



European Innovation Partnership on Active and Healthy Ageing

A1 ACTION GROUP 2016-2018

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Background and context

After three years of intensive work, European Innovation Partnership on Active and Healthy Ageing become an important part of European social and healthcare landscape. Originally set up by European Commission, it become a vivid collaboration of diverse European stakeholders, sharing the vision of prosperous economies, and happy societies due to the broad introduction of the concept of Active and Health Ageing into daily life.

Undoubtedly, one of the basic conditions for both healthy, and active ageing is patient adherence to medical plans. Adherence to healthy diet, active lifestyle and – last but not least – medication are the cornerstones of wellbeing in every age group. However, due to the characteristics of an old age, with multimorbidity at the top of it, they play even more important role in this growing portion of European societies.

And that is why, along with several other key preconditions for healthy ageing, patient adherence is directly in the focus of EIP on AHA interest. A clear reflection of this fact is the foundation of Action Group A1 ‘Prescription and Adherence to Medical Plans’.

Within the first period of its activity, EIP on AHA proved to be matured collaboration of European stakeholders able to initiate cross-European movement toward active and healthy ageing. AG A1 played an important role in this process, as proven by a recently published summary of their achievements.¹

Now, there is a time to get ready for the new tasks, and the new perspective of collaboration within the years 2016-2018. The EC has provided a clear guideline to frame the renovation of the existing Action Plans in the EIP on AHA Strategic Implementation Plan² and Operational Plan³.

With this target in mind, AG A1 started early enough (April 2015) the process of the renovation of the Action Plan. This well-structured iterative work led to the identification of the most relevant areas of their further activities, and forming of the Renovated Action Plan. In this document, one can find details of this process, and its outcomes, that set the frame for the AG A1 activities in the years to come.

¹ https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/a1_achievements_2015.pdf

² http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/implementation_plan.pdf#view=fit&pagemode=none

³ http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/operational_plan.pdf#view=fit&pagemode=none

INTRODUCTION TO THE ACTION GROUP AND THE ACTION PLAN

The Action Group A1

In agreement with the overall goals and triple win defined in the Strategic Implementation Plan⁴ (SIP) of the EIP on AHA, the A1 Action Group aims to contribute to the improvement of adherence to medical plans and medication at European level under the pillar on "Prevention, screening and early diagnosis". In particular, the implementation plan called for a set of actions to be launched, namely, delivering a prescription and adherence action at regional level as well as developing innovative tools and applications to promote health literacy and patient empowerment for informed lifestyle choices. These actions would contribute to the overall aim of the Action Group to improve the quality of life and health outcomes of older people living with chronic conditions in at least 30 EU regions, through a holistic approach, including enhanced self-care, personalised care, better adequacy of treatment and increased adherence to safe and effective care plans.

In response to the SIP, the European Commission launched two invitations for commitments, in 2012 and 2013, inviting stakeholders to contribute to the implementation of its objectives. Through this process, the A1 Action Group brought together 62 'main' partners representing 68 multi-stakeholder commitments from 31 different countries.

Within the first period of its activity (2013-2015), A1 Action Group partners focused their work around five broad domain areas that have been identified to address the challenges and respond to the objectives of the Action Plan, namely:

- Adherence to care plans
- Empowerment of patients and caregivers
- Improvements of the health care services
- Research and methodology
- Communication

In addition, three collaborative work areas have been established, in line with the above mentioned action areas:

- Adherence to care plans and research
- User/ patient empowerment
- Improvements of the healthcare system with a focus on polypharmacy and innovative pharmaceutical care

⁴ 1 http://ec.europa.eu/research/innovationunion/pdf/active-healthy-ageing/steeringgroup/implementation_plan.pdf#view=fit&pagemode=none

The renovated Action Plan

In order to meet the challenges posed by the new period of their collaboration, and boost the effectiveness of their work, AG A1 partners decided to renovate their Action Plan for years 2016-2018.

This process started with critical analysis of AG a1 achievements, which have been collected in the State of Play publication, published November 2015⁵. This analysis not only pointed at the strengths of the group work, showcasing the areas where the work should be continued. Moreover, it allowed for identification of gaps that have not been achieved or even ideas that can be included in this renovation phase.

With all these ideas in hand, AG A1 started the process of the renovation of Action Plan in a systematic way, which finally led to the conclusions described in this document, which sets the perspective for the further collaboration of AG A1 members.

Of a note is that Renovated Action Plan is an evolving and iterative document that will undergo further development. Therefore, this document will be updated along the 2016-2018 period.

Rationale

Over the last century, Europe has experienced a considerable economic development, improved living conditions and great advances in medical sciences leading to more effective healthcare systems. These factors have contributed to the emergence of a new situation in beginning of the third millennium: Europe is facing a completely new demographic challenge.

The increased percentage of older people in Member States may be perceived both as an opportunity for the boost of Silver Economy as well as a source of continuous rise of healthcare and social security costs. Regardless of which of these two perspectives one adopts, the consequences of this demographic challenge for national healthcare systems are acute. Older people represent a large proportion of the population affected by chronic diseases or multiple chronic diseases. Therefore, in order to adapt and get ready to respond to the needs of these new patients, European healthcare systems' design has to be revisited and redefined.

Safe and effective treatments for a range of chronic conditions are widely available in Europe. However, the effectiveness and cost-effectiveness of these treatments is dependent on patient adherence. Adherence is defined as the level to which patient

⁵ https://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/a1_achievements_2015.pdf

behaviour coincides with treatment plan that has been mutually agreed with healthcare professionals. This includes lifestyle factors, such as diet, and physical activity. Of the utmost importance, however, is the adherence to medication – a *sine qua non* condition of positive outcomes.

Economic impact of non-adherence in older people is substantial. Particularly in this age group, non-adherence results in increased hospitalisations and readmissions, as well as in the misuse of resources and adverse medical outcomes. All these make this phenomenon a major concern for public health. However, these consequences are in many instances preventable.

The evidence arising from existing research does not support one single intervention to solve the puzzle of medication nonadherence in older patients. As proven with previous works of AG A1, a large number of approaches targeting different steps of the patients' journey through the healthcare system have been designed and have found to be effective in reducing the extent of this problem. Therefore, the challenge in practical terms results in selecting the right interventions, their adoption, and scaling-up.

Moreover, the time is ripe to adopt the novel approach of an increased patient role in the treatment decision-making process. Under this approach patients cease being inactive figures subject to accepting impositions in their treatment – as commonly accepted under the old-fashioned paternalistic model of doctor-patient interaction – and become increasingly free to take part in their health decisions. Indeed, with increased health literacy and ICT support, they become co-producers of better health outcomes.

All these make a perfect opportunity, and a rationale for further collaboration of European stakeholders gathered within Action Group A1, under an umbrella of Renovated Action Plan for the next period of 2016-2018.

PROCESS FOR GATHERING IDEAS APRIL-OCTOBER 2015

Gathering ideas for AG A1 Renovated Action Plan was a well-structured, transparent process, open for every AG A1 member, that included several steps, namely:

- 2 participatory meetings (8th AG A1 meeting, April 16th, 2015, and 9th AG A1 meeting, October 14th, 2015)
- 2 on-line surveys (June and November 2015)
- the collaborative preparatory work done within each potential new collaborative area by the interested partners (January 2016)

This process was supported by:

- the European Commission, which provided, between the others, general strategic and project management support to the Group; and organisation of meetings and communications activities
- PROEIPAHA project and AG A1 Promoter, which facilitated day-to-day communication, collected stakeholders feedback, and drafted relevant documents.

The outcome of this process is this Renovated Action Plan, with its ideas for collaborative work, Sprints, and synergies.

Ideas for collaborative work

The 8th AG A1 meeting provided useful starting point for the renovation of the Action Plan, that needed to be confirmed and/or further developed during the next meeting. In the meantime, an online survey among AG A1 members (June 2015) assessed lessons learned along the first period of their collaboration. This served for a background of the 9th AG A1 meeting, during which stakeholder expressed their expectations from the Renovated Action Plan, and provided first inputs toward its outline. During focused discussion, stakeholders pointed out that the A1 vision for the period 2016-2018 should be inspired along several themes, e.g.:

"Recognize the Pharmacist as a key player improving prescriptions and supporting adherence to treatments"

"Promoting the role of the pharmacist and improvement of the collaborative work between healthcare professionals"

"To provide more information aimed to patients on pharmacological treatments and chronic diseases in elderly population"

"Adopt a holistic approach of adherence"

“Improve communication skills of health professionals in their relations with patients and care givers

“Exploit the potential of ICT for better adherence”

“Disseminate among policy-makers the impact of non-adherence”

“Identify and disseminate promising practices”

For the period 2016-2018, the most relevant areas of development for the definition of the renovated Action Plan’s objectives have been identified as follows:

- Promote participation of citizens in health policies
- Collaborating results with all professionals
- Development of innovative technologies
- Improve adherence to medication and chronic treatments
- Scale-up efficient strategies
- Patient empowerment
- Recommendations to governments
- Promoting the role of pharmacist
- Risk stratification tool
- Model for improving prescription
- Faster for clinical trials approval/revision

As a result of 9th AG A1 meeting, several ideas for collaborative areas were shortlisted, along with stakeholders interested in their further development. Members happy to become coordinators of these area were preliminarily identified, as well. Further fine-tuning of collaborative areas ideas was performed with the means of on-line survey (November 2015) and focused collaborative preparatory work done within each potential new collaborative area by the interested partners (December 2015-January 2016). Due to this process, details of the Renovated Action Plan for AG A1 have been agreed, with General objectives, Specific objectives, Coordinators, and the relevant timelines.

Priorities identified as sprints for 2016-2018

‘Sprints’ is a new concept introduced for the first time to the renovated Action Plan. This is a collaborative work that is carried out by a number of organisations in a short period of time (often 6 months), and leads to one or several associated deliverables. ‘Sprint’ refers to the prioritisation of collaborative work. During the AG A1 face to faces meetings and subsequent teleconferences and surveys, several Sprints have been proposed, details of which are provided in the ‘ACTIVITIES, SPECIFIC RESULTS AND IMPACT’ section.

Ideas for synergies

Synergies are thematic working groups which interests are cross-cutting to at least two or more Action Groups of the EIP on AHA, and are established in a collaborative approach. The synergies include collaborative work and sprints agreed among representatives of the different AG involved. For the management of the set of synergies identified across Action Groups, the EIP on AHA will have a promoter and a person for administrative secretariat services.

During the process of designing of Renovated Action Plan, AG A1 members focused on domains of common interest where synergies could be developed:

- Nutrition and socio-cultural determinants of health, to design adequate primary nutritional interventions, with AG A3
- Management of politherapy with the ICT support and integrated care (link with AG C2 and B3).
- Screenings for frailty could take advantage from the integration with D4 age friendly initiatives that involve local stakeholders (municipalities etc)

These ideas have been put forward to the attention of the Task Force Synergies for the definition of the final set of Synergies which has been approved. For the time being, as many as 8 synergies have been accepted by the Task Force, their details are provided in a table below.

Ref.	Title	General Objectives	Interested AGs
SYN_01	Information technology and adherence in ageing population with chronic diseases and polypharmacy	To increase the adherence to treatment of older age adults with chronic diseases and polypharmacy (i) assessing the role of ICT - based solutions such as advanced processing of data, decision support applications and remote monitoring and consultation systems, and (ii) implementing tailored ICT- based interventions We expect that the knowledge that will be created will support stakeholders to take action in the direction of improving elderlies' quality of life.	A1, A2, A3, B3, C2

SYN_02	'Masters of AHA' – educating seniors, health and social carers and entrepreneurs	To contribute to the development of dynamic and sustainable care systems of tomorrow by development of a distinctive Master of Gerontology and Geriatrics that will encompass education, stakeholders empowerment and inter-disciplinary, interprofessional research according to different backgrounds and competencies.	A1, A2, A3, B3 C2 D4
SYN_03	Patient and citizen Empowerment across the EIP Action	To develop a consensus view of what patient empowerment is, sharing progress plans regarding the evolution of the respective patient/user empowerment objectives within the different Action Groups. On the basis of a common understanding, both of the content of the topic and of what the different groups are doing, look across the EIP as to how this more holistic perspective can contribute to scaling up of good and effective practices via transverse as well as vertical processes and can support the overall objectives of the EIP.	A1, A2, A3 B3 C2 D4
SYN_04	Maturity Model for Scaling-up Innovative Solutions in Europe	To share learning and expertise with the development of the B3 Maturity Model for Integrated Care by developing other specific challenges and a self-assessment tool; To test and validate the Maturity Model(s) as a tool supporting scaling-up and replication of innovative solutions in Europe and as a tool facilitating the knowledge transfer and exchange of good practices in Europe.	A1, A2, A3 B3 C2
SYN_05	Active and Healthy Ageing in the framework of Responsible Research and Innovation	To create an ecosystem around RRI for AHA by identify the current state of the actions and initiatives, fostering policy dialogue among the relevant stakeholders in AHA, proposing a new roadmap trying to involve in place as much local and regional stakeholders as possible and providing and monitoring	A1, A2, A3 B3 C2 D4

		indicators of progress.	
SYN_06	Falls and fall injuries - A Grand Societal Challenge involving prevention and healthy ageing of seniors	To enable macro-, meso- and micro-level analysis including, on the one hand, governance and policy-making based screening, prevention, rehabilitation and monitoring, and, on the other hand, an integration with Silver Economy, and related to WHO's consultation on Global Strategy and Action Plan on Ageing and Health To support regional and municipal levels to act and become deeply engaged in fall prevention campaigns, thereby enabling and promoting early frailty and fall risk assessment, and identifying frail and faller profiles To Raise awareness and promote behavioural change among citizens in prevention of frailty and fall injuries.	A1, A2, A3 B3 C2 D4
SYN_07	Impact of Community-based Program on Frailty Prevention and frailty Mitigation (ICP – FPM)	To set up a public health approach to manage frailty in community dwelling older adults, to be validated in different EU member states (at least six) by integrating in the community and primary care and assessing good practice and impact, including ICT tool.	A1, A2, A3 B3 C2
SYN_08	Multimorbidity of chronic respiratory diseases in old age adults: an under-recognised societal	Chronic respiratory diseases (CRD) are major chronic diseases intertwined with ageing. CRDs negatively impact AHA. Prevention and control of CRD in the ageing population is a priority. A stepwise action plan is proposed including scientific societies and patient's organisations.	A1, A3 B3

OBJECTIVES

In agreement with the overall goals of the EIP on AHA to improve quality of life, increase systems and services sustainability and increase the EU economy's competitiveness, the Action Group A1 aims to contribute to 4 General objectives listed below.

General objectives

General objectives agreed for the AG A1 renovated Action Plan are as follows:

- **General objective 1. Scientific Research and Advocacy on Adherence**
- **General objective 2. Reinforce the role of the pharmacist**
- **General objective 3. Education and empowerment**
- **General objective 4. Exploit the potential of ICT for better adherence**

Specific objectives

In a table below, Specific Objectives being proposed for each General Objective are listed.

General objectives	Specific Objectives
General objective 1. Scientific Research and Advocacy on Adherence	1.1 New consensus on adherence definition
	1.2 Assessing the impact of adherence
	1.3 Determinants of non-adherence
	1.4 Tools and methodologies to improve adherence
General objective 2. Reinforce the role of the pharmacist	2.1 Establish and evaluate the current status of the pharmacist's intervention, and its real added value, on the topic adherence
	2.2 Pilot Study on reinforcement the role of the pharmacist in adherence management
	2.3 Social and Economic Evaluation of

	<p>pharmacists' interventions regarding adherence improvement</p>
	<p>2.4. To assess the adherence to a chronic treatment in patients attending a community pharmacy through the individual measurement of the adherence and the factors associated.</p>
	<p>2.5 The multidisciplinary (medical and pharmacist) clinical role in review of prescription of patients with multiple morbidities to ensure appropriate polypharmacy and support then in the management of their medications and improve adherence</p>
	<p>2.6 To determine the pathway to develop potential new models for delivery for review of appropriate polypharmacy with the pharmacist working with the GP/ hospital physician. This would be achieved by evaluating existing schemes and proposing new models</p>
	<p>2.7 To provide some economic data to support the development of these models</p>
<p>General objective 3. Education and empowerment</p>	<p>3.1 Qualification of counselling for the empowerment of polymedicated patients</p>
	<p>3.2 Improving decision making and adherence levels for polymedicated patients through patient empowerment, care team proactiveness and decision support systems</p>
<p>General objective 4. Exploit the potential of ICT for better adherence</p>	<p>4.1 Applications and ICT tools for supporting Adherence in medical plans</p>
	<p>4.2 New advancements in integrated care and intelligent DSS systems to support Adherence models.</p>
	<p>4.3 Information ontologies of poly-medicated adherence to treatment</p>

	<p>4.4: Promoting better integration of health-related databases in EU through networking and data sharing protocols to support adherence in medical plans</p>
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ACTIVITIES, SPECIFIC RESULTS AND IMPACT

Activities to be undertaken to progress on the Action Plan are numerous, will involve different resources and actors and will be common to different objectives. They cannot be displayed to its whole extension in this document. As a result of these activities several **results** will be achieved. What follows is a list of key activities that will be carried out by the partners under each objective to develop the plan and a list of the expected tangible results that different partners have committed to obtain.

Generic objective 1: Scientific Research and Advocacy on Adherence

Coordinator: Alessandro Monaco

Specific Objectives	Specific objective coordinator	Activities/Sprints	Deliverables & Impact	Start Day - End Day
1.1 New consensus on adherence definition	Alessandro Monaco	1.1.1 Mapping EIP AHA Adherence (SPRINT)	EU deliverable and scientific position paper on behalf of all A1 group	Q2-Q4 2016
		1.1.2 Consensus paper on Adherence definition	Group deliverable on the format of: abstract, poster & /or Infographics	Q2-Q4 2016
		1.1.3 Communication plan I (SPRINT)	Scientific paper	Q2-Q4 2016
		1.1.4 Measuring Adherence	Scientific papers; consensus for standardization of measures to be used in adherence trials; edition of a book on adherence subjects	Q2-Q4 2017
1.2 Assessment of the impact of Adherence	Alessandro Monaco	1.2.1 Socio economic evaluation of non adherence	Scientific paper proposing a comprehensive model for the evaluation of economic impact of non-adherence in specific settings	Q2-Q4 2016
		1.2.2 Policy Consensus White paper	White Paper evidence based supporting decision makers	Q2 2016- Q1 2017
		1.2.3 Communication plan II (SPRINT)	Scientific paper	Q2 2016- Q1 2017
1.3 Determinants of non-	Alessandro Monaco	1.3.1 Multimorbidity and polymedication (SPRINT)	Online training course	Q2 2016 - Q4 2016

adherence				Scientific papers (experimental protocol; results obtained)	Q2 2016- Q4 2018
		1.3.2 Promoting better integration of health-related databases in EU through networking and data sharing protocols	1.3.2.1 Establishing a cross-country network for health-related databases	Scientific paper	Q2 2016- Q4 2017
			1.3.2.2 Cross-country comparison on Medication Adherence based on Observational Database	Study protocol, Report on analysis, Publication/Participation to ISPOR and other congress	Q2 - Q4 2016
		1.3.3 Data sharing and linking, notably between various sources for drug utilization		Publication	Q2-Q4 2016
1.4 Tools and methodologies to improve adherence	Alessandro Monaco	1.4.1 ICT tools	1.4.1.2 Assess Hypertension app		Q2 - Q4 2016
			1.4.1.3 Test the platform MakeYourHeartFeelGood	Measurement the number of patients reached via this channel (population targeted)	Q2 - Q4 2016
		1.4.2 Non ICT (SPRINT)	1.4.2.1 Non-ICT systems for better adherence.	Scientific review paper; Scientific report to conferences	Q2 2016 - Q1 2017

Generic objective 2: Reinforce the role of the pharmacist

Coordinator: Lúcia Santos & Alpana Mair

Specific Objectives	Specific objective coordinator	Activities/Sprints	Deliverables & Impact	Start Day - End Day
2.1 Establish and evaluate the current status of the pharmacist's intervention, and its real added value, on the topic adherence	Lúcia Santos	2.1.1 Identification of the most relevant services provided by pharmacists	Updated report	
		2.1.2 Systematic review on the topic adherence and the role of the pharmacist in improving adherence to medical plans	Scientific review paper	01.02.2016 – 30.06.2016
2.2 Pilot Study on reinforcement of the role of the pharmacist in adherence management	Lúcia Santos	2.2.1 Design and validation of the pilot study	Improving adherence	01.03.2016 – 30.03.2017
		2.2.2 Implementation phase at the local level (15 - 20 community pharmacies)	Improving patients global health status	
		2.2.3 Scaling up to other regions	Cost savings Increase effectiveness of treatment	30.12.2017
2.3 Social and Economic Evaluation of pharmacists' interventions regarding adherence improvement	Lúcia Santos	2.3.1 Definition of methodology and specific objectives of the study – Conceptualization step	Scientific evidence of the social and economic pharmacist's added value in the therapeutic process	01.03.2016 – 30.06.2018
		2.3.2 Development of the analysis/study – implementation step		
2.4. To assess the adherence to a chronic treatment in patients attending a community pharmacy	Blanca Lumberras Lacarra/Elsa López Pintor	2.4.1 Assessment of the pharmacist's role, as part of their routine work, in improving the outcomes of patients taking medication, by improving adherence, by evaluating existing schemes and proposing potential new models for delivery	Literature review on interventions to improve the adherence to chronic treatment in community	Q3 2016

through the individual measurement of the adherence and the factors associated.			pharmacies.	
			Research article based on a multicentre study in community pharmacies	Q2 2016
			Scientific meeting with pharmaceuticals from community pharmacies	Q4 2017
2.5 The multidisciplinary (medical and pharmacist) clinical role in review of prescription of patients with multiple morbidities to ensure appropriate polypharmacy and support then in the management of their medications and improve adherence	Alpana Mair	2.5.1 best skill mix models of delivering polypharmacy reviews	to establish by undertaking a review the best models of delivering polypharmacy reviews	Q3 2016
		2.5.2 process steps to deliver reviews that includes checking adherence as part of the steps	Establish process steps to deliver reviews that includes checking adherence as part of the steps	Q3 2016
		2.5.3 to present this data and outcomes with partners and at EU conferences	To present this data and outcomes with partners and at EU conferences	Q3 2016- Q4 2018
2.6 To determine the pathway to develop potential new models	Alpana Mair	2.6.1 to gather stakeholder input inform model for implementation	Through SIMPATHY work gather information on different models that	Q4 2016

for delivery for review of appropriate polypharmacy with the pharmacist working with the GP/hospital physician. This would be achieved by evaluating existing schemes and proposing new models			have been implemented to deliver appropriate polypharmacy	
		2.6.2 To get stakeholder views on and assess EU countries current implementation of review of appropriate polypharmacy	To get stakeholder views as part of work in SIMPATHY to assess EU countries current implementation of review of appropriate polypharmacy via SIMPATHY project	Q3 2016-Q4 2018
		2.6.3 to provide strategy for implementation of polypharmacy reviews with partners	To provide strategy for implementation of reviews by working with SIMPATHY outputs to share with partners	Q4 2017
2.7 To provide some economic data to support the development of these models	Alpana Mair	2.7.1 to share with partners key tools to implement review of appropriate polypharmacy and adherence across Europe	To share with partners key tools identified by SIMPATHY to implement review of appropriate polypharmacy and adherence across Europe AND present at	Q3 2016-Q4 2018

			EU forums to disseminate information.	
		2.7.2 To share with partners outcomes from work gathered from countries with benefits of implementing model	to share with partners outcomes from work gathered from countries with benefits of implementing model	Q3 2016- Q4 2018

Generic objective 3: Education and empowerment

Coordinator: Giuseppe Fico

Specific Objectives	Specific objective coordinator	Activities/Sprints	Deliverables & Impact	Start Day - End Day
3.1 Qualification of counselling for the empowerment of polymedicated patients	Clara Cena	3.1.1 Identification of barriers against efficacy in education to elderly patients and of new expertises to be enrolled in multifaceted educational approach to empower patients	Scientific publication on perceived barriers and necessary actions to qualify counselling to polymedicated old people in Europe	Q2-Q4 2016
		3.1.2 Collection from polymedicated patients of relevant information on underthreshold adverse effect of polypharmacy	Review paper on initiatives, diffused in EU countries, supporting identification and reporting of medication problems in polymedicated elderly and on emerging underthreshold adverse effects of polypharmacy	Q3 2016-Q3 2017
		3.1.3 Proposal of an integrated educational toolkit of interdisciplinary counselling	educational kit to qualified education	Q3 2016 - Q4 2017
		3.1.4 Support pharmacist active role in counselling qualification	Poster presentation Position Paper on the state of the play in Pharmacists Education in Europe	Q1-Q3 2017
3.2 Improving decision making and adherence	Giuseppe Fico	3.2.1 To define an intervention that takes into account the	Study Protocol for Interventions	Q2-Q4 2016

levels for polymedicated patients through patient empowerment, care team proactiveness and decision support systems		results of the A1 CWs to test them in clinical practice.	to Improve Adherence to Polymedicated Patients	
		3.2.2 To conduct an experiment and test the results and achievements of the A1 CWs in a real scenario	Intervention to Reduce Adherence to Polymedicated Patients	Q1-Q4 2017

Generic objective 4: Exploit the potential of ICT for better adherence

Coordinator: Homer Papadopoulos

Specific Objectives	Specific objective coordinator	Activities/Sprints	Deliverables & Impact	Start Day - End Day
4.1 Applications and ICT tools for supporting Adherence in medical plans	Homer Papadopoulos	4.1.1 Assess Hypertension app		Q2 - Q4 2016
		4.1.2 Test the platform MakeYourHeartFeelGood	Measurement the number of patients reached via this channel (population targeted)	Q2 - Q4 2016
		4.1.3 Assess iwelli remind me app	Qualitative study of the results of a running pilot of a pill remind ubiquitous application	Q4-2016
4.2 New advancements in integrated care and intelligent DSS systems to support Adherence models.	Homer Papadopoulos	4.2.1 Explore how new advancements in integrated care can support patients to take active role in self-management of their medical plan and pharmacists and doctors to successfully review adherence in polypharmacy.	A study and a framework that will connect technology for integrated care with adherence to medical plans policies.	Q2 2018
		4.2.2 Explore how new advancements in intelligent ICT tools and artificial intelligence and DSS can support professionals like pharmacists and doctors to successfully review adherence in polypharmacy	Produce a framework and publish a paper that will try to connect AI and DSS with adherence to medical plans policies.	Q4 2017
4.3 Information ontologies of	Homer Papadopoulos	4.3.1 Identification of the data sets and relations, pilot	Develop an information standard ontology	Q4 2018

poly-medicated adherence to treatment	s	results and relevant studies that will be used in the study.	of polymedicated adherence to treatment	
			Systematic review of the body of literature, information and analysis of the results	Q4 2018
4.4: Promoting better integration of health-related databases in EU through networking and data sharing protocols to support adherence in medical plans	H. Papadopoulo s	4.4.1 Establishing a cross-country network for health-related databases	Scientific paper	Q2 2016-Q4 2017
		4.4.2 Cross-country comparison on Medication Adherence based on Observational Database	Study protocol, Report on analysis, Publication/Participation to ISPOR and other congress	Q2 - Q4 2016

GOVERNANCE AND COORDINATION

Governance principles

Each Action Group establishes its own working methods and governance, with the EC acting as a facilitator. There are three components to governance structure: the partners, the action group coordinators and the EC. The governance structure will ensure timely development of the Action Plan and the incorporation of newly interested partners (NB the new call for commitments will be open in the beginning of 2016). Overall, the rules of engagement between the parties are based on the following principles:

- Openness and partnership – common willingness of all partners to cooperate with other relevant partners.
- Coordination – participation of a representative(s) in the coordination meetings of the Action Group
- Reporting – regular reporting from the Action Group's meetings, progress of actions and deliverables to be made public
- Evaluation – outcome of actions to be evaluated, and results made public

Role & responsibilities of Partners

- Implement the agreed Action Plan to the agreed standards and deadlines
- Ensure the effective preparation and delivery of all AG results
- Evaluate of AG performance and report on progress

Role & responsibilities of Coordinators

- Implement the agreed Action Plan to the agreed standards and deadlines
- Lead the AG team and coordinating all matters of the commitment contents
- Coordinate the work of their Collaborative work area
- Regular liaison with the EC and facilitator on all AG related matters
- Define strategic lines for the A1 group in collaboration with the other coordinators, the EC officials and the promoter
- Ensure the effective preparation and delivery of all AG results
- Participation at meetings and in discussions
- Take the responsibility for the effective flow of information between AG members
- Work on communication and advocacy. Support evaluation of AG performance and report on progress
- Submit of the final results of the Action Plan based on data provided by all AG members

Role & responsibilities of the European Commission

- Representation of the Action Group
- Handling of external communication
- Monitoring framework
- Ensuring regular communication among partners
- Taking responsibility for the effective flow of information and interactions between AGs
- Seeking opportunities to consolidate EIP

Governance and coordination of AG A1 within 2016-2018 period

Within 2016-2018 period, the A1 Action Group is expected to become more and more autonomous, while EC will focus its attention on policy-making, and not on project management anymore. Therefore, AG A1 partners are invited to adopt internal governance rules and agreements that can improve the current functioning and renew their coordinators. The following aspects of the governance are of the utmost importance:

- Self-management of AG A1
- Internal communication
- External communication/advocacy/dissemination
- Synergies across AGs
- Scaling up of good practices
- Creation of national focal points in Member States to communicate on the EIP on AHA to local/national stakeholders
- Advocate for funding dedicated to support activities on adherence to medical plans and to scale-up strategies on ageing

On the basis of the new Action Plan 2016-2018, new coordinators have been appointed.

Appendix 1. Glossary of key terms used in the Action Plan

Commitments: commitment is defined as individual tasks regarding the declaration of intention on the work that one or several organisations will be doing in the context of an Action Group. Usually ‘commitments’ should refer only to individual tasks (for example, the ones that were committed to in the two invitations for commitments launched in 2012 and 2013). Nevertheless, following the processes to join existing commitments, Action Groups were in the situation of commitments managed by two or more organisations. In the context of Action Groups work, AG B3 did not follow the individual commitments approach and started developing collaborative works, AG A1 and AG A3 are working on tracking the progress of these individual commitments and D4 is using a mixed approach, tracking progress of individual commitments and some collaborative works planned under a specific action area.

Collaborative work: A collaborative work is considered as an agreed project carried out by several organisations, in some cases, a set of individual commitments can be grouped and create collaborative work. In the period 2012-2015 some Action Groups collaborative work has been named as joint deliverables, common project or even other less used terms. Even if the result in practical terms is the same, the following different types of collaborative works can be identified:

- a. Being ‘born’ in the EIP on AHA as a new project idea
- b. An individual project that was presented to Action Group members and ‘recruited’ new members for the project from the pool of partners of a given AG
- c. Any other formal way used within Action Groups to conceptualise collaborative work.

Sprints: This is a new concept introduced in the renovated Action Plan. A collaborative work that is managed as a project “sprint”, it means that it is carried out by a set of organisations in a short-time period (normally 6 months) and it has one or several associated deliverables. Sprint refer to the prioritisation of collaborative work.

Synergies: Even in the first period (2012-2015) the synergy concept has been introduced for reinforcing the collaboration of the Action Groups on specific matters of common interest, reinvigorated engagement for this kind of cooperation is needed in the renovated Action Plan. Synergies are referenced as thematic working groups which interests are cross-cutting to one or several Action Groups under the EIP on AHA and are established in a collaborative approach. They may include collaborative works and sprints agreed among representatives of the different involved groups.

Results:

In the definition of the individual commitments, collaborative works, sprints or synergies, the renovated Action Plan should pay attention to ensure that expected results are specific, measurable, achievable, results-oriented and time-bound. Results could be divided in some cases in a set of actions; these actions could be

also be time-related and may include “milestones”. In most of the Action Groups, these results were previously named as “Deliverables”. For the purpose of the renovated Action Plan it is suggested to use the term “Results” instead of “Deliverables”.