is online (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Materials on NCDs	Project manager; Medical doctors; IT experts	CIP	CIPH	January 1 - December 31, 2022	No. of produced: web articles, online leaflets
Dissemination of produced materials (GPs, their respective patients, and visitors of the web page)	GPs; Patients; Project manager; NGO	CIPH CHIF	CHIF CIPH	February 15 - December 31, 2022	No. of GPs introduced to materials, web campaign
Monitoring	GPs; Project manager; IT experts	CIPH	CIPH	February 15 - December 31	No. of monthly web page visits

Local Core Feature 2: The Digital Health Centre.

- *SMART objective*: By the end of JADECARE (December 2022), the Croatian Institute of Public Health will have contributed to the transition to digitally enabled integrated person-centred care, by establishing a Digital Health Centre with special emphasis on sustainability.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Identification of healthcare professionals connected on a digital platform	IT experts; Project manager	Croatian Health Insurance Fund registry	Croatian Health Insurance Fund	January 1 - February 28, 2022	No. of healthcare professionals that are users of the digital platform
Identification of diabetes mellitus patients that are users of the digital platform	General practitioners (GPs); IT experts	Medical records from GPs	GPs offices	January 1 - May 31, 2022	No. of patients with diabetes mellitus that are users of the digital platform

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Communication channel through digital platform	GPs; IT experts; patients	Central e-health platform CEZIH	Croatian Health Insurance Fund Ministry of Health	January 1 - December 31, 2022	Availability of digital communication (Y/N)
Preparation of materials for web page	IT experts; Project manager; Healthcare professionals	www.hzjz.hr website	Croatian Institute of Public Health	February 15 - May 31, 2022	Materials prepared for upload on web page (Y/N)
E-learning about diabetes mellitus for patients	GP; patients; IT experts; Other healthcare professionals; NGO	www.hzjz.hr website	Croatian Institute of Public Health	June 1 - December 31 2022	No. of articles and courses on the website No. of visits to the website No. of filled-in questionnaires

***Name of the Next Adopter*: REGION NORDJYLLAND (NORTH DENMARK REGION) (RND)**

LOCAL GOOD PRACTICE REGION NORDJYLLAND (NORTH DENMARK REGION) (RND)

Title of the Local Good Practice: Region of North Denmark (RND).

Target population: The North Jutland region has 590,439 inhabitants in 2021. The project will have a special focus on active diabetes patients in the hospital (5,627 active based on the current patient status).

Setting(s): The regional health system - possibly in collaboration with selected municipalities.

Main aim: The North Jutland region has already come a long way with its strategic use of data. The reason for joining JADECARE is to be inspired to further develop our own solutions with the mix´n´match approach. The purpose has therefore not been to implement all or parts of the IT systems from oGPs, but primarily to learn from positive experiences from other EU countries. Our NAWG has expressed interest in these parts:

OptiMedis: Core Feature 5.1: Potential analysis tool and Core Feature 5.2: Performance dashboards

Kronikgune: Core Feature 1.1: Stratification Data extraction and construction of Dashboards and Core Feature 1.2: Classification of patients. 1.3: Stratification in the framework contract

These are the areas where we would like to be inspired to find ways to build our dashboards and develop new project ideas. Therefore, our local action plan and local Core Features is more of an exchange of ideas for areas where we expect to be able to learn from oGPs.

We would like to be inspired on two levels:

First Main aim: Focus on the diabetic patients (5.627 active patients)

Here we would like to realize Steno Diabetes Centre North Jutland's vision:

- Increase quality of life and life expectancy for citizens with diabetes;
- Create a coherent diabetes treatment close to the citizen;
- Slow down the growth of new cases of diabetes.

This must happen based on strategic use of data and data dashboard in the field of diabetes. Although this part is focused on the diabetes area, there are many external actors (other hospitals, municipalities, rehabilitation units, etc.) who can strengthen cooperation with SDCN through joint use of dashboards.

Second main aim: Focus on the entire population in North Jutland (590,439 inhabitants)

The second focus is a main aim for the whole region. Among North Jutland health actors (11 municipalities and one region), there is a strong focus on citizens with chronic diseases and/or complex issues. To ensure a new and more data-driven approach to the health field, new knowledge and methods are needed to focus on the entire population group and not only on active patient groups in the hospital.

Outcomes:

Short term outcomes for the project will be:

- New data dashboards and strategical data usage;
- New competencies at RND and SDCN;
- New projects on the basis of data.

The long-term effect of this project will be better and more targeted patient care, but this cannot be documented within the JADECARE project period.

Local Core Features and their Components:

- Further development of SDCN Data dashboards;
- Data-driven approach for the North Jutland population: feasibility study;
- New projects based on data.

(all is based on experience from OptiMedis Core Feature 5 and Kronikgune Core Feature 1)

Inputs: Funding (Novo Nordisk foundation); BI staff (recruitment); Program managers; Decision makers; IT system (need for ACG Grouper?)

General description: A significant investment for Steno Diabetes Center Nordjylland (part of RND) is a new database of all North Jutland diabetes patients, to make a more targeted patient treatment.

The database must be the central basis for an ambitious digitization and research effort in SDCN and serve as a valuable basis for both patients, healthcare professionals and researchers in the development of new and improved healthcare services for diabetic patients.

There are a large number of data sources that support the field of diabetes today, and with increased digitization and the use of home technology and wearables, even more possibilities arise. The aim of the project is to establish a coherent and generic data platform where the diverse data types are brought together. This development work is already well initiated.

The database must be able to be used for clinical use, at citizen level, for quality development and clinical research, as well as for the development of models for value-based management.

To ensure the usage of the latest methods, SDCN would like to incorporate methods such as patient stratification and risk assessment into the database, so that, in the long-term, new treatment methods can be created for the individual patient groups. Therefore, RND would like to investigate the ideas, data sources and methods in solutions such as Johns Hopkins ACG System in Kronikgune and the systems of OptiMedis, including which data (Finance data, PRO-data , Quality of Life) the method is based on and if the data can be found in the Danish context.

Local Core Feature 1: Further development of SDCN Data dashboards.

Local Core Feature 2: Data-driven approach for the North Jutland population: feasibility study.

Local Core Feature 3: New projects based on data.

ACTION PLAN REGION NORDJYLLAND

Related original Good Practices and their Core Feature (s):

Mix 'n' Match

OptiMedis: Core Feature 5.1: Potential analysis tool and Core Feature 5.2: Performance dashboards.

Kronigune: Core Feature 1.1: Stratification Data extraction and construction of Dashboards and Core Feature 1.2: Classification of patients 1.3: Stratification in the framework contract.

Local Core Feature 1: Further development of SDCN Data dashboards (LCF).

- *SMART objective*: At the end of JADECARE (September 2023), the Region of North Denmark will have designed a new dashboard approach to the diabetes patients in North Denmark which, after the project period, will provide better patient care through more targeted offers.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Examination of programs used by OptiMedis and Kronikgune	NAWG and Optimedis/Kronikgune (Datamanagers etc,)	Communications platform Licenses or demo	Web-based meeting	2021/2022	1 overview over relevant programs, software, tools and license (both Kronikgune and OptiMedis) 1 overview of data sources (both Kronikgune and OptiMedis)
Examine data sources in OptiMedis and Kronikgune	NAWG and OptiMedis/Kronikgune (data managers, etc)	Communications platform	Web-based meeting	2021/2022	

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Examine selected activities and project that are initiated by OptiMedis and Kronikgune on the basis of data. These could be both diabetes project and general health projects	NAWG and OptiMedis/Kronikgune (project managers)	Communications-platform	Web-based meeting	2021/2022	1 overview of project with diabetes (both Kronikgune and OptiMedis) 1 Danish overview of Danish health data sources (Both existing and potential) 1 new Dashboard for use at Steno Diabetes Center North Denmark
Identify the location and conditions for Danish data sources (Fit gap)	NAWG		NA's site	2022	
Development of a new dashboard in the diabetes field in North Denmark	NAWG and Optimedis/Kronikgune	Next Adopter's database – Development cost	NA's site	End of 2022	

Local Core Feature 2: Data-driven approach for the North Jutland population: feasibility study (LCF).

- *SMART objective*: At the end of JADECARE (September 2023) the Region of Northdenmark will have new competencies to use data strategically for better patientcare. This competencies are both at employee level and at management level and can be documented that they have been in knowledge sharing process with Optimedis and Kronikgune.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Knowledge development for chief physician and chief nurse about the use of data and patient stratification	Chief physician and chief nurse (RND); Optimedis/Kronikgune (chief physician and chief nurse)	Study visit (time and travel expenses)	OGP site	2022	4 managers have completed exchange visit
Knowledge development for Business intelligence consultants about development of dashboards and data sources	Business intelligence consultants (RND); Optimedis/Kronikgune (Business intelligence consultants or data managers)	Study visit (time and travel expenses)	OGP site	2022	2 business intelligence consultants have completed exchange visit
Knowledge development for researchers about data sources	Researchers (RND) Optimedis/Kronikgune (researchers)	Study visit (time and travel expenses)	OGP Site	2022	2 researchers have completed exchange visit

Local Core Feature 3: New projects based on data (LCF).

- *SMART objective*: At the end of JADECARE (September 2023), the Region of North Denmark will have a list of new project ideas based on data that can be submitted to the Steno board and patients boards.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Prepare specific project proposals based on data from RND. An example of a project idea could be "Type 1 diabetes patient absences"	NAWG; "The idea clinic"	Communication with OGP (Emails, Teams, etc.)	NA site	End of 2022	2 project proposals
Prototype for data model for stratification – both for diabetic patients and the entire population	NAWG "The idea clinic"	Communication with OGP (Emails, teams etc)	NA site	End of 2022	prototype for a new data model
Presentation of the results of JADECARE to the internal and external strategic decision-makers in North Jutland	"The idea clinic"; "The health innovation platform" in RND (policy level representative)	Communication with OGP (Emails, Teams, etc.)	NA site	End of 2022	1 project summary to policy makers

***Name of the Next Adopter*: SIHTASUTUS VILJANDI HAIGLA (VH)**

LOCAL GOOD PRACTICE SIHTASUTUS VILJANDI HAIGLA (VH)

Title of the Local Good Practice: A funding model for person-centred and integrated services.

Target population: ~50 000.

Setting(s): Viljandi county.

Main aim: Improve the results of the health and quality of life of the population and increase the efficiency of the healthcare system through better planning and use of resources.

Outcomes: Cooperation between Viljandi Hospital and other service providers is carried out; IT tools supporting integrated care funding modelling and risk stratification; Funding model has been proposed in integrated care provision in Viljandi county; Assessment feasibility of nationwide implementation of oGPs.

Local Core Features and their Components:

Develop a funding model for person-centred and integrated services:

- Risk stratification model;
- Case finding;
- Value-based contracting and payment framework;
- Analytical model to execute the contract.

Inputs: Assessment of transferability of OptiMedis framework; Assessment of transferability of risk stratification and case finding tools; Identification of steps for adoption of the Catalan population-based risk stratification tool into the ecosystem of the Next Adopter.

General description: Generating predictive model is needed in order to strengthen population health management and provide better-tailored services for risk groups. Contracting and funding models developed are lined with person-centred and integrated services.

Local Core Feature 1:

Develop a funding model for person-centred and integrated services:

- Risk stratification model;
- Case finding;
- Value-based contracting and payment framework;
- Analytical model to execute the contract.

ACTION PLAN SIHTASUTUS VILJANDI HAIGLA (VH)

Related original Good Practices and their Core Feature (s): Mix'n'Match OptiMedis, Catalonian AMG

Local Core Feature 1:

Develop a funding model for person-centred and integrated services:

- Risk stratification model
- Case finding
- Value-based contracting and payment framework
- Analytical model to execute the contract.

- *SMART objective*: Design a contracting and payment framework approach based on OptiMedis that includes Catalonian AMG risk stratification model.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create a core group to define the local contracting and payment framework model	GPs, nurses; Hospital doctors and nurses; Healthcare planning experts	Professionals from different settings	GP practices Viljandi Hospital Estonian Ministry of Social Affairs	01.01.2022, 3 months	Number and profile of professionals engaged in the definition of the contracting and payment framework approach
Establish criteria for contracting and payment framework	Healthcare professionals; OptiMedis experts; AMG experts	Professionals from different settings	Viljandi Hospital Estonian Ministry of Social Affairs EHIF	02.02.2022 4 months	List of criteria used for contracting and payment framework (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Set up the data extraction and processing mechanisms	IT experts; Data scientists; OptiMedis experts; AMG experts	OptiMedis experts AMG experts IT infrastructure Subcontractor for technical development	Viljandi Hospital	01.01.2022 5 months	Database creation (Y/N) Technical design (%) Functional design (%)
Implement case finding and risk stratification	IT experts; Data scientists; OptiMedis experts; AMG experts	IT infrastructure Subcontractor for technical development	Viljandi Hospital	01.04.2022 5 months	Case finding and risk stratification tool is implemented (Y/N)
Design contracting and payment framework	GPs; Hospital management; OptiMedis experts AMG experts	Professionals from different settings	Viljandi Hospital Estonian Ministry of Social Affairs EHIF	01.04.2022 5 months	Contracting and payment framework agreed (Y/N)
Assess case finding and risk stratification based contracting and payment framework against established criteria	Experts; Healthcare professionals; Healthcare planning experts	Professionals from different settings	Viljandi Hospital GP practices Estonian Ministry of Social Affairs EHIF	01.09.2022 3 months	Conformance report (Y/N)

***Name of the Next Adopter*: University Hospital Olomouc, CZE**

LOCAL GOOD PRACTICE University Hospital Olomouc, CZE

Title of the Local Good Practice: Support program in tele-psychiatry\psychology and cooperation between health providers

Target population: Selected patients requiring specialist care

Setting(s): Cooperation UHO with Jesenik district (also with other subjects)

Main aim: The UHO proposes a number of interventions to promote better integration and proactive care for patients from more remote parts of the county. These interventions include identifying appropriate patients through the process and promoting communication and sharing of care plans, documentation among health care professionals. Our strategy is taking place in a context where increasing numbers of patients, coupled with an ageing population, are being met with decreasing numbers of medical staff. Our approach is in line with the MoH plans and the new Health Electronicisation Act. The practice presents an opportunity to integrate and coordinate efforts to provide timely and ideally integrated care in the future, when fragmentation of the health care system complicates and makes the entire system more expensive. Factors that could negatively impact our goals are the lack of participation of clinical experts in the process, barriers caused by privacy issues, and difficulties in addressing communication barriers. The reluctance of subjects to change established practices and, last but not least, the increasing age of professional staff.

Outcomes: Facilitate the availability of psychiatric/psychologic assessment for target groups in accordance with care needs; Develop a tele-psychiatry/psychology programme via IT aimed also at people in social care institutions; Increase care for patients with mental illness and cognitive-functional disorders in residential care and guarantee continuity of care; Improve the knowledge of the processes of cognitive-functional deterioration and mental illness among social care workers in social care institutions; Improve communication between the psychiatric team of the University Hospital Olomouc, patients (clients of social care facilities), their families and guardians and professional teams of social health care units, general practitioners, Jesenik Hospital, etc.; Reduction of commuting from social care facilities to hospital medical facilities for regular consultations; Facilitate various bureaucratic and administrative tasks online for seniors, families, caregivers and professional social health services staff.; Provide an online space as an alternative to the traditional interview, which may be more acceptable to some groups of people; Due to all these outcomes shape a change in thinking towards mental health care and their patients.

Local Core Features and their Components:

Tele-Psychiatry\psychology online.

Online management of the psychological and behavioural disorders.

Online access to documentation (awareness of medication and medical treatment process).

- Contact with the socio-sanitary professionals of the social care facilities to provide information on the program and the various technological aspects used.
- Preparation of psychiatric programs adapted to the different evolutionary moments of mental illnesses and the functional cognitive situation of the elderly or homeless in social care facilities.
- Possible online communication channels between the elderly, family members, socio-health professionals and some of the psychiatric team (nurse or physician).
- Development of application for tele-psychiatry/psychology for electronic medical documentation of the UHO.
- Development of the Application for mobile devices.
- Online questionnaires to assess progress.
- Online Tele-psychiatric/psychologic consultations.

Inputs: Financing; Staff time for the design, development and implementation of the tele-psychiatric/psychologic program; IT experts; Computer system: improvement of web applications in electronic medical records; Creation of simple manuals for an application used to share documentation; Hardware for the development and usage of the program; Training and technical assistance

General description: An online tele-psychiatry/psychology program focused on the health care of a select group of patients, designed to facilitate access to specialized care without the need for travel. Through patient-centered care and a patient-centered environment, better symptom control, diagnosis of psychiatric disorders, improved health outcomes, and reduced direct and indirect costs can be achieved. This mode of online service delivery encompasses a wide range of care services, from assessment and diagnosis to pharmacological and psychosocial interventions, follow-up and residential care, and the development of clinical care plans. Sharing documentation will increase collaboration and coordination among health care providers.

The outcome sets the stage for the development and expansion of case management, crisis intervention, liaison services for other medical specialties, nursing care, etc. Sharing medical records is also a relief for social service facilities, especially homes for the elderly, for caregivers, reducing the number of trips and paper transfers between patients and physicians.

Sharing documentation will facilitate better delivery of health services to patients who are referred to UHOs from other facilities for specialist examinations, or who attend here while receiving outpatient (ambulatory) care.

Local Core Feature 1: Tele-Psychiatry/psychology online

Local Core Feature 2: Online management of the psychological and behavioral disorders.

Local Core Feature 3: Online access to documentation (awareness of medication and medical treatment process).

ACTION PLAN University Hospital Olomouc, CZE

Related original Good Practices and their Core Feature (s): B2CF3 - Care coordination and communication between health provider (Basque Country), B2CF2 Telepsychiatry (Southern Denmark).

Local Core Feature 1: Tele-Psychiatry\psychology online.

- *SMART objective*: Description, identification and setup Tele-Psychiatry\psychology.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Create a Specific Working Group (SWG) for the local model	NAWG (1 GP, 1 coordinator for computering health care from MoH, 1 pychiatric, 1 psychologist, 1 project manager, 1 deputy director of UHO, 1 office worker from municipality, 1 social worker)	Experts	Olomouc Region	1-30 October 2021	SWG formed (N° of memebers)
Literature, law etc. review for identifying possibilities in Tele-Psychiatry\psychology.	UHO	Time	CZE	1-30 October 2021	Literature reviewed (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Establish criteria and methods for GPs, social care institution to identify suitability Tele-Psychiatry\psychology.	SWG	Time Identification criteria Available literature	Olomouc Region	15 October -30 November 2021	List of criteria to be used for stratification (Y/N) Identification method detected (Y/N)
GPs, psychiatric, psychologist identification	NAWG	Time	Olomouc Region	1 October – 30 November 2021	At least 4 identified specialists (Y/N)
Establish procedures and providing the assistants to the specialists	NAWG	Assistance for the specialists available Financial resources	Olomouc Region	1 October – 30 November 2021 1 December 2021-30 September 2022	Descriptive document about the sustainable incentive system (Y/N) Incentive system implemented (Y/N)
Train identified specialists on the methods to be used for Tele-Psychiatry\psychology. Define modalities for nurse involvement to encourage adherence to the project.	NAWG SWG	Time Trainers available	Olomouc Region	15 November -30 November 2021 (fortnight)	Training performed (Y/N) Treined identified specialists trained (N° of trained staf) Trained identified nurse (N° of trained staf)
Identify complex patients and including them in the "ICP (Individual Care Plan) Folder" of the outpatient EHR. EHR not in the strict sense, but	SWG GP	Time	Olomouc Region	1 December 2021-28 February 2022	Complex patient lists defined with at least 10 identified patients (Y/N)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
appropriate and realistic implementation in an application that allows secure sharing.					
Support and monitoring activities	NAWG	Time	Olomouc Region	1 October 2021-30 September 2022	Support and monitoring activities performed (Y/N)

Local Core Feature 2: Online management of the psychological and behavioral disorders

- *SMART objective*: Creation of a basic description of the problem, appropriate labeling and proposal of the reimbursement for the health insurance company.

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Definition of the most common cases to solve	Members of the NAWG: (1 Coordinator, 1-2 specialist) Coordinators of Nursing Units	Time	Olomouc district	1 October – 30 December 2021	Document (analysis) about common cases (Y/N)
Adaptation of the application for the needs of psychiatry, psychology	Members of the NAWG: (coordinator, IT specialist)	Time Financial resources	Olomouc district	1 November – 30. December 2021 1. December 2021-30 September 2022	Basic modification (Y/N) Continuous modifications (N° of modifications)
Approval of acts for health insurance companies used for reimbursement of care by the health insurance company.	NAWG (coordinator, deputy director of UHO, MoH, insurance company)	Time	Olomouc district	1 December 2021-28 February 2022	Descriptive document about aproved codes available (Y/N)
The system enables a secure online call between the doctor and the patient, patient's representative, consular consultation, etc.	Members of the NAWG: (coordinator, IT specialist)	Time Financial resources	Olomouc district	1 October – 30 December 2021	Modification done (Y/N)

Local Core Feature 3: Online access to documentation (awareness of medication and medical treatment process).

- *SMART objective*: Creating and setting up a system that will enable the sharing of documentation between health care providers, including those provided in social service facilities. Facilitating access to health records as a step towards integrated care, which will lighten the burden on the system in terms of making duplicate copies of health records, physically sending records (which also takes place between other entities, caregivers, etc.)

Activities	Actors	Resources	Setting(s)	Timeline	Key Performance Indicators
Setting the conditions and operation of shared documentation via a secure server on the UHO network.	NAWG (UHO)	Time Financial resources	Olomouc district	1 October – 30 December 2021	Document (analysis) about common cases (Y/N)
Adaptation of the application for the needs of other organisations involved.	Members of the NAWG: (coordinator, IT specialist)	Time Financial resources	Olomouc district	1 November – 30. December 2021 1. December 2021-30 September 2022	Basic modification (Y/N) Continuous modifications (N° of modifications)
Support and monitoring activities	Members of the NAWG: (coordinator, IT specialist)	Time Financial resources	Olomouc district	1 November – 30. December 2021 1. December 2021-30 September 2022	Basic modification (Y/N) Continuous modifications (N° of modifications)

Increasing the number of organisations and documents in data sharing through a secure application	UHO	Time	Olomouc district	1. December 2021-30 September 2022	Data shared via app (N° of saved data for sharing, N° of real shared descripted data)