COMPETITIVENESS AND INNOVATION FRAMEWORK PROGRAMME

PROPOSAL PART B

ICT PSP seventh call for proposals 2013

Pilot Type B

ICT PSP Objective identifier: 3.1.b: Wide deployment of integrated care

Acronym: INCA

Full title: “INclusive INtroduction of INtegrated CAre” (IN³CA)

Number: 621006

Name of coordinating person (organisation): IDI EIKON

ANNEX 1 – “Description of Work”

Number and Date of preparation: v06 of 05/08/2013 – accepted on 28/11/2013
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>B1. Relevance</td>
<td>3</td>
</tr>
<tr>
<td>B1.1. Project objectives</td>
<td>3</td>
</tr>
<tr>
<td>B2. Implementation</td>
<td>25</td>
</tr>
<tr>
<td>B2.1 Consortium and key personnel</td>
<td>25</td>
</tr>
<tr>
<td>Partner 1: (COORDINATOR) IDI EIKON, S.L. – IDI EIKON (IDI) - Spain</td>
<td>27</td>
</tr>
<tr>
<td>Partner 2: AYUNTAMIENTO QUART POBLET – Spain</td>
<td>29</td>
</tr>
<tr>
<td>Partner 3: INTERFUSION SERVICES LIMITED (IFS) - Cyprus</td>
<td>30</td>
</tr>
<tr>
<td>Partner 4: Kenus Informática - Spain</td>
<td>31</td>
</tr>
<tr>
<td>Partner 5: Hospital de Manises - Spain</td>
<td>32</td>
</tr>
<tr>
<td>Partner 6: GEROSKIPOU City Council Social Department – Cyprus</td>
<td>34</td>
</tr>
<tr>
<td>Partner 7: VENTSPILS City Council Social Care Board – Latvia Republic</td>
<td>36</td>
</tr>
<tr>
<td>Partner 8: Ziemeļkurzemes reģionālā slimnīca – Latvia Republic</td>
<td>35</td>
</tr>
<tr>
<td>Partner 9: Croatian Health Insurance Fund - Republic of Croatia</td>
<td>37</td>
</tr>
<tr>
<td>Partner 10: RIJEKA City Council Department of Health and Social Welfare - Croatia</td>
<td>38</td>
</tr>
<tr>
<td>Partner 11: Foundation for Training and Healthcare Research of Murcia Region – Spain</td>
<td>40</td>
</tr>
<tr>
<td>B2.2a. Chosen approach</td>
<td>43</td>
</tr>
<tr>
<td>B2.2b. Work plan</td>
<td>44</td>
</tr>
<tr>
<td>B3.2c. Project management</td>
<td>73</td>
</tr>
<tr>
<td>B2.3 Resources to be committed</td>
<td>73</td>
</tr>
<tr>
<td>B2.4 Indicators</td>
<td>76</td>
</tr>
<tr>
<td>B2.5 Security, privacy, inclusiveness, interoperability; standards and open source</td>
<td>79</td>
</tr>
<tr>
<td>APPENDIX I: Ethical Screening</td>
<td>80</td>
</tr>
</tbody>
</table>
B1. Relevance

B1.1. Project objectives

The aim of INCA is to Validate and to start a pragmatic Initial Deployment in Europe, of inclusive friendly and engaging multi-channel “patient-centric” communication care NETWORKS of integrated socio-sanitary care e-Services (integration of the whole personalised care chain provision of health care, social care, long-term and self-care in any kind of health/living conditions) among Public, Private and Third sector stakeholders and served from “the cloud”.

INCA wants to be seen initially (ICT PSP project phase) as a contribution towards first-time introduction of integrated care programmes and coaching of “first time deployment” by “early adopter” regions in New Member States, including “proactive” engagement and Remote Patient Monitoring, as the present Objective 3.1b aims. However, INCA, beyond the scope of ICT PSP project phase, is worth enough for tackling too healthy people, as a powerful preventive eHealth tool.

Initial “statu quo”:

Euro-diversity” is well represented in INCA polyvalent “living labs” pilots by diverse Geographic areas, with different expertise in European common Health initiatives:

- On one side, 1 old Member State (Spain) as “early adopter” of “health and social integrated care” and coacher Region and the pilot of reference;
- On the other, all “first time deployment” regions with different ethnical status: urban, rural and insular areas. The battlefield of INCA validation will be 4 Member States (Spain, Cyprus, Latvia and Croatia1), where the fragmentation and “silo” approaches of Health and Social care is the common “statu quo” and INCA benefits will represent an outstanding frog-leap in better care integration.

INCA validation scope:

Accordingly, the specific objective of INCA is to validate, in these different Regions of the European Union, the replication and expansion of USA “best practice” (now in full deployment phase and not funded by ICT-PSP Programme).

In summary, INCA validation (our mainly task in WP4, page 61) has to provide a sound feedback (PROS & CONS) for making decisions of GO / NO GO in INCA full deployment phase, beyond the timeframe of this project phase, in a sustainable way (WP5, page 67).

INCA Consortium propose to do these tasks in a timely and progressively "customized” (WP3 page 58) roadmap of the previously described “friendly and engaging multi-channel “patient-centric” set of integrated socio-sanitary care e-Services” among Patients and informal and formal caregivers, in the context of the Top challenges identified by the Co-ordination Group of B3 Integrated Care ACTION PLAN.

Specific description of Scenarios and Partners involved

All INCA pilots will be operational longer than 12 months and will report evidence on benefits related to health outcomes and daily activities, as well as effectiveness and efficiency of INCA innovative care.

The customization and technical testing of the pilots will be done during the first part of the project (from month 4 to 10). The service provision of the INCA services will start at month 12 lasting until month 28 (16 months), longer than the 12 months requested for pilots B. From month 11 to the end of the project, INCA services will be maintained and improved with users’ feedback. The

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1 At the time of starting INCA project, Croatia will be the newest Member State in EU.
never-ending provision of service is due to the commitment of INCA Consortium in following the continuity of INCA after the funded CIP ICT PSP phase in a sustainable way and expanding the service to new European niches.

The final result of the project will be a real service deployed and impacting into more than 125,000 European citizens and a feasibility of FULL deployment report consisting of the following elements:

- Demonstration of the operational service in 4 Member States of Europe involving a significant number of users in real-life conditions: 1 coaching area in Spain (now including 2 pilots) and 4 "first time deployment pilots”.
- Additional demonstration in other countries where INCA can be deployed (belonging to the ‘first’ of ‘second’ waves of the pan-European movement of INCA) that will be associated to the project.
- Peer review of the service, through a series of dissemination and networking activities taking the form of local trials in the INCA areas, and of a series of workshops / seminars / conference and thematic fairs.
- Documented feedback from the user population, including the description of specific challenges and barriers (if any) to overcome prior to full deployment.
- A refined business/investment plan for FULL Deployment of INCA.

Specific aspects of each pilot:

<table>
<thead>
<tr>
<th>PILOTS</th>
<th>Citizens impacted</th>
<th>Active Users (minimum)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYPRUS</td>
<td>15,300</td>
<td>150</td>
</tr>
<tr>
<td>LATVIA</td>
<td>19,800</td>
<td>200</td>
</tr>
<tr>
<td>CROATIA</td>
<td>27,000</td>
<td>200</td>
</tr>
<tr>
<td>SPAIN (Valencia)</td>
<td>33,150</td>
<td>500</td>
</tr>
<tr>
<td>SPAIN (Murcia)</td>
<td>30,000</td>
<td>500</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>125,250</strong></td>
<td><strong>1,550</strong></td>
</tr>
</tbody>
</table>
Brief Pilot Description (state of the art before INCA)

During the last 6 years as part of “Home Care” initiative, the Municipality of Geroskipou was offering the free service of personal home care-giving to elder people that could not take care of themselves. The service included medical treatment, house cleaning, personal exercise and food provision to the elder population that were unable to achieve for themselves or they had no guardians. Due to the increased cost of the service and budget cut-offs, in 2013 the Municipality decided to replace this service with a weekly visit from Iasis doctors in Geroskipou Council for Community Welfare where the doctors had to examine and monitor the health condition of around 65 elder patients per visit (260 per month) and advise the social caregivers of the Council of further exercise, medical treatment and special diet the patients had to follow.

Cardio-vascular diseases and strokes (cerebrovascular accidents CVAs) are the most deadly disease in Cyprus where around 2000 people die every year and 39000 are suffering from. Unbalanced diet, reduced physical activity and increased consumption of tobacco products are the main risk factors associated with heart disease challenge. Regular blood pressure and anthropometry measurements, reformulated diet guide are important precaution measures to reduce the deaths as a consequence of these diseases.

INCA provides the opportunity for Geroskipou Municipality to facilitate and monitor elder patients suffering from cardio-vascular diseases and strokes more efficiently and in essence make the “Home Care” initiative a more economically viable solution.

INCA platform will give the opportunity to the Community Welfare personnel to exchange information on patients with their doctors either proactively before they suffer from cardio-vascular diseases and strokes or for rehabilitation purposes. At the same time the patients will be able to contact directly their doctors when required from their homes via INCA or vice versa, the doctor will be able to alert the patient for a check-up, when noticing parameters that could lead in to a cardio-vascular disease or a stroke.

Caregivers lack deeper knowledge about the nature and course of the disease while the patient on how to change quality of life, to live with this disease. This gap will be closed by more personal messages received by the patients and caregivers that are active end-users of INCA (from their homes or from the Community Welfare centre) as well as more general cardio-vascular disease and stroke messages presented through info-kiosks in public spaces informing and reminding elder people about the new healthy lifestyle they need to follow to avoid such diseases (stopping smoking, balanced diet, limit the use of salt and alcohol, frequent exercise and maintain ideal body weight).
Project goal
Electronic Data Interchange system for social rehabilitation program for patient that suffered cardio-
vascular diseases and strokes (cerebrovascular accidents CVAs), who require social and medical care
at their home or in Community Welfare centre, which will enhance their social inclusion and improve
quality of life. Secondary goal is to proactively inform people about possible symptoms and personal
health improvement habits to reduce deaths from these diseases.

InterFusion will be actively involved in the Cypriot pilot, acting as its Coordinator and manager. Its
role is essential for the provision of guidance and support to the Municipality of Geroskipou in terms
of integration and interchange of information between the Municipality Department of Social Care
and the primary and secondary healthcare services of the Pafos district.

Interfusion will maintain a guidance role to the Municipality of Geroskipou, providing assistance in the
decision making process to the high level decision makers at municipal the pilot in level, and
providing the training to the staff on the operation and provision of the services to be implemented.

Expected Benefits (after INCA)
1) Developed electronic information exchange system between the Iasis Hospital and
Geroskipou Municipality, as well as the patients themselves, which will allow early detection
of those patients who require social care in time to provide the necessary services and
monitor the evolution of the disease.
2) Designed rehabilitation program that includes prevention and early intervention package to
prevent possible crises and the current deteriorating state of health.
3) Replace the costly “Home Care” program with a more economical and innovative solution. Social services at home are adapted to the customer’s individual needs.
4) Social care-givers would enhance their knowledge of cardio-vascular diseases and strokes
something that could lead into identifying symptoms in an earlier stage increase their skills
and customer care.
5) Electronic Records of patients could be easily shared between doctors and care-givers in the
Community Welfare centre to discuss the progress of the patients health during the week
(between doctor’s visits).
6) 150 patients received advice about necessary changes in their life, nutritional characteristics,
drug usage and required arterial blood pressure monitoring while living independently or
visiting the Community Welfare centre.
7) Elder people are informed of proactive actions to avoid cardio-vascular diseases and strokes.
8) Significant improvements in quality of life of the target group.
9) Tested system can be transferred to other target groups.
10) Monitoring of rehabilitation after stroke that focuses on the three major elements of the
rehabilitation:
    a. Re-ablement: the restoration of functional abilities;
    b. Re-settlement: adaptation of the patient to the surrounding environment and health
care professional; and
    c. Re-adjustment: psychological adaptation by setting goals and targets for the patient
for establishing self-esteem and motivation.
11) INCA is pilot-tested in Paphos District and in particular in Geroskipou Municipality, the
second largest Municipality of the district as part of the preparatory activities of becoming
the European Capital of Culture in 2017 and contribute towards achieving the goals of “foster
the participation of the citizens living in the city and its surroundings and raise their interest
as well as the interest of citizens from abroad” and “be sustainable and be an integral part of
the long-term cultural and social development of the city”.

INCA DoW v06 accepted on 28/11/2013
Main Tasks to be completed during the pilot

<table>
<thead>
<tr>
<th>Stage of Pathway in the pilot</th>
<th>Core Tasks/Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Start Up Scenario Analysis</td>
<td>• Analyse and set up a start up scenario measuring current organization and usage of socio-sanitary services.</td>
</tr>
</tbody>
</table>
| 1. Patient Identification     | • Participant’s inclusion criteria decision and creation of a list of participants (Patient identification).  
• Circulate list between peers and departments involved and final selection of the participants.  
• Risk Stratification process to classify patients into risk groups.  
• (Segmentation of patients into “risk groups” according to their clinical condition -based on guidelines provided by Iasis Hospital). |
| 2. Care Planning              | • Every Patient (and related Care-givers) in the pilot receiving a personalized integrated care plan from his General Practitioner / Case Manager / Social Worker.  
• Pilot patients acknowledging and giving consent to their personalized integrated care plan. |
| 3. Care Delivery              | • Training and coaching of the participants and support by Interfusion.  
• Socio-sanitary Providers using **INCA** platform to deploy personalized care plans.  
• Patients using **INCA** platform to accomplish personalized care plans.  
• As a result of this work, additional Clinical Indicators will be generated.  
• First Quality of life measurement. |
| 4. Care Co-Ordination         | • Providers, mainly General Practitioners, Case Managers and Social Workers, coordinated by Interfusion, using **INCA** platform, share information on personalized care plans.  
• Patients (and related Care-givers) having access to any document or data their socio-sanitary condition coming from every provider attending them (and participating in the care process when asked to do so: fulfilling questionnaires, providing blood pressure measurements, attending reminders on medication, etc.) |
| 5. Performance Review Analysis| • Comparing core performance indicators against Start Up Scenario  
• Use those indicators to calculate potential savings (and better quality of service) in the integrated socio-sanitary experience.  
• Comparison of the final situation (**INCA** Benchmarking indicators) of the participants with their initial situation in the Start Up scenario thus giving a complete picture of the improvement in Quality of Life.  
• Conclusions and Post-Implementation Review |
## Indicators to be used to track pilot performance

<table>
<thead>
<tr>
<th>Stage of Pathway in the pilot</th>
<th>Indicators to be used</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0. Start Up Scenario Analysis</strong></td>
<td>All those listing below; mainly those at point 5 – Benchmarking</td>
</tr>
<tr>
<td></td>
<td>• Initial Level of access to information.</td>
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<tr>
<td></td>
<td>• % of homes equipped with possibly needed hardware (PC, Mobiles, iTV) before the pilot.</td>
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<tr>
<td></td>
<td>• Initial cost of providing information.</td>
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<td></td>
<td>• Number of patients examined weekly from Iasis doctors in the Community Welfare centre.</td>
</tr>
<tr>
<td></td>
<td>• Number of recorded incidents of cardio-vascular diseases and strokes in the district.</td>
</tr>
<tr>
<td><strong>1. Patient Identification</strong></td>
<td>% of Patients into a “risk group”</td>
</tr>
<tr>
<td></td>
<td>• Pilot Patients representation exists for any of the three risk groups (low, medium, high)</td>
</tr>
<tr>
<td><strong>2. Care Planning</strong></td>
<td>% of Pilot Patients getting a personalized care plan at their home.</td>
</tr>
<tr>
<td></td>
<td>• % of Pilot Patients getting a personalized care plan in the Community Welfare centre.</td>
</tr>
<tr>
<td></td>
<td>• % of Pilot Patients consenting to (and agreeing to implement) a personalized care plan.</td>
</tr>
<tr>
<td><strong>3. Care Delivery</strong></td>
<td>Providers’ Adherence to <strong>INCA</strong> platform (measuring daily use of <strong>INCA</strong>).</td>
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<tr>
<td></td>
<td>• Patients’ Adherence to <strong>INCA</strong> platform (measuring answers to tasks providers request using <strong>INCA</strong> platform) when an active role is assigned to Patients.</td>
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<td></td>
<td>• % of Personalized Care Plan Actions completed (per patient).</td>
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<td></td>
<td>• Number of initial services offered.</td>
</tr>
<tr>
<td></td>
<td>• Level of easiness of following the service.</td>
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<td></td>
<td>• Level of easiness to learn how to use it.</td>
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<tr>
<td></td>
<td>• % of users that manages the system without supervision after training.</td>
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<td></td>
<td>• % of users that do not understand services workflow.</td>
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<td></td>
<td>• % of user awareness for proactive actions to reduce cardio-vascular diseases and strokes risk.</td>
</tr>
<tr>
<td><strong>4. Care Co-Ordination</strong></td>
<td>Number of Case Conferences on Specific Cases hold per month. A minimum number is to be agreed on the Pilot, to ensure coordination and integration as an always on-going task.</td>
</tr>
<tr>
<td></td>
<td>• % of providers’ documents and data on patient condition being available to pilot patients under their Patient Care Repository.</td>
</tr>
<tr>
<td><strong>5. Performance Review Analysis</strong></td>
<td>Pilot Patients Satisfaction Level.</td>
</tr>
<tr>
<td></td>
<td>• Average number of routine visits to General Practitioner / Case Manager / Social Worker.</td>
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<td></td>
<td>• Average number of routine visits to Specialists.</td>
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<td></td>
<td>• Average number of Emergency Hospital Admissions.</td>
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<td></td>
<td>• Average length of Hospital Stay.</td>
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<td></td>
<td>• Compare average cost of “Home Care” initiative and <strong>INCA</strong> per patient.</td>
</tr>
<tr>
<td></td>
<td>• Care-givers awareness on cardio-vascular diseases and strokes symptoms.</td>
</tr>
<tr>
<td></td>
<td>• Easiness of following the service.</td>
</tr>
<tr>
<td></td>
<td>• Patient’s easiness of learning to use the service unattended.</td>
</tr>
<tr>
<td></td>
<td>• Level of usefulness, accuracy and adequacy.</td>
</tr>
<tr>
<td></td>
<td>• End-users awareness and satisfaction beyond rehabilitation.</td>
</tr>
<tr>
<td></td>
<td>• Percentage of users that do not understand services workflow.</td>
</tr>
<tr>
<td></td>
<td>• Average number of users accessing the system.</td>
</tr>
<tr>
<td></td>
<td>• Numbers of users willing to continue using <strong>INCA</strong>.</td>
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<tr>
<td></td>
<td>• Number of final services offered.</td>
</tr>
<tr>
<td></td>
<td>• Number of patients examined weekly from Iasis doctors in the Community Welfare centre.</td>
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<tr>
<td>Community Welfare centre.</td>
<td></td>
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<tr>
<td>--------------------------</td>
<td></td>
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<tr>
<td>- Number of recorded incidents of cardio-vascular diseases and strokes in the district.</td>
<td></td>
</tr>
</tbody>
</table>
PILOT CASE: VENTSPILS & Northern Kurzeme Hospital - LATVIA

Partners: Ventspils Municipality Social Care Board and Northern Kurzeme regional hospital

Integrated Care for Hypertension patients in Ventspils Municipality (Social Care and at home recovery)

Brief Pilot Description (state of the art before INCA)

Ventspils municipality has created an opportunity for alternative care or home care for people living alone without guardians. The 2013 budget allocated to carers is approximately 60,000 Euros. For persons who cannot take care of themselves municipality provides support for home care provision. It can be delivered after signing a trilateral agreement between reliant person, municipality and the caregiver. Social Care department has record of 155 home cared persons, of which 79 personal home care services are twice a week, while 56 persons receives home care services tree times per week. This service is provided by 135 caregivers.

Annually Ltd. "Northernkurzeme regional hospital" treat 625 patients with the diagnosis - hypertension. 13% of the treated patients return to the hospital again, but approximately 4% of patients with this diagnosis receive treatment more than twice a year. Hypertension patient treatment costs on average 296,875 euro annually.

During the INCA project hospital plans to reduce the number of patients re-stationed. This will be possible if patients health status is regularly monitored and preventive actions are placed.

Past experience has shown that Social Care Department has insufficient co-ordination with Northernkurzeme Regional hospital because there is no mutual exchange of information on patients who are being discharged from the hospital and who have disease requiring social home care.

Assessing the need for home care, 65% of dependent people have shown arterial hypertension as one of the accompanying diagnoses. When assessing a person's abilities, insufficient attention was paid to social assistance clients disease diagnosis characteristics. In case of hypertension these parameters are crucial:

1. The need to regularly keep track of blood pressure changes
2. The regular use of medication
3. a healthy diet
4. physical activity

Caregivers lack deeper knowledge about the nature and course of the disease while the patient on how to change quality of life, to live with this disease. This often leads to situations when hypertension patients over and over again going through critical situations in arterial hypertension, which can lead to stroke, heart attack risk, heart disorders, kidney problem, may raise glaucoma risk, a leading cause of blindness. Often after critical situations in arterial hypertension, the person enters hospital that actually impairs a person's quality of life and raises the cost of the treatment process.

After hypertension crisis patients are recovering at home and it is necessary to strengthen person's social care at home because the person may find it difficult to do daily tasks like- food shopping and cooking, cleaning and laundry, personal hygiene.
**Project goal**

Electronic data interchange system for social rehabilitation program for patients with hypertension who require social and medical home care, which will enhance their social inclusion and improve quality of life.

**Expected Benefits (after INCA)**

1) Developed electronic information exchange system between the Northern Regional Hospital and Ventspils City Council Social Care Department, as well as the patients themselves, which will allow early detection of those patients who require social care home in time to provide the necessary services and monitor the evolution of the disease.
2) Designed rehabilitation program that includes prevention and early intervention package to prevent possible crises and the current deteriorating state of health.
3) Social services at home are adapted for the customer's individual needs.
4) 135 social carers are being trained of pre-existing hypertension arterial characteristics that simultaneously increases the skills and the customer care.
5) A database of persons with appropriate diagnosis, which is also available Social Care Department.
6) 200 patients received advice about necessary changes in their life, nutritional characteristics, drug usage and required arterial blood pressure monitoring while living independently.
7) reduced chance of getting hypertension patients in hospital
8) significant improvements in quality of life of the target group
9) tested system can be transferred to other target groups

**Main Tasks to be completed during the pilot**

<table>
<thead>
<tr>
<th>Stage of Pathway in the pilot</th>
<th>Core Tasks/Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Start Up Scenario Analysis</td>
<td>Analyse and set up a start up scenario measuring current organization and usage of socio-sanitary services</td>
</tr>
</tbody>
</table>
| 1. Patient Identification | Segmentation of patients into “risk groups” according to their clinical condition [based on guidelines provided by Northern Regional Hospital]  
Segmentation of patients into "risk groups" according to their social condition [based on guidelines provided by Social Care Department]  
Both guidelines are to be agreed among stakeholders to develop a unique way of attending patients: pilot ICP |
| 2. Care Planning | Northern Regional Hospital and Social Care Department developing a set of care actions and packages related to previously identified “risk groups” (INCA Protocol for Elderly Care with Hypertension). Guidelines from this Pilot ICP can be loaded and managed using INCA ICT tool to have customized ICPs for every patient, caregiver and provider to follow.  
Every Patient (and related Caregivers) in the pilot receiving a personalized integrated care plan from his General Practitioner / Case Manager / Social Worker  
Pilot patients acknowledging and giving consent to their personalized integrated care plan |
| 3. Care Delivery | Socio-sanitary Providers using INCA platform to deploy personalized care plans  
Patients using INCA platform to accomplish personalized care plans  
As a result of this work, additional Clinical Indicators will be generated to specifically track not only Elderly Care but Hypertension specific issues (blood pressure measurements, adherence to medication, diet and activity issues, etc.) |
| 4. Care Co-Ordination | Providers, mainly General Practitioners, Case Managers and Social Workers, using INCA platform to share information on personalized care plans and managing referrals and case conferences on specific cases |
Patient (and related Caregivers) having access to any document or data on his socio-sanitary condition coming from every provider attending him (and participating in the care process when asked to do so: fulfilling questionnaires, providing blood pressure measurements, attending reminders on medication, etc.)

5. Performance Review Analysis

- Comparing core performance indicators against Start Up Scenario
- Use those indicators to calculate potential savings (and better quality of service) in the integrated socio-sanitary experience

<table>
<thead>
<tr>
<th>Stage of Pathway in the pilot</th>
<th>Indicators to be used</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Start Up Scenario Analysis</td>
<td>All those listing below; mainly those at point 5 – Benchmarking</td>
</tr>
</tbody>
</table>
| 1. Patient Identification     | % of Patients into a “risk group”  
                               | Pilot Patients representation exists for any of the three risk groups (low, medium, high) |
| 2. Care Planning              | % of Pilot Patients getting a personalized care plan  
                               | % of Pilot Patients consenting to (and agreeing to implement) his personalized care plan |
| 3. Care Delivery              | Providers’ Adherence to INCA platform (measuring daily use of INCA)  
                               | Patients’ Adherence to INCA platform (measuring answers to tasks providers request using INCA platform) when an active role is assigned to Patients.  
                               | % of Personalized Care Plan Actions completed (per patient) |
| 4. Care Co-Ordination         | Number of Case Conferences on Specific Cases hold per month. A minimum number is to be agreed on the Pilot, to ensure coordination and integration as an always on-going task.  
                               | % of Referrals handled in the pilot among providers using INCA  
                               | % of providers’ documents and data on patient condition being available to pilot patients under their Patient Care Repository |
| 5. Performance Review Analysis| Pilot Patients Satisfaction Level  
                               | Average number of routine visits to General Practitioner / Case Manager / Social Worker  
                               | Average number of routine visits to Specialists  
                               | Average number of Emergency Rooms visits  
                               | Average number of Emergency Hospital Admissions  
                               | Average length of Hospital Stay |
**PILOT CASE: Croatian Health Insurance Fund & Rijeka City - CROATIA**

**Partner**: Croatian Health Insurance Fund (CHIF or HZZO)  
**Partner**: Rijeka City Department of Health and Social Welfare

**Integrated Care for Mental Health problems patients in Rijeka City**  
(Systemic therapy in Geropsychiatric patients)

**Brief Pilot Description (state of the art before INCA)**

Three partners, with different roles and duties, will participate in this pilot.

Partner **Croatian Health Insurance Institute (HZZO)** is financially part of State Treasury. Its main duties are:

1. To manage the Health Insurance Fund and contract health care services
2. To have a key role in the definition of basic health services covered under statutory insurance
3. To establish performance standards and price setting for services covered by the HZZO

HZZO is also responsible of the - pricing and reimbursement decision on drugs and medical devices.

The **City of Rijeka Department of Health and Social Welfare** responsible of carrying out activities related to community’s care for citizens who due to unfavourable personal and social reasons and circumstances are not in a position to independently meet their basic living needs. The Department also implements activities regarding the improvement of accessibility and quality of health care in the city area and provides for citizens a higher standard of health care from the one which is secured by the state.

The City of Rijeka has made bridging the digital divide one of its priorities and there is a plan to systematically address the needs of groups that are at risk of exclusion from the Information Society. Primary targets of ongoing efforts are disabled and elderly people, but also many other groups on Social Welfare programs. The proportion of the population that is over 60 years old increased in last 10 years from 22% to 27%. The number of the population suffering from the mental health problems or other mental health disorders increased for more than 50%.

**Psychiatric Hospital "Lopača"** (founded by the City of Rijeka) treatment is performed within socio-dynamic therapy where emphasis is put on the extended treatment of chronic mental patients and their rehabilitation, which is conducted through organized occupational therapy and group and socio therapy. The hospital provides systemic therapy in geropsychiatric patients, and psychotherapy with family members of patients, and it also provides help in the events of crisis. Hospital activities include: diagnostics, medical treatment, rehabilitation and re-socialization of mental patients and drug addicts, children and adolescents with associated mental disorders; specialist health care and diagnostics, treatment of patients in the field of psychiatry and related fields (epilepsy, terminal patients); providing specialist medical opinions and findings at the request of the institutions and bodies and forensic expertise, outside of family care for mentally ill adults.
Project Goal

**INCA** pilot in the City of Rijeka will consist on **health and social services coordination** with the aim of improving accessibility of health and social services.

Main target groups are:

- people over 60 suffering from mental health problems or other mental health disorders

Stakeholders to actively participate in the pilot are:

- **City of Rijeka Department of Health and Social Welfare**
- **Psychiatric Hospital "Lopača"**
- Clinical Teaching Hospital Rijeka
- Primary health care centers in Rijeka city (general practitioners)
- Domiciliary Care Service “Kantrida” Home for the Elderly and the Disabled
- Community Nurses Service
- County Centre for Social Care

**Expected Benefits (after INCA)**

1. to make improvement of health and quality of life of the people suffering from mental health problems or other mental health disorders
2. to enhance communication between all stakeholders
3. to recognize the processes within the value chains in order to increase the efficiency and quality of services
4. to improve level of mental care service in the area of Rijeka
5. to improve accessibility of health and social services
6. to inform the public, by using ICT, of programmes and services for mental health protection
7. 193 directed impact users (from a pilot hospital: Patients (suffering a Mental Health condition), Carers (formal and informal), Doctors, Psychologists, Social Services Officers)
8. Establishing a Local Stakeholder Multi-Disciplinary Group / Chain obstacles identification with the following proposed members / institutions:
   - City of Rijeka
   - Psychiatric Hospital Lopača
   - Clinical Teaching Hospital Rijeka / Psychiatric Department
   - Primary health care (2 general practitioners)
   - Kantrida Home for the Elderly and the Disabled
   - Domiciliary Care Service “Kantrida” Home for the Elderly and the Disabled
   - Community Nurses Service
   - County Centre for Social Care
   - Croatian Health Insurance Institute
   - Informal and volunteering supporters
## Main Tasks to be completed during the pilot

<table>
<thead>
<tr>
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| 1. Patient Identification     | • Segmentation of patients into “risk groups” according to their clinical condition [based on guidelines provided by Lopača Hospital]  
                                • Segmentation of patients into “risk groups” according to their social condition [based on guidelines provided by City of Rijeka Health and Social Welfare Department]  
                                • Both guidelines are to be agreed among stakeholders to develop a unique way of attending patients: pilot ICP |
| 2. Care Planning              | • Lopaca Hospital and City of Rijeka developing a set of care actions and packages related to previously identified “risk groups” (INCA Protocol for Elderly Care for Mental Health condition). Guidelines from this Pilot ICP can be loaded and managed using INCA ICT tool to have customized ICPs for every patient, caregiver and provider to follow.  
                                • Every Patient (and related Caregivers) in the pilot receiving a personalized integrated care plan from his General Practitioner / Case Manager / Social Worker / Specialist  
                                • Pilot patients acknowledging and giving consent to their personalized integrated care plan |
| 3. Care Delivery              | • Socio-sanitary Providers using INCA platform to deploy personalized care plans  
                                • Patients using INCA platform to accomplish personalized care plans  
                                • As a result of this work, additional Clinical Indicators will be generated to specifically track not only Elderly Care but Mental Health condition specific issues (adherence to medication, social habits and related issues, etc.) |
| 4. Care Co-Ordination         | • Providers, mainly General Practitioners, Case Managers and Social Workers, using INCA platform to share information on personalized care plans and managing referrals and case conferences on specific cases  
                                • Patients (and related Caregivers) having access to any document or data on their socio-sanitary condition coming from every provider attending them (and participating in the care process when asked to do so: fulfilling questionnaires, attending reminders on medication, etc.) |
| 5. Performance Review Analysis| • Comparing core performance indicators against Start Up Scenario  
                                • Using those indicators to calculate potential savings (and better quality of service) in the integrated socio-sanitary experience |
### Indicators to be used to track pilot performance

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| **1. Patient Identification** | - % of Patients into a “risk group”  
- Pilot Patients representation exists for any of the three risk groups (low, medium, high) |
| **2. Care Planning** | - % of Pilot Patients getting a personalized care plan  
- % of Pilot Patients consenting to (and agreeing to implement) his personalized care plan |
| **3. Care Delivery** | - Providers’ Adherence to INCA platform (measuring daily use of INCA)  
- Patients’ Adherence to INCA platform (measuring answers to tasks providers request using INCA platform) [when an active role is assigned to Patients]  
- % of Personalized Care Plan Actions completed (per patient) |
| **4. Care Co-Ordination** | - Number of Case Conferences on Specific Cases hold per month. A minimum number is to be agreed on the Pilot, to ensure coordination and integration as an always on-going task.  
- % of Referrals among providers in the pilot handled using INCA  
- % of providers’ documents and data on patient condition being available to pilot patients under their Patient Care Repository |
| **5. Performance Review Analysis** | - Pilot Patients Satisfaction Level  
- Average number of routine visits to General Practitioner / Case Manager / Social Worker  
- Average number of routine visits to Specialists  
- Average number of Emergency Rooms visits  
- Average number of Emergency Hospital Admissions  
- Average length of Hospital Stay |
Brief Pilot Description (state of the art before INCA)

Manises Hospital manages Valencia Region Health Department number 23, which covers 10 different Primary Care Centers at 14 different municipalities and offers services to close to 200,000 patients.

In order to better attend to this population, Manises Hospital has developed an Integrated Care Pathway (ICP) for different chronic conditions (Heart Failure, Diabetes, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), dyslipidemia, palliative care). Chronic population in this Health Department is visiting Primary Care facilities 7 times per year as an average (regular patients visit Primary Care 3 times per year); Emergency Rooms 3.4 times per year as an average (regular patients pay 1.6 visits per year); and stay at the hospital 6.4 days as an average (regular patients stay only 2.1 days per year).

This new strategy to attend needs for chronic populations is based on the need to act more proactively to get chronic patients information flowing, across a multi-disciplinary group, to detect potentially dangerous situations in advance, avoiding undesired scenarios like ER visits or Hospital admissions. This model is perceived as a “better QoS” by patients and it helps Hospital managers to use resources in a smarter way, generating economic savings for the entire Health Department.

INCA shows as a good opportunity for Manises Hospital to take this model a little further. Quart de Poblet local council is one of the 14 towns inside Manises Health Department. The Council Social Services Area shares with the Hospital some of the people that use both services: Hospital Care Services (secondary care) and the Council Social Services (dependency, meals on wheels, domiciliary care...) are Council responsibility.

Social Workers at Quart’s Social Services Department, evaluate, track and attend social needs for these persons, that as a result pay less visits to the Hospital. For doing their work, Social Workers use their own “social pathway”, where issues like caregivers’ support or personal autonomy are measured. Until now, Social Workers from Quart de Poblet perform their “social work” without access to relevant clinical information on chronic patients; and this is the same for Manises Hospital, that know nothing (or near nothing) on the social situation of the patients they visit, resulting in a “bad usage” of health services (lack of informal caregivers, patient’s personal autonomy level, education level, etc.).

In the INCA pilot, Quart de Poblet Social Workers will join Manises Hospital Multi-Disciplinary group to share a common integrated care pathway when attending the needs of chronic populations from Quart de Poblet. Clinical and Social information will flow among providers allowing them to make better decisions, and the clinical side will benefit from available resources (social workers visit beneficiaries for their services at least once per month to ensure that information being collected on visits and virtual meetings is reliable enough to have a confident system. Initially, a total of 150 users, including chronic persons from the Heart Failure program living at Quart de Poblet will participate from this experience, that will be track in order to ensure that quality of service can be improved, while needs for physical visits at Primary Care, ER rooms and hospital stays can be significantly reduced, as the result of having customized care plans delivered to chronic patients.

Kenus will be actively involved in the Valencian pilot, acting as the main mediator between all the groups involved (primary care centres, secondary care centres, social services councils departments and other stakeholders. Just to mention informal care givers, associations of care professionals, patients and elders (most under the umbrella of Local and/or Regional Authorities) and also NGOs and all type of Volunteers, including the involvement of new actors with expertise in the roles of reimbursement scheme providers, insurers, procurers and regional development planners.
**Project goal**

Quart de Poblet Social Workers integration into Manises Hospital Multi-Disciplinary Group for Chronic Populations, resulting in a new network of available resources to:

- Effectively exchange clinical and social information for better decisions
- Better reaching chronic patients at their homes relying on a “proximity network” (social workers)
- Improving chronic patients’ perception of Quality of Services
- Managing more efficiently economic resources at Manises Health Department

**Expected benefits (after INCA)**

1. Developed electronic information exchange system between the Manises Hospital and Quart de Poblet Local Council Social Care Department, as well as the patients themselves, which will allow early detection of those patients who require social care home in time to provide the necessary services and monitor the evolution of their chronic conditions.
2. Designed social programs include prevention and early intervention package to prevent possible crises and the current deteriorating state of health.
3. 40 Primary Care Physicians, Nurses and Case Managers tracking how Integrated Care Plans are being deployed
4. 30 social carers trained to act as INCA’s “proximity network” in Quart de Poblet
5. A new Patient Care Repository where both Social and Clinical information exists, allowing to develop holistic models of care in a realistic way.
6. 430 patients received customized care plans and were supported by a “proximity network” to track how they implement them
7. Reduction of average consumption of primary care visits, ER visits and Hospital stays among Quart de Poblet’s chronic population
8. Significant improvements in quality of services’ perception among end users
9. Learnt lessons can be transferred to other municipalities in Manises Health Department
### Main Tasks to be completed during the pilot

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• Both guidelines are to be agreed among stakeholders to develop a unique way of attending patients: pilot ICP |
| **2. Care Planning** | • **Manises Hospital and Quart de Poblet Municipality** developing a set of care actions and packages related to previously identified “risk groups” (**INCA Protocol for Elderly Care for Heart Failure condition**). Guidelines from this Pilot ICP can be loaded and managed using **INCA ICT tool** to have customized ICPs for every patient, caregiver and provider to follow.  
• Every Patient (and related Caregivers) in the pilot receiving a personalized integrated care plan from his General Practitioner / Case Manager / Social Worker  
• Pilot patients acknowledging and giving consent to their personalized integrated care plan |
| **3. Care Delivery** | • Socio-sanitary Providers using **INCA platform** to deploy personalized care plans  
• Patients using **INCA platform** to accomplish personalized care plans  
• As a result of this work, additional Clinical Indicators will be generated to specifically track not only Elderly Care but Heart Failure condition specific issues (bio-measurements, adherence to medication, social habits and related issues, etc.) |
| **4. Care Co-Ordination** | • Providers, mainly General Practitioners, Case Managers and Social Workers, using **INCA platform** to share information on personalized care plans and managing referrals and case conferences on specific cases  
• Patient (and related Caregivers) having access to any document or data on his socio-sanitary condition coming from every provider attending him (and participating in the care process when asked to do so: fulfilling questionnaires, providing health measurements, attending reminders on medication, etc.) |
| **5. Performance Review Analysis** | • Comparing core performance indicators against Start Up Scenario  
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PILOT CASE: HEALTH AREA 2 (CARTAGENA) IN THE REGION OF MURCIA – SPAIN (2)

Partner: Foundation for Training and Healthcare Research of Murcia Region (FTH)

Improvement in Diabetic and Heart Failure over 65 Years in Cartagena Health Area

Brief Pilot Description (state of the art before INCA)

Health Area 2 (Cartagena) in the Region of Murcia serves a population of 269,019 people, distributed among 16 Primary Care Teams comprising 15 Health Centers and 44 Local Consulting Rooms. Among the non-hospital care resources involved in diabetes and heart failure care, Cartagena Health Area has 5 Primary Care Emergency Services, 3 Continuity Care Points (CAP), 7 Physiotherapy Units, 3 Home Care Support Teams and 16 Social Work Units. Among hospital resources it counts with an Endocrinology service located in Santa Lucía.

Of the population assigned to this Health Department, 58,442 people are > 65 years. We have selected this scenario because it has an appropriate population size, is an area with proven professional involvement and has identified the improvement of care for diabetic patients (5,000) and heart failure patients (5,200) as a priority and integration and coordination of the care they receive as a major challenge.

Pilots target groups, will be:

- Diabetics >65 years of the Health Area of Cartagena (Murcia), since they are patients especially frail with a high consumption of health resources (consultations test strips, medication ...) what, currently, does not results in a better control of their health.
- Heart failure patients >65 years show an adjusted prevalence at that age (over 65 years) of 9%. This group is selected for the pilot because they are people with mobility limitations conditioned by the low stress tolerance, which will benefit from the use (direct or delegated) of ICTs and tele-assistance. On the other hand, they represent a high consumption of health resources (consultations, medication...) and constitute the most frequent cause of hospitalization in this age group as they grow older.
- In both cases Diabetics and Heart Failure patients tend to worsen with age, adding other health problems to their condition, which lead them to visit different care specialists in different assistive levels, resulting in a fragmentation of their medical history across different health information systems (primary care, secondary care ...).

We believe that the key to the better control of chronic conditions like diabetes and heart failure is comprehensive monitoring thereof, unifying medical histories and making it visible from all levels which will improve safety (decreasing interactions) and efficiency (reducing duplication), all people involved acting with a unified approach. We also think that is key to its good control empower patient self-management, health education, caregiver training and connection with available social and health resources.

With the INCA project we intend to demonstrate that an improvement of these patients is possible, through an appropriate stratification and by establishing clinical pathways agreed between all the assistive levels, supported by a tool allowing to reconstruct the patient clinical history, providing a visibility that makes easier its tracking among all the levels implied, so much clinical as social, allowing the application of care pathways agreed and the carry out of the assistive programs recommended in each case.

The project will start starts with an adequate segmentation of patients not only based on clinical criteria (severity of illness, presence of other diseases, level of medication, use of health resources ...), but social ( level of dependency, family or informal caregivers support ...) such that, for each patient, will identify a socio-sanitary resource network versus a clinical risk.

Once patient population is segmented,

- 500 diabetics will be recruited in two pairs. 250 will constitute the intervention group and 250 will stay as the control group, resulting in two comparable cohorts, so that the intervention study can be seen as a Randomized Clinical Trial (single blind).
- 500 heart failure patients will be recruited in pairs, 250 constituting the intervention group and 250 the control group, resulting in two comparable cohorts, so that the intervention study is presented as a Randomized Clinical Trial (single blind).
The objectives of **INCA** intervention are:

1. Improving the quality of life perceived by the patient, which we will measure with a satisfaction survey, as the tool allows doing.
2. Improve the quality of life of the main caregiver.
3. Improving diabetes control through the results of the glycosylated hemoglobin, main objective parameter to measure the state of control.
4. Improving assistive efficiency, optimizing the use of resources (consultations, medication test strips ...).
5. Reducing added complications and hospital admissions.
6. Improving the social support, promoting in a proactive way the network of socio-sanitary resources of the patient.
7. Improving patient autonomy through encouraging self care.
8. Studying whether there are differences in morbidity and mortality between the two cohorts during the intervention by continuous monitoring.
Main Tasks to be completed during the pilot

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| 0. Stratification of all the diabetics of the Health Area of the Pilot | - Analyze clinical, assistive and social variables, determining the degree of difficulty for the management of these patients  
- Establish difficulty groups (stratification) |
| 1. Preparation of the two cohorts | - Once population is segmented, we will take 2 groups of 250 randomized patients (single-blind) for the intervention group and another two groups of 250 with the same features to form the control groups (one for Diabetics and one for Heart Failure).  
- All patients groups as well as their main caregivers, will be informed about their participation in a pilot programme and will sign an inform consent. This will be a mandatory requirement. |
| 2. Care architecture | - Care alerts, rules and communication protocols will be constructed based on the diabetic Integrated Care Plan agreed between the different assistive and social levels.  
- Care alerts, rules and communication protocols will be constructed based on the heart failure Integrated Care Plan agreed between the different assistive and social levels.  
- Those Integrated Care Plans will be adapted to every stratum. |
| 3. Connecting inputs | - Identify the variables to be measured, their hierarchy and data source, establishing sub-indicators and indicators, both clinical and social through the **INCA** platform. |
| 4. Connecting outputs | - Establishing the roles involved in patient care, as well as their behaviour in each phase of the socio-sanitary pathway, according to the different phases and different Integral Care Plans  
- Establishing **INCA** tool accesses of the different players in the process and ensuring their training and support. |
| 5. Dashboard | - A monitoring system to be fed with performance indicators, returning an information in real time and allowing to supervise and correct the rules created in the Socio-Sanitary pathway, with speed enough to assure their adequacy and accuracy within a strategy of continuous improvement, and finally obtaining the results of the intervention impact, always comparing with the control group. |
## Indicators to be used to track pilot performance

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| 0. Stratification of all diabetics pilot Health Area | • % Patients in each stratum.  
• % Stratum variations. Strata variations of all patients will be periodically reviewed (annual re-stratification), allowing, with long temporal series, the establishment of predictive models. |
| 1. Preparation of the two cohorts | • Number of patients replaced in the intervention group due to rejection or exclusion criteria. |
| 2. Care architecture | • % % changes over previous socio-sanitary pathways in use |
| 3. Connecting inputs | • Number of incidents on access to data sources (interoperability barriers). |
| 4. Connecting outputs | • User access time (socio-sanitary professional, patient or caregiver).  
• Tool satisfaction level (online satisfaction survey) broken down by roles. |
| 5. Dashboard | **Resources Consumption** Indicators (differences between intervention and control groups):  
• Admissions. Disaggregated welfare levels and strata.  
• Degree of medication.  
• Consumption of tests strips.  
**Health** indicators (differences between intervention and control group):  
• % Well-controlled diabetes (glycated hemoglobin below 7%)  
• % Well-controlled heart failure (mainly measured through a significant reduction in hospital admissions and stays length  
• % Diabetics that improve their control  
• % Heart Failure patients that improve their control  
• Hospitalization days  
• Mortality  
**Social** indicators (differences between intervention and control group):  
• Dependency level (median after intervention).  
• % Diabetics that improve their dependency level. |
B2. Implementation

B2.1 Consortium and key personnel

Currently in Europe, different Member States are trying to do similar things in very different ways and there is an enormous potential for countries to learn from each other. Initiatives as INCA present enormous potential benefits to do this in a "coaching approach", integrating the European dimension into Health.

Furthermore, given that Health is a uniquely complex intersection problem, with multifaceted dimensions, the need of a polyvalent Consortium composed by aggregated capabilities, was the main driver of the present INCA composition:

- On one side, INCA Consortium involves DIRECTLY the necessary value-chain of stakeholders needed for deploying “integrated care programmes for the first time”, both in the “coaching team” and the “first time deployers teams”:
  - The “coaching team” is based in an Old Member State: Spain (with Manises Hospital Area with expertise in European Health care Programmes) and composed by Public partners (Social Services of Quart de Poblet), Private partners (technical provider IDI EIKON and business Healthcare deployer KENUS) and a Public-Private-Partnership Health Care Manises Hospital, that, will carry out this work as a living lab experiment.
  - The “first time deployers teams” are based in New Member States like Croatia and Latvia, that started painful reforms in early 90s after the fall of the communist governments. The health care system in general was not the prime benefactor of these changes. Insularity of Cyprus is also a jeopardising factor of good quality in Healthcare systems.

However, all of them are putting on board the required competences (including the "insurer" role) for receiving successful technical training and coaching in organisational and business issues of socio-sanitary integrated care, fostering also the Public and Private collaboration.

- On the other side, INCA Consortium is aware that help outside the Consortium will provide INDIRECTLY extra competences that can contribute to a successful validation. Just to mention informal care givers, associations of care professionals, patients and elders (most under the umbrella of Local and/or Regional Authorities) and also NGOs and all type of Volunteers, including the involvement of new actors with expertise in the roles of reimbursement scheme providers, insurers, procurers and regional development planners.

INCA Consortium pilots are placed in Spain and in new Member States and in Cyprus and care has been taken also in the matching of partners profile according the chosen Objective (3.1.b: wide deployment of integrated care).

Focusing the pilots in Regions of New Member States of European Union, INCA Consortium wants to highlight the potential frog-leap to reduce information and communications technology (ICT) costs into a readily available, affordable operating expense. This is especially true for New Member States of

**INCA** Consortium that may not have the technology, skilled personnel, or resources to create world-class ICT infrastructures and nowadays is equally valid for old Member States.

**Consortium composition**

<table>
<thead>
<tr>
<th>Partner Short Name, Country</th>
<th>Main Role in the project</th>
<th>PROFILE</th>
</tr>
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<tbody>
<tr>
<td>1. IDI EIKON, Spain</td>
<td>Project Management, overall Coordination External Dissemination Management Portal Development and Maintenance Coordination of the post-project permanent structure Coordination of customisation and deployment activities Participation in national and international events Initial Deployment validation Management</td>
<td>COORDINATOR Technical Provider and Technical Manager WP1 and WP3 leader PR: Business Deployer</td>
</tr>
<tr>
<td>2. Ayuntamiento Quart de Poblet, Spain</td>
<td>Dissemination <strong>INCA</strong> activities at all levels: Regional, National and European Pilot Partner Expanding the &quot;best practice&quot; Valencia Region (combination of ICT-PSP and Structural Funds) across all the European Union Supporting exploitation activities and backing PPP actions in support of <strong>INCA</strong> deployment</td>
<td>PA: Project Dissemination WP2 and Data Protection Policies WP6 leadership</td>
</tr>
<tr>
<td>3. Interfusion Services, Cyprus</td>
<td>Leading Validation Planning and feedbacks Coordination of the post-project permanent structure Coordination of customisation and deployment activities Participation in national and international events Pilot Partner</td>
<td>PR: Validation leader WP4</td>
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<td>4. KENUS, Spain</td>
<td>Leading Exploitation Planning Pilot Partner Coordination of the post-project permanent structure Coordination of customisation and deployment activities Participation in national and international events</td>
<td>PR: Business Deployer WP5</td>
</tr>
<tr>
<td>5. Hospital Manises, Spain</td>
<td>Pilot Partner; Reference Case; Coaching Activities</td>
<td>PR</td>
</tr>
<tr>
<td>6. Geroskipou, Cyprus</td>
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</tr>
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<td>7. ZKRS, Latvia</td>
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</table>

PA = Public Administration; PR = Private Organization; NP = non-for-profit
A software house established in 1989 and based in Valencia, Spain, IDI EIKON is a Services Provider Company in the areas of Telecommunication and the Internet. Its core business is the development of advanced IT and Internet-based technologies for specialist markets.

The company has a long and sound tradition of participation in public-funded, mostly European, RTD-projects, eTEN and CIP projects in most of which it has acted as coordinator or exploitation manager.

IDI EIKON’s business revolves around creativity and innovation. For the company innovation is the lifeblood deal with new opportunities on an ongoing basis and we are constantly presenting ideas with new value to sustain growth. IDI EIKON practices the idea that knowledge generates not just in universities and research centres, but also in a very wide variety of locations within the economy, and notably as a product (learning-by-doing) or of consumption (learning-by-using).

Using the latest technologies, our expert developers have extensive experience developing leading-edge software. Our current focus is developing: Internet Solutions in the areas of e-Government, eInclusion and ERP addressed to SMEs. We serve most of our solutions under the “SaaS” model and they can be deployed across different channels: web, mobile devices and digital TV.

From an internal perspective, innovation in IDI EIKON is driven by:

- Senior management responsible that devotes time to investigate the future and to understand the needs of the marketplace, the resources at their disposal and the competitive business environment.
- Working environments that encourage creative solutions.
- Strong support for joint ventures and collaborative efforts that develop and commercialize innovative solutions.
- Good project management for the identification, development and commercialization of innovations.

From an external perspective, IDI EIKON can be considered a KIO, a knowledge intensive organization, since building knowledge is its primary value-adding process.

**Transatlantic eHealth/health IT Cooperation**

IDI EIKON is aligned with the policy strategies to reinforce transatlantic cooperation.

Health related information and communication technology (most usually referenced as “eHealth” in Europe and “health IT” in the US) is an important and growing sector in the United States (also in the European Union). It is a rapidly developing and highly innovative area. It has considerable potential to promote individual and community health while fostering innovation and economic growth.

IDI EIKON decided (more than two years ago) to start cooperative action plans for the deployment of solutions addressed to improve centric patient care and advance the health of individuals and communities, while helping to reduce the costs and show professionals engagement. Since then is working together with people in US (physicians, patients, businessmen, providers, lawyers...) to deploy solutions for improving centric patient care, while helping to reduced the costs and showing professionals engagement.

Even if approaches and situations are different, problems are similar. US advantage over Europe lies in its pragmatism to deal with the problems. But ICTs solutions backed by interoperability and standards should prevent unnecessary divergences.

**Research & Development**

We are considered a R&D performing SME since we devote a high percentage of our resources (more than 60%) to research and innovation. IDI EIKON has two objectives for Research and Development: supporting the improvement of operational performance and enhancing existing expertise. In the IDI
EIKON Roadmap, R&D is a dedicated function, and even without a budget of its own, we give priority to this area, since R&D enhances efficiency in operations through the development of innovations and new methods. Another goal is to be able to rapidly deploy R&D results in practical activities. Making operations strategically oriented are also high priorities.

The strategic development areas for R&D are lifecycle expertise, partnership skills, and information flows and data models that enable fuller exploitation of ICT technologies in all the IDI EIKON’s operations.

**Participation in European projects:**
- Co-ordinator in the CIP: T-SENIORITY: Expanding the benefits of Information Society to Older People through digital TV channels. (2008-2010)
- Co-ordinator in eTEN project e-SEVESO: digital services for Industrial collective protection (2004-2005)
- Innovation project ESPLANADE: Exploitation of Scenario Planning and Data-searching Expertise (2002-2004).

**Project Key Persons (main)**

**Miguel Alborg Dominguez**, founding member and Managing director of IDI EIKON. He is an IT executive by occupation and with a passion for trying new things, he is managing a small company but one of the pioneering and more innovative Information and Communications Technology (ICT) firms in Spain. A highly effective and experienced researcher and project manager/team leader-member with substantial related experience. Unique capability to apply analysis tools and techniques to identify problems and their effects and causes. A strong believer in "leading from the front" he is independent and progressive in his thinking, believes in his decisions, and above all is prepared to drive them through. Being an entrepreneur, he is always looking for new opportunities that complement the company’s core focus. Believing that the world is increasingly moving towards a knowledge-based economy, he seeks to maximize the potential of ICT as a tool for knowledge enhancement and management. His personal “crossroad” of a “humanist” background and Information Society Technologies, has driven his interests and objectives, to master complex and multi-disciplinary data and information, especially in very complex "human life" problems where conflicts are present and applying to it the new "solving problem" technologies. A present personal advocacy is to raise the awareness of the enabling use of ICT and to enhance the quality and accessibility of solutions for the world of prevention. He has been involved in R&D projects from the early 90’s and with European projects from 1998.

**Miguel Alborg Farinós** He is a graduate in Enterprise Management and Administration from Valencia University. He participates in European projects since year 2000 and is in charge of the European commercialization of products/services coming out from projects. Actually shares his responsibilities between the marketing and the creation of new companies. His business driven profile is
complemented with a deep understanding of the latest technologies acquired since his early years at the University, carrying out practices in real working environments.

**Víctor Sánchez.** Technical Engineer in Computer Science of Administration. Senior Analyst-Programmer in European projects lead by IDI. Senior Analyst-Programmer in Java 2 platform, j2me mobile phones and embedded systems, web services like soap, xml-rpc, wsdl, and in depth use of other technologies like JSP, XML, JAXP, JAXB, ebXML, XHTML. Experience as System Administrator: O.S.: Microsoft; Unix (especially Linux); DB: Oracle, SQL Server, PostgreSQL, PHP; IP networks: remote communications, firewalling, webservers; Experience with Web Services under SOAP and XML-RPC. Knowledge of XML, JSP, EJB, encryption, etc and first notions of P2P having developed some small applications with JXTA. He is current on Internet technologies including HTML and Java, with experience in a structured development environment. He is the technical director of IDI EIKON and is the responsible for testing the impact of the introduction of new technologies in the IDI EIKON developments.

**Josefa Farinós** Co-founder of IDI EIKON company (1989), based in Valencia (Spain). Ms. Farinós has worked in the ICT industry for more than 15 years and has over 5 years of experience in European projects management in which she is involved since 1999. She works in the preparation of proposals involved with the transfer of the company’s technology to accelerate its adoption and exploitation at an international level. This work is combined with the conduction of research and analysis on a broad range of new developments and trends in the information society technologies.

In the **INCA** project, IDI EIKON acts as **Technical Coordinator, Technical Manager and Technical Provider** of the solution that contributes to the project as pre-existent IPRs. Customisation and deployment activities Coordination; preparation and “mise en scène” of the pilots, participation in National and International events; Initial Deployment Validation Management; and closed collaboration with the Exploitation Manager, are its main tasks, although this partner intervenes in all the workpackages, from beginning to end.

**Partner 2: AYUNTAMIENTO QUART POBLET – Spain**

Quart de Poblet is a municipality of the province of Valencia, located 6 km to the west of the capital, with a population over 25.000 inhabitants.

The Council is a reference in different fields. Its name is associated with the fight against gender violence, quality in sport services, the concern for the preservation of the environment, the promotion of association networks and civic participation, with the will to conserve our roots and to recover the legacy of our ancestors, with social integration, and in summary with the search and development of formulas to improve the quality of life and to assure a future better.

The New Information and Communication Technologies has become an indispensable tool for carrying out the tasks of the Council that has developed its municipal portal, www.quartdepoblet.org, actually in phase of upgrading, in order to provide better services to the citizenship. Broadband, cable television and a free municipal network for accessing Internet are already in place in the municipality.

Info-accessibility is one of the highest priorities of the Council. The City council of Quart de Poblet is running its second Integral Accessibility Plan started in 2000 aiming to end with any architectural barrier in the municipality. Quart is the first municipality in Spain subscribing an agreement with the Institute of Elders and Social Services (IMSERSO) and ONCE Foundation for the development of a municipal Infoaccessibility Plan. The plan focus in aspects like info-accessibility in public libraries, the subtitling and auto-description in cinemas, theatres and shows, and the setting of services directed to reinforce civic participation, as the electronic vote or popular meetings with local participation.

Aspects like the availability and access to updated information services about transports and mobility, health, sanitary and social emergency, education, public services in general and endowments and infrastructures of the Information Society are considered high-priority.
Within the initiative “New Technologies for All”, a literacy programme is undergoing with the aim to teach the basics of informatics and training people to be able to access them.

Since Quart de Poblet is collaborating with the Secondary Health Hospital of the Area (Manises Hospital) where it is located, participation in INCA can be seen as a natural step for them, willing as they are to contribute to the improvement of their citizens and to serve as a sample to follow by other municipalities. Quart offers its experience and good will (best practices) endorsing INCA objectives that are fully online with its own.

**Project Key Persons (main)**

**David Herrero.** Senior Computer Engineer, graduated at the Universidad Politécnica de Valencia. He acts as technician of the Municipality of Quart de Poblet and under his management have taken place the modernization projects that have been carried out up to today in the municipality. Currently this area is in charge of the technical deployments and developments that take place within the Council competence.

**Juan Medina.** Coordination Policies in Socio-Cultural areas. He is the face of Cultural services in the Council and very closed to citizens. Youth services, Sports promotion, Education, Library, Cultural Heritage, development programs ….are all inside his attributions

Besides his responsibilities at the Department of Youth and Communication and Sports, he leads the development of the Open Government at the municipal level, being the first councillor of Spain in Open Government.

**Partner 3: INTERFUSION SERVICES LIMITED (IFS) - Cyprus**

InterFusion Services Ltd is an innovative R&D SME based in Cyprus comprising three core Departments: 1. ICT & Media Department, 2. Socio-Humanities & Political Studies Department, and 3. The Environmental Policy Department. InterFusion employs experts in the above departments with vast experience in the management and coordination of research funded projects in both national and European level projects. All three departments support a dynamic intellectual team of members that focus on actively contributing and exploring links between the most important core areas related to political developments and in horizontal ICT fields like e-learning, e-government and e-inclusion, while keeping in tune with the regional, national and international developments.

**Previous relevant experience**

Leader of the Sustainability work package in the CIP-ICT projects DIEGO and SEED supporting municipalities of Pafos and Pegeia respectively; pilot leader in the FP7-ICT-2011-7 integrating project (IP) titled ‘Future Policy Modelling’ with acronym FUPOL. In Eurostars program, project titled ‘A Secure Platform for IPTV Systems’, ASPIS Interfusion contributed to the development of a technical solution that will allow users to share their personal details in an easy, controlled and secure manner on the IPTV platform. IFS also participates in the Interreg IVC program, project titled "Open Source software usage by European Public Administrations" (OSEPA). In the NGO Fund project Thalassaemia Specific Electronic Communications (TSEC), Interfusion was responsible for the creation of an online EHR (Electronic Health Record) composed of two major modules (Module1 - serious infections register and Module 2 - adverse drug reaction record) in an effort to enhance clinical support and to improve patient care.

**Project Key Persons (main)**

**Haris Neophytou** is the R&D Manager of Interfusion. He holds a B.Sc. degree in Computer Science from the University of Cyprus and an MBA from the Cyprus International Institute of Management. He is the coordinator of the Cypriot pilot for SEED, ICT-PSP project and successfully supervised in the past the implementation of DIEGO (Digital Inclusive e-Governance) ICT-PSP project. He served as an
advisor to NIMONIA TV for the SARACEN, FP7 project. In his previous job assignment he was leading the R&D efforts of a prestigious telco, PrimeTel Plc and was involved in many R&D projects including FP7-ICT projects SmoothIT and MIMAX, CIP-IST-PSP project T-SENIORITY, EUREKA Celtic projects R2D2 Networks and MOTSWAN, EUREKA EUROSTARS project ASPIS. Areas of expertise include e-inclusion, e-government, IPTV, overlay networks, fuzzy cognitive maps and media.

Giannis Chrysostomou is Chief Technology Officer at InterFusion responsible for the ICT & Media Department. He holds a B.Sc. degree in Computer Science from University of Leeds and an MBA from the Cyprus International Institute of Management. He worked in the past as an IT Officer in AMDOCS, the market leader in software and services provider for telecommunication companies responsible for Quality Assurance of their products. He has experience in the methodology of developing bulk software and co-coordinating their requirements definition, coding and testing. He has knowledge in Grid technologies, scheduling algorithms, computer networks, Windows, UNIX, Python, C, C++, HTML/XML, Java, JSP, DBA. He is responsible for the implementation of an interactive e-training and online seminars platform for individuals interested on setting up a start-up Company, as part of Interreg MESUP Project. He was the focal point for the development of TSEC’s project EHR system.

In the INCA project, Interfusion acts as the Coordinator and manager of the Cypriot pilot. Its role is essential for the provision of guidance and support to the Municipality of Yeroskipou in terms of integration and interchange of information between the Municipality Department of Social Care and the primary and secondary healthcare services of the Pafos district.

Interfusion will therefore operate on a dual level within the project: a) will maintain a guidance role to Municipality, providing assistance in the decision making process to the high level decision makers at municipal level, and providing the training to the staff on the operation and provision of the services to be implemented, b) will maintain a technology advisory role in the project, as the Municipality will require a closely related partner throughout the project for the implementation of the e-services.

Interfusion will also support the Municipality in the progress and financial management of the pilot in Cyprus and will ensure that the activities conform to the action plan and the programme guidelines and requirements.

Partner 4: Kenus Informática - Spain

Kenus Informática is an emerging avenue in healthcare that helps enhance operations in all aspects of healthcare management, by optimizing the acquisition, storage, retrieval and use of information.

With a view to keep abreast with changing technologies and innovations, our Healthcare & Information Technology business unit caters to the technological needs of the healthcare industry. Combining our expertise and embracing industry best practices with comprehensive tools & methodologies, we deliver high impact and sustainable solutions.

Through valued partnerships, with leading companies, we are able to offer customized premium as well as low-end solutions that cater to the needs of our customers and facilitate operations in hospitals and medical institutions.

Since its inception in 1996, Kenus has been growing from strength to strength blending the latest of technology with impeccable business acumen and meeting the most challenging requirements of a fast–evolving technology landscape

Kenus defines, designs and delivers technology-enabled business solutions that help companies win in this competitive world. Kenus also provides a complete range of services to various verticals like Government, Finance, Telecommunication, Energy, Healthcare and Education by leveraging our technology, domain and business expertise, high quality customer support and strategic alliances with leading global technology providers.
Going all the way
Each customer demand requires a unique operational framework. Kenus provides turnkey solutions encompassing various technology areas to its customers. Continuously evolving by venturing into diversified fields in the most dynamic markets, Kenus has transformed itself to be a highly influential technology based business solution/service provider meeting the strategic objectives of the clients. Kenus believes, nurtures and takes pride in building strategic long-term client relationships.

Looking ahead, the company is set on the road to move forward with a clear vision, a sound and consistent strategy, financial strength and an unwavering focus on serving the customers with pioneering state-of-the-art solutions, by the fusion of a stable technology, qualified experts, quality services and long term commitment

Kenus, that understands the importance of “service”, will be able with INCA solutions, to leverage its business and technological expertise to help healthcare providers maximize their patient care.

Role in INCA
We have been selected to act as leader of WP5, with the important mission to assist and to encourage Consortium partners to identify longer-term financial and capacity-building resources, to help ensure the sustainability of their work and the viability of their organizations in what refers to the project proposal.

We will help Consortium partners explore co-benefits of approaches that enhance healthcare sustainability and financial savings. In other words, we are to help decision makers and key executives to explore innovative and pragmatic approaches to reconciling profitability and sustainability.

We are also to encourage cooperation among all stakeholders by supporting the free exchange of information and by promoting stakeholders chain participation in decision-making.

Project Key Persons (main)

Dr. Lars T. Berger, Dipl.Ing. degree in electrical engineering, the M.Sc. degree in communication systems and signal processing, and the Ph.D. degree in wireless communications from the University of Cooperative Education Ravensburg (Germany), the University of Bristol (United Kingdom), and Aalborg University (Denmark) in 1999, 2001, and 2005 respectively.
In his career Dr. Berger has been working for DaimlerChrysler (Germany), Nortel Networks (United Kingdom), Nokia Networks (Denmark), and Design of Systems on Silicon (DS2, Spain). He also held faculty positions at Aalborg University (Denmark) and the University Carlos III of Madrid (Spain) and has since 2001 (FP5) been working and directing R&D efforts in EU R&D projects.

Vicente Peñalver Camps, co-founder and finance director of Kenus Informatica. In 1989 he graduated from the Technical Institute of Manises in the areas of Business Administration and Foreign Trade. Since 1996 Mr Peñalver Camps is General Director of Kenus Informatica with significant experience in the protection of intellectual property, sublicensing of software and commercialization of IT services.

Partner 5: Hospital de Manises

Hospital de Manises, in Valencia, is a pioneering public-private partnership that has seen Sanitas, Bupa’s Spanish brand, take responsibility for the healthcare of an entire region.

Opened in May 2009, Hospital de Manises was created in partnership with the Valencia Government. Built and managed by Sanitas, Hospital de Manises provides public healthcare in a new public-private model being adopted across Spain aimed at driving quality and efficiency in national healthcare. With over 200 rooms and a capacity of over 300 beds, Hospital de Manises has almost 1,500 health professionals working in primary and specialty health care. 30 million euros has been invested in advanced medical equipment.
The hospital covers 14 towns and a population of 197,000 and Sanitas also manages 20 primary health centres in the surrounding area and two specialty centres.

Since 2010 Sanitas has also been managing a hospital for chronic patients, the Hospital de Crónicos de Mislata, which has become the country’s first health department to manage all the public health resources within one catchment area.

An emphasis on patient care, innovation and medical excellence are reflected in Hospital de Manises’ priorities to provide the best specialists, embrace modern medical techniques and equipment, and focus on efficiency.

Although born as a community hospital, it has expanded its portfolio of services incorporating specialties usually found only in larger hospitals.

Hospital de Manises runs also since May 2010 the Chronic Hospital in Mislata, a date which is a milestone at a national level as it is the first time a health department manages all health resources of an area, from primary to specialized care, and including care for chronic patients.

The goal of the Chronic Hospital in Mislata is to pay attention to chronically ill patients who need palliative care; are convalescing after surgery; affected by subacute and chronic conditions; patients with brain damage or with chronic infectious processes such as HIV.

In INCA Hospital de Manises plays the important role of COACHERS. They are excited to contribute their experiences in the project and share them with the rest of partners. The project will help establish a foundation for patient-centered outcomes that will give patients, caregivers and clinicians the tools they need every day.

Manises project responsible, some of them drivers of the patient’s Primary Care team within their daily tasks, will be involved in understanding how patients make decisions when they work with a health coach. The project will use direct observation of patients with clinicians and health coaches, focus groups with patients and family members, and individual interviews with patients, family members, health coaches and clinicians.

Providing patients, their caregivers and clinicians with the evidence-based information needed to make better-informed health care decisions is the final goal to achieve.

Manises partner hopes the project will improve their understanding of how to proceed in ways that are more responsive to the needs of patients and the health care community.

**Project Key Persons (main)**

**Carlos Rodrigo:** Rodrigo is a medical doctor with the specialties of Internal Medicine and Endocrinology and Nutrition. He began his work at the Hospital Clinic of Valencia as an internist, but also worked as coordinator of Primary Health Center “Economista Gay” in Valencia. In July 2003 he was appointed Director of Primary Care in the area 6 of Valencia and since 2006 hold that same position at Hospital La Fe.

He has been recognized for his capacity for work and leadership in the integration of primary care in Hospital La Fe. His work aims to achieve a better coordination of health care resources and contributes to a gradual integration between primary and specialized care.

From this position as Director of Primary Care, he will be responsible for deepening the process of integration of primary and specialty care and be responsible for all aspects of quality, managing the points of primary care, health centers and clinics under the Department of Health of Manises.

**Joaquin Casanova.** Surgical Director of Manises Hospital (recently appointed). Previously was Primary Care Director (2011-2013)

The recent moves address the new policies toward prevention and integration.

Dr. Joaquin Casanova, former director of Primary Health area, holds currently the position of Director Surgical. Casanova, who had also previously led the direction of “Aldaia Specialty Center”, has an
extensive knowledge about the different structures of the department of health care and takes on a new challenge in front of a high-performance surgical block with more than 17,000 calls a year and surgical units of great complexity and highly specialized services like Dug Reconstructive Surgery, Neurology, Thoracic Surgery, Bariatric Surgery or Dr. Mir Hepatobiliopancreatic unit.

Dr. Casanova succeeds, Carlos Rodrigo now new director of Primary Care. Dr. Rodrigo leaves the position of Director Healthcare had hitherto Manises Hospital and he occupied since 2010. From this position will be responsible for deepening the process of integration of primary care and specialty care and be responsible for all aspects of quality. Rodrigo will manage 20 points of primary care, health centers and clinics are there in the Department of Health of Manises.

**Partner 6: GEROSKIPOUCity Council Social Department – Cyprus**

Geroskipou Municipality was founded in 1994 and it has been developing rapidly ever since. The city of Geroskipou is situated in the District of Paphos, and it extents to an area of 12sq km. The traditional centre of Geroskipou is located about four km east from the city of Paphos. Only 10 km away from Geroskipou there is International Airport of Paphos hence Geroskipou is considered one of the major tourist destinations of the district.

Geroskipou is situated in the District of Paphos and is one of the four Municipalities along with 101 Communities that constitute Paphos Province. The Province of Paphos (aprox. 90,000 citizens) was selected to be the European Capital of Culture for the year 2017, hence since the outcome of INCA is in line to the goals set for 2017, it was decided that Geroskipou would represent the whole Province of Paphos in INCA project.

Geroskipou Municipality constantly strives for improving the quality of life of elder people living in the district in all possible ways and hence it is a point of reference in Paphos District regarding this. The Municipality offers advanced facilities of Social Community Welfare for the elder and free house-to-house Doctor visits on a weekly basis. Back in 2010 as part of the “European Year for Combating Poverty and Social Exclusion” the municipality has conducted a field research to identify all elder and disabled citizens that needed the support of the Council in order to help them. The municipality was also actively involved in the program “Expansion and Improvement of Care Services for the Children, the Elderly, the Disabled and Other Dependants” co-funded by E.U. and Cypriot Government.

Towards this direction, the Municipality participates in an Interreg IVC Project entitled INN.O.V.Age “Improvement of Effectiveness of regional development policies in eco-innovation of Smart Home and Independent Living to increase the quality of Life of Aging people” with an objective to help older people to live independently for longer in their own homes by increasing their autonomy and by emerging of new ‘technological supply chains’ associated with new developments like independent living and eco-innovation, with a valuable contribution to minimize environmental impact of elderly daily life activities.

Cyprus Planning Bureau has recently approved the funding of the construction of a modern Medical Center in Geroskipou Municipality with aim to serve both the overall district of Paphos and at the same time attract Medical Tourists since Cyprus climate conditions are considered perfect especially for long lasting treatments combined with relaxed vacations mostly offered to elder tourists.

**Role in the project:**
Geroskipou Municipality is participating in INCA project as a pilot partner, willing to learn from other experiences in the field of the eco-independent living for the elderly and thus implement some of the best good practices in our region.

**Project Key Persons (main)**
**Kostas Anastasiades.** Is employed in the Municipality of Geroskipou as an Administrative Officer. He studied Financial Science at the Aristotle University of Thessaloniki and has a Master in Public Sector Management and Business Management with specialization in MicroEconomics from the University of Cyprus. He is the main focal point representing the Municipality in European Funded Projects.
Partner 7: Ziemeļkurzemēs reģionālā slimnīca - Latvia Republic
(Northern Kurzeme Regional hospital) - (ZKRS)

Registered in 30.04.2010., after consolidation of LTD “Ventspils Hospital” and JSC “Talsu Hospital”.
Hospital shares are held by five counties – Ventspils City municipality, Talsu county municipality, Dundagas county municipality, Rojas county municipality and Mērsrags county municipality. ZKRS is one of the seven multi-profile hospitals, which are situated outside of capital Riga.
Hospital activity is providing public health care - stationary, ambulatory and emergency medical help support to inhabitants of Northern Kurzeme region. Impatient has 289 beds for different profile medical treatments – surgery (included urology), trauma (including orthopaedics), oral diseases, neurology, paediatrics, maternity ward, gynaecology, ophthalmology, otolaryngology, infectious diseases, palliative care, cardiology (including stroke unit), and intensive therapy. Outpatient provides treatment elective treatment of patients, including various operations, and haemodialysis services.
Hospital serves an area of 110 000 inhabitants. Every year Ventspils has more than 10000 impatient and more than 38 000 patients who receive emergency medical help.
Hospital is employing 492 employees including 99 doctors, 204 – medium level employees including nurses, obstetrics, emergency medical assistants, 100 junior staff including nursing assistants, orderlies and 89 other staff in regional hospital departments.
Every year hospital contracts with the National health department, which is responsible for government finance distribution for health care for funding for state-funded health care services - emergency medical assistance, medical treatment, inpatient and outpatient services (specialist consultations, diagnostic services, day hospital, hemodialysis, etc.).
Hospitals income consists: 85 % from public funding of health care; 15% from health care provided by the hospital for charged.
Hospital is located in Ventspils city, but it has a branch in Talsi, where also stationary, ambulatory and emergency medical help is provided thus providing necessary health care to patients closer to where they live.

Previous Experience

ZIEMEĻKURZEMES REĢIONĀLĀ SLIMNĪCA since year 2004 has and still is implementing different European Union co-financed investment projects. Investment projects are connected with hospitals infrastructure development – buildings energy efficiency, reconstruction and rebuilding of departments, in addition various improvements in hospital patient accounting and servicing system using various IT applications has been done.
Currently hospital in implementing an EU co-funded Project for constructing a new building for TALSU branch.
It has been planned to locate emergency medical point, department of intensive treatment and therapy, and surgery care beds as well as outpatient medical bodies and organizations which provide medical processes and support functions in the new building.

Project Key Persons (main)

Egija Širova – Ltd “Northern Kurzeme Regional Hospital” Chairmen of the board
• 1999 - University of Latvia Bachelor degree in Economics
• 2001 – Masters degree in International Economic relations
• 1997 - 1999.gadam Project coordinator in Ministry of Environment Investment department
• 1999 – 2001 Senior Project Manager in Latvian Environment investment fund
• 2001 – 2007 Board member and Project department manager in Ventspils municipality water supply Ltd. “Udeka”
• Since 2005 worked in “Ventspils Hospital” EU project “Emergency medical service providers a streamlined framework for Ventspils” realization, Manager of project department
• Since 2007 Ltd “Northern Kurzeme Regional Hospital” Chairmen of the board
Dainis Gīlis - Ltd “Northern Kurzeme Regional Hospital” Chief medical, Board member, certified surgeon, certified phlebologist:

- 1985 Graduated Riga Medical institute
- Works in Ventspils hospital starting from 1985, started in surgery department
- Member of the board since 2007
- Additional qualification: Certificate in health care management
- Regular participation in phlebologist congress in Latvia and internationally
- Learning the latest surgical techniques, as well as participating in Ventspils hospital development strategy creation gained experience twin hospitals in Lorean (France), Stralsund (Germany), Västervik (Sweden) and Waterbury Hospital (USA)
- Since 1997 Deputy in Ventspils municipality
- 12 year experience as Councillor for Ventspils municipalities Mayor in health care
- Board Member of Latvian Phlebology association, Member of Healthcare management professionals Association

Partner 8: VENTSPILS City Council (Social Care Board) – Latvia Republic

Ventspils Social Care Department (VSCD) was established as a department of Ventspils City Council (VCC). Under the instruction of the municipality, the Social Care Board of Ventspils City Council carries out activities aimed at ensuring that all inhabitants of Ventspils in need are provided with social assistance and social services.

In accordance with regulations governing work in the social sphere, the task of the Social Care Board is to render social assistance, as well as organize and provide social services to the community of Ventspils.

Social workers work with individuals, families, groups and communities, helping them to identify, solve, or at least reduce their social problems using the resources of the individual (family) and involving other support systems.

Persons (families) in crisis and/or lacking money for basic needs can receive social assistance. In accordance with the Social Services and Social Assistance Law of the Republic of Latvia, social services shall be provided by the local government only on the basis of an evaluation of the individual needs and resources of a person carried out by a social work specialist. A benefit for the provision of the guaranteed minimum income level and a housing allowance are benefits for satisfying basic needs.

Employees of the Social Care Board provide inhabitants of Ventspils with advice about the possibilities of obtaining the status of an underprivileged or low-income family (person), benefits from the local government and social services to satisfy appropriate needs of on individual.

Social Care Department has two branches in city and in Parventa so that inhabitants of this area can receive social assistance and social services as close to their place of residence as possible and inhabitants of Ventspils have an opportunity to get 33 different social benefits and 10 different social services.

Social Care department provides citizens the following services:

- Social assistance and services based on need, determining the level and duration of social assistance and collaborative activities
- Assessment of each family (person) - soliciting material condition, and other resources
- Information for Social Service visitors about Ventspils available benefits and social services
- Provision of social services or arrange the provision to families with children in which the child’s development in disadvantaged, foster families, guardians, persons who take care of a family member, disabled, persons with mental disabilities, the homeless and other groups of population
- Cooperation with governmental or municipal institutions, NGO’s, religious dominations, individuals and legal entities on issues related to social assistance and social services.
- Encouragement for able-bodied individuals to enhance their social situation.

Previous Experience

VSCD working together with Ziemeļkurzemes Regional Hospital are the key stakeholder in the local social care system. Social department has implemented several local and European cross border projects.

- European Social Fund project No. 1DP/1.4.1.2.4/10/APIA/NVA/096 “Social Rehabilitation and support measures for families with children in Ventspils”
- Latvian – Lithuanian cross border programme project “My Social Responsibility” No. LLIV-322
• Latvian Ministry of Welfare project “Youth house” creating of an half way house within an Ventspils orphanage “Selga”

Project Key Persons (main)

Dace Kaņepa, held’s a Masters degree in Economics and a Master’s degree in Social care institution management. Currently she is the Director of Ventspils Municipality Social Care Board and has more than 15 year experience in management and financial auditing.

Daiga Zipava-Biumane, held’s a Bachelor degree in Physics, Master’s degree in Business Administration and a Masters degree in Social care. She has more than 10 year experience as a Social care department Manager in Ventspils Municipality. Previous experience in work with EU projects as a Project Coordinator and Technical expert.

Partner 9: Croatian Health Insurance Fund - Republic of Croatia

Croatian Health Insurance Fund (CHIF) was established to enforce the at that time basic health insurance and carrying out of other duties under the Health Insurance Act from 2001 and Healthcare Act from 1993. The rights, duties and obligations of the CHIF are established with the Compulsory Health Insurance Act (“Official Gazette" No. 150/08.), which applies from January 1st, 2009 and the Statute of the CHIF. The Statute of CHIF was brought by the Administrative Council of CHIF on February 14th, 2001, in accordance with the at that time valid Health Insurance Act and it was confirmed by the Croatian Government on February 14th, 2001. Supervision over the legality of the CHIF activities is carried out by the Ministry of Health and the audit of CHIF is carried out by the State Audit Office. CHIF is incorporated into the State Treasury System. The contributions for compulsory health insurance are paid to the single Treasury account, and as such they constitute the State Budget revenue. In the implementation of compulsory health insurance, CHIF particularly carries out the following tasks:

• implements the policy of development and improvement of healthcare from the compulsory health insurance,
• carries out duties in connection with exercising the rights of insured persons, takes care of legal exercise of these rights and provides them with necessary professional assistance in exercising the rights and protection of their interests,
• plans funds of compulsory health insurance and pays for the services to the contracting entities of CHIF,
• proposes to the Minister of Health the scope of rights to healthcare under Article 16 of this Act,
• gives to the Minister of Health its opinion on the establishment of medical facilities and approval of activities of healthcare workers in private practice for the inclusion into the network of the public healthcare service,
• concludes contracts with contracting entities of CHIF and contracting suppliers of aids,
• determines the cost of healthcare services in the total amount for the full value of the right from compulsory health insurance, with the approval of the Minister of Health,
• determines the manner of exercising the right to healthcare services at the expense of the CHIF funds in cases where the insured person cannot obtain healthcare services at the contracting entities of CHIF within the terms prescribed by the general regulation of CHIF,
• ensures the implementation of international treaties in the part relating to health insurance,
• supervises the fulfillment of contracting obligations of contracting entities of CHIF in accordance with the concluded contract,
• regulates other matters related to exercise of rights under the compulsory health insurance.

In addition to the activities related to compulsory health insurance, CHIF also implements the supplementary health insurance according to the provisions of the Voluntary Health Insurance Act ("Official Gazette" No. 85/06 and 150/08) for coverage of participation in healthcare service costs from the compulsory health insurance.

Previous Experience

CHIF is a key stakeholder in the National Health care system. Knowing that the future lies is in informatization of health care, under the supervision of CHIF and IT department large scale health
Care projects have been implemented using national resources. For example, primary health care providers are connected with CHIF using VPN through a system of messages. ePrescription is in full function, telemedicine has been implemented in many segments of the health care system. Strategic projects for the upcoming period (some of which are already in a piloting phase) include e-waiting lists, e-ordering, e-orthopaedic devices system, e-pharmaceutical monitoring system, e-prevention, e-guidelines for prescribing pharmaceuticals, e-clinical guidelines etc. CHIF also operates the central information system with the registry of patients, health resources registry including portal of messaging system for communication between health providers and CHIF.

CHIF clearly has its interest in early prevention of illness and supports it through efficient models of contracting primary health care providers and together with them they try to find a way to be more involved in promoting healthy ageing and healthy lifestyle choices. CHIF is also involved in the CHBIS project which is a project about health reporting and planning with a GIS component.

**Project Key Persons (main)**

**Tatjana Prenda Trupča**, M CS (born on June 17th, 1974, Zadar, Croatia) graduated from the University of Zagreb, Faculty of Electrical Engineering and Computing in 1998, where she majored in Computing Science, finished Academy for Political Development of the Council of Europe and currently studying EMBA. Within 13 years of her carrier she was working as IT manager, project manager and consultant for the Ministry of Health, Ministry of Justice, Ministry of Crafts, Cap Gemini, World Bank and the Delegation of the European Union in the Republic of Croatia. Today, she is leading development of the e-Health in Croatia. In 2012 she became Assistant Director for IT at CHIF, and currently she is Managing Director Deputy at CHIF. She was a member of negotiation team during Croatian accession to EU for Chapter 23: Judiciary and Human Rights.

**Hrvoje Belani**, MSc EE (born on December 14th, 1978, Koprivnica, Croatia) graduated from the University of Zagreb, Faculty of Electrical Engineering and Computing in 2003 where he majored in Telecommunications and Informatics. He is an experienced software engineer, with advanced knowledge of software methods and processes, requirements engineering and business process modelling. From 2010 he works as a senior inspector for informatics in IT division of HZZO and as information security officer. He is an adjunct lecturer in information systems development at VERN' University of Applied Sciences. He is also a PhD student at University of Zagreb, Faculty of Electrical Engineering and Computing, Croatia.

**Partner 10: RIJEKA City Council Department of Health and Social Welfare - Republic of Croatia**

With a population of approximately 130,000, The City of Rijeka is the third largest city in Croatia. It is the most important Croatian harbour and is an industrial, administrative, cultural and university centre of the Region. Over the last decade, the city has merged activities and applies a more responsible administration approach to urban development projects. Rijeka is benefiting from the introduction of Croatian Codex in consultation processes with the public and EU Smart Regulation, and adjusting accordingly in order to achieve open access to the administration and ensure the rights of the citizens to participate in decision making processes.

The City of Rijeka Administration consists of 13 departments and 2 offices situated in five locations, and among them are: The City Department of Health and Social Welfare and Information Technology Department.

**The City Department of Health and Social Welfare**

The City Department of Health and Social Welfare carries out activities related to community's care for citizens who due to unfavourable personal and social reasons and circumstances are not in a position to independently meet their basic living needs. The Department also implements activities regarding the improvement of accessibility and quality of health care in the city area and provides for citizens a higher standard of health care from the one which is secured by the state. The goal is to protect and improve the quality of life, as well as, physical and mental health of Rijeka' citizens. For
the realization of these goals the Department collaborates with different institutions, associations and other legal persons.

This is an outline of the more important activities carried out by the Department:

- Implementation of the Social Program of the City of Rijeka
- Implementation of the Provisional Accommodation Program (for the socially most threatened category)
- Implementation of the Psychosocial Protection Program (for vulnerable population categories)
- Implementation of the Health Promotion and Disease Prevention Program
- Implementation of the Animal Protection Program
- Implementation of educative and promotional activities related to health and social welfare
- Coordination of activities related to the participation of the City of Rijeka in the WHO project named the European Healthy Cities Network
- Coordination of activities related to the Interest Groups of the Rijeka Healthy City project
- Coordination of activities related to City Council of Pupils-Rijeka Healthy City
- Coordination of activities related to the participation of the City of Rijeka in the Action: Towns and Districts-Friends of Children
- Coordination of activities of the City of Rijeka related to the implementation of the National Population Strategy
- Coordination of the Anti-addiction Commission of the City of Rijeka
- Observation of health statistical and relevant socio-economic and socio-demographic indicators, estimation of citizens' needs, evaluation of projects and programs
- Making strategies and action plans of the City of Rijeka directed towards protection of vulnerable population groups (people with disabilities, the elderly, etc.)
- Observation of building, furnishing and maintenance of the facilities owned by the City of Rijeka, where health and social welfare activities are performed
- Support for equipment procurement for health care institutions
- Support for professional training of personnel and for the organization of professional conferences in the field of health care and social welfare
- Support for activity and surveillance over the performance of health and social welfare institutions founded by the City of Rijeka (Psychiatric Hospital "Lopača" and Child Day Care Home "Tič")

Since 1998, the City of Rijeka has been included in the WHO European Healthy Cities Network, where together with other European cities it has been undergoing various project phases, the focus of which is health and all that health implies. Joining the WHO European Healthy Cities Network, marked the beginning of a direct communication with the World Health Organisation, the cities included in the European Healthy Cities Network, and the promotion of innovations and changes in health policies at local level. In addition to its direct contribution to the local community, especially in the promotion of health, the project can serve as a positive model for other Croatian cities, especially those included in the Croatian Healthy Cities Network.

**Information Technology Department**

The Information Technology Department carries out the activities relating to planning, projecting, developing and establishing IT systems, geo-information systems (GIS), integrating alphanumeric and graphic data, the City's websites and two-way communication systems, as well as citizen on-line services within the development of e-Government. It carries out the activities relating to planning, acquisition and managing ITC resources, network supervision and operation (intranet and internet) and provides data safety and protection. Furthermore, it carries out the activities relating to the development, maintenance and management of the electronic communication infrastructure owned by the City. It implements the activities relating to the development, establishment and maintenance of the City of Rijeka Contact Centre.

**eGovernment Unit**

This service cooperates with organisations, institutions and other administrative bodies of the City when preparing and implementing projects dedicated to the development and application of new technologies in business process management and in the promotion of new approaches for communicating with citizens, business and scientific communities (eGovernemnt, eDemocracy, eInclusion).
The service implements or cooperates on EU and international projects, projects relating to eServices, it introduces and takes care of the Intranet and other collaborative surroundings, social media application and other WEB 2.0 tools and manages projects relating to eInclusion and education for targeted citizens’ groups.

The service cooperates and coordinates the implementation of national and European strategic guidelines tied to the implementation of the "Digital Agenda for Europe".

**Project Key Persons (main)**

**Suzana Belošević** is Advisor to the Mayor of the City of Rijeka for EU projects. Suzana holds a BSc in Sociology and for the last 10 years has been working on Regional Development (coordination of designing and implementation of strategic documents - Regional Development Strategy, Regional Operational Programme) and project design, management and implementation of EU financed projects (under CARDS, PHARE, IPA, FP6 and FP7, CIP programmes).

**Antonić Danijel** is security advisor and system architect of IT Institute, City of Rijeka, Croatia. He has 17 years of professional experience in managing, planning and implementing IT solutions. Mr Antonić holds a BSc in Mathematics and Physics. He is a certified, MCT, MCSE+Security, MCSA+Security, with 9 years working also as technology and enterprise security trainer. His main responsibilities include all aspects of planning, architect, development, implementation and maintenance of networking infrastructure, server infrastructure and enterprise security aspects in City of Rijeka and, partly, in the companies owned by the municipality.

**Kristina Dankić**, MSc is Advisor for programs and health psychologists in the Department of Health and Social Welfare of the City of Rijeka. Among her major competencies are applied research, statistical analysis of data, program evaluation, strategic planning and social marketing. Topics that she is particularly involved with are health promotion and healthy lifestyles, disease prevention, care of the elderly and children.

**Karla Mušković** graduated from Faculty of Medicine and she is Senior Advisor for Health in the Department of Health and Social Welfare of the City of Rijeka. She is responsible for monitoring of activities, organization and the implementation of public health programs and for monitoring of health statistics. As a part of her job she works closely with institutions of health and social welfare and with civil society organizations.

**Partner 11: Foundation for Training and Healthcare Research of Murcia Region – Spain**

The **Foundation for Training and Healthcare Research (FFIS)**, is a foundation dependent on the Health and Social Affairs Regional Department of Murcia (HSARD), and aims at knowledge management, research and innovation project management in bio-medicine.

This Foundation has got a model management more flexible than the HSARD it depends on, and specially indicated to manage European projects.

The **Health and Social Affairs Regional Department of Murcia (HSARD)** that shares the positive EU view on aging of the European citizens, and leads a consortium integrated on the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA), is the Department of the Autonomous Community of the Region of Murcia with planning and execution competencies in health, hygiene, pharmaceutical, drug addiction, and health care.
It also owns the responsibilities for social care and welfare, protection of the family, elderly and child policies; integration of social groups in need of special protection, promotion of personal autonomy and care for people in situations of dependency.

Integrated in this Department (HSARD) is the Public Health Agency of Murcia (SMS), which is responsible for health care in the Region of Murcia, integrating a total of 11 hospitals, with 3,651 beds and 508 outpatient appointments of primary care, and providing health care to 1.47M inhabitants (about 3.09% of the whole Spanish population).

In the exercise of its functions, the SMS provide services and develop the following actions:

a) Health Promotion.
   b) Prevention of the disease.
   c) Comprehensive primary care health.
   d) Specialized Healthcare.

Also integrated in the HSARD is the Social Care Institute of Murcia (IMAS), which has competences in social policy in the region, and its areas of activity include:

- Seniors.
- Persons with disabilities.
- People with chronic mental illness.
- People at risk of social exclusion.
- Any other group in need of protection

It is noteworthy that the Region of Murcia is considered by firms specialized in the implementation and evaluation of health-related technologies, as a perfect location for a number of reasons including the following:

Single-province region, which means faster political and administrative decision-making, saving time, money and resources.

The population typology and characteristics of the different health districts are heterogeneous.

There is an increasing number of foreign people that choose to retire in Murcia.

The technological infrastructure of the Public Health Agency of Murcia, which has a tradition of supporting innovation, allows for rapid, solid implementation of added value applications.

Project Key Persons (main)

Gorka Sanchez Nanclares. He is a Family and Community Medicine Physician Specialist. He accumulates clinical experience in both the Emergency Hospital (2000-2004) and Primary Care (2004-2008) in addition to the specialist training years (1997-2000). He has combined clinical activity as a Tutor teaching both residents and Hospital Coordinator specialist training.

He also developed management responsibility work as Coordinator of Primary Care Team in their last two years of clinical activity. In 2009 he joined the management team of the Primary Care Management of Cartagena and in 2010 assumed responsibilities at the central level within the Murcia Health Service as Information Systems Coordinator, a role in which currently remains. Since then has been dedicated to developing standards projects, monitoring, Business Intelligence and ICT health applications, based always in end user needs and vision, making success stories like "CIMA AP Pharmacy" who got historical improvement in the efficiency of pharmacy in primary care.

Maria José Tormo
Specialized in Preventive Medicine and Public Health. Trained at the Harvard School of Public Health in Epidemiology and Public Health (1988-1990) developed her research in surveillance, monitoring and etiological study of chronic diseases (cardiovascular, neurological, mental, cancer, diabetes, etc.).
Since 1985 to present working for the Epidemiology Service of the Ministry of Health and Social Policy. CIBER Researcher in Epidemiology and Public Health (CIBERESP, ISCIII; http://www.ciberesp.es/) shares the most potent Spanish network platform in this area. Teaches regularly as an associate professor of Public Health at the University, since 2000 in Murcia University. Has secured funding in many national and European projects as IP or collaborator, resulting in more than 100 high-level publications. As a result of her interest in changing from a focus purely etiologic to an applied one, to chronic, aging and tertiary prevention of chronic patients, integrating always a strong emphasis on methodological aspects of research, took advantage, as a GP, during a brief post in Primary Care (2011-2012) to rethink the best way to tackle this issue. Back to the Health Department got the support to launch the Coalition of the Region of Murcia in the European Innovation Partnership on Active and Healthy Ageing (EIP AHA http://ec.europa.eu/health/ageing/innovation/) where the project IN³CA presents as an excellent initiative in the two activities selected as priorities for the Coalition: Action Group A1: Adherence to treatment and Action Group B3: Integration of Socio-Sanitary Care. Dr. Sanchez Nanclares from the Directorate of healthcare services and the economist B. Martinez-Lozano Aranaga from the general coordination (Secretariat) of all health activities of the Ministry of Health and Social Policy, are the other two pillars of the Coalition backing and supporting the IN³CA initiative in Murcia.

Beatriz Martínez-Lozano Aranaga
Degree in Economics and Business. Working for different Departments of Public Administration of the Region of Murcia in Communitarian Funds for more than 15 years. First for the Department of Finance with responsibility for management, analysis, implementation and monitoring of EU funds (ERDF Operational Programme, the Cohesion Fund, Interreg IIC, EAGGF, etc.). Since 2010 works for the Department of Health and Social Policy where besides other activities, she is the contact of the Department for all European issues, including proactive information on the different calls and finding European partners in collaboration with the Office of Murcia in Brussels, contributes to the preparation of financial and mandatory reports and advises on budgetary and accounting aspects of the projects, thus closing the complete cycle in the translation of European initiatives. From her current position as advisor to the Secretary General of the Ministry performs actions of coordination between different departments of the Ministry, including (of interest to the project IN³CA), DG Health, DG of Planning, Health and Pharmaceutical and Research, and DG Social Policy, in addition to the public entity Murcia Health Service (SMS), and Murcia autonomous Social Action Institute (IMAS), which includes DG Seniors, and the Foundation for Training and Health Research in the Region of Murcia (FFIS), who represents the Regional Health Administration IN³CA project. She is founder, with Dr Sánchez Díaz Nanclares and Dr Tormo, of Murcia Coalition integrated in the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA), and representative in the Action Group B3: Integration where she leverages objective 3: Workforce Development, Education and Training, and coordinates the task Training and Capacity Building.
B2.2a. Chosen approach

For properly tackling **INCA full** deployment, **initial** Deployment requires a complete and realistic combination of business and technological works. This Work Plan describes all the necessary tasks and their relationship, based on the outcomes obtained in the previous Market Validation Phase.

This task will be done in **two complementary activities** running wholly integrated:

1. **Horizontal** activities provided by a **common technological** (IDI EIKON), **dissemination** (QUART DE POBLET), **validation** (INTERFUSION) and **business** (KENUS) approach.
2. **Vertical** activities throughout **customized** local, regional or national pilots following a **common European** approach. The pilots will address specific needs of "Replicating and tutoring **integrated care models** for **chronic** diseases of **older people**, including **remote monitoring** at regional level" of Member States partners of the Consortium and in line with national Programmes following the same strategy. Namely: Cyprus, Latvia Croatia and Spain.

The proposed project work is divided in **6 Work Packages (WP)** corresponding with logical phases, each with a separate description and a designated work package leader. The structure of the logical phases in **INCA** is divided as follows:

**Managerial tasks:**
- **Administrative**: The project will be conducted by IDI EIKON. Their experience in the management of projects, mainly in the ICT PSP Programmes, makes them especially suited for performing the managerial tasks of the project. The managerial tasks of the project (administrative management, financial management and technical management), are included in a specific work package (WP1) that will deal with all of them. It will be of special relevance (and will be considered as such) the quality assurance of the project (that will have special measures and procedures).
- **Technical**: The project will be conducted by partner IDI EIKON, the technological partner of the Consortium contributing the technology and contributing also to all the work packages. Central to **INCA** is the need to meet the diverse needs of stakeholders throughout Europe. A key part of the work will be ensuring a high standard service for users and citizens. For the deployment of the **INCA** service at the different countries an intensive technical effort is required and IDI EIKON is ready to stand it and fully committed with its deployment.

**Project Monitoring**

In **INCA** monitoring will be a regular activity to know where the project exactly stands and determine how closely initial plan resembles reality. Monitoring will allow us to know questions as, if we are on schedule or how, (if not) can we catch up; if we are over budget; if goals are still the same; if there are warning signs... Monitoring will allow us to validate decision done in regards to implementing changes and also to make the necessary adjustments regarding resources.

**Project Risk Management**

**INCA** project Risk Management will include the processes of conducting risk management planning, identification, analysis, response planning, and monitoring and control on the project, to increase the probability and impact of positive events, and decrease the probability and impact of negative events in the project.

**INCA** approach to risk management will be an iterative one being the intention to tackle high risk areas of the project sooner rather than later. This will get problems out in the open while still having time and budget to work on them and to reduce the effort invested in work that needs scrapping.
Dissemination and Promotion tasks:

The aim of these activities is to ensure news of the project and its objectives and its status, the service itself and the possibilities it provides is made known to the widest audience.

**INCA** aims, in what refers to the dissemination and exploitation processes, are to develop the full potential of the project’s results – by creating a virtuous cycle of influence making results more sustainable, maximizing their impact, optimizing investment, improving systems, pooling knowledge to avoid overlap of effort, and then feeding back into policy-making.

**B2.2b. Work plan**

**INCA** project involves multiple partner and teams and managing different people and tasks is anything but easy. To give a visual picture of the whole project in an easy to understand format, we have drawn a Gantt chart. To be able to produce **INCA** Gantt chart Coordination knows all of the processes involved and how long each of the tasks will last, also how many resources are needed to complete the task, as well as the sequence of events to finally fix the milestones to be reached throughout the project.
### GANTT Chart

#### Project Management

<table>
<thead>
<tr>
<th>WP</th>
<th>Task Description</th>
<th>Project Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP1</td>
<td>Management Activities</td>
<td>MS1, MS2, MS3, MS4, MS5, MS6</td>
</tr>
<tr>
<td>WP2</td>
<td>Establishment of a Management structure &amp; Communication</td>
<td>MS1, MS2</td>
</tr>
<tr>
<td>WP3</td>
<td>Progress Reports &amp; Financial Statements</td>
<td>MS1, MS2, MS3, MS4</td>
</tr>
<tr>
<td>WP4</td>
<td>Management Operational Hand Book</td>
<td>MS1, MS2, MS3</td>
</tr>
<tr>
<td>WP5</td>
<td>Final Report</td>
<td>MS1, MS2, MS3, MS4</td>
</tr>
</tbody>
</table>

#### Dissemination Activities

<table>
<thead>
<tr>
<th>WP</th>
<th>Task Description</th>
<th>Project Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP2</td>
<td>Dissemination Plan</td>
<td>D2.1, D2.2, D2.3</td>
</tr>
<tr>
<td>WP3</td>
<td>Project Web Site</td>
<td>D2.1, D2.2, D2.3</td>
</tr>
<tr>
<td>WP4</td>
<td>Dissemination Plan Update</td>
<td>D2.4, D2.5, D2.6</td>
</tr>
<tr>
<td>WP5</td>
<td>Dissemination Plan Update</td>
<td>D2.7, D2.8, D2.9</td>
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</tbody>
</table>

#### Service Adapation & Customisation

<table>
<thead>
<tr>
<th>WP</th>
<th>Task Description</th>
<th>Project Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP3</td>
<td>Services and Pilots specifications and requirements</td>
<td>D3.1, D3.2, D3.3</td>
</tr>
<tr>
<td>WP4</td>
<td>System Architecture &amp; Users Roles</td>
<td>D3.4, D3.5</td>
</tr>
<tr>
<td>WP5</td>
<td>Standards and Interoperability</td>
<td>D3.6</td>
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#### Deployment & Operation (PILOTS)

<table>
<thead>
<tr>
<th>WP</th>
<th>Task Description</th>
<th>Project Milestones</th>
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</thead>
<tbody>
<tr>
<td>WP4</td>
<td>Deployment Planning</td>
<td>D4.1, D4.2, D4.3</td>
</tr>
<tr>
<td>WP5</td>
<td>Pilots Evaluation Methodology and Quality Assurance</td>
<td>D4.4, D4.5</td>
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<tr>
<td>WP6</td>
<td>Trials Testing: Assessment and Evaluation</td>
<td>D4.6, D4.7</td>
</tr>
<tr>
<td>WP7</td>
<td>Post-Implementation Report</td>
<td>D4.8, D4.9</td>
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#### Planning for Sustainability

<table>
<thead>
<tr>
<th>WP</th>
<th>Task Description</th>
<th>Project Milestones</th>
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<tbody>
<tr>
<td>WP5</td>
<td>Market Overview</td>
<td>D5.1, D5.2, D5.3</td>
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<tr>
<td>WP6</td>
<td>Sustainability Strategies (Public and Private)</td>
<td>D5.4, D5.5</td>
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<tr>
<td>WP7</td>
<td>Producing Business Plans</td>
<td>D5.6</td>
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<tr>
<td>WP8</td>
<td>Socio Economic Impact Assessment</td>
<td>D5.7</td>
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#### Data Protection Policies

<table>
<thead>
<tr>
<th>WP</th>
<th>Task Description</th>
<th>Project Milestones</th>
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<tr>
<td>WP6</td>
<td>Data Protection Policies (Legal and Regulatory Requirements)</td>
<td>D5.8, D5.9</td>
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<tr>
<td>WP7</td>
<td>Business Plan(s) Ready</td>
<td>D5.10</td>
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<tr>
<td>WP8</td>
<td>Data Protection Policies (Legal and Regulatory Requirements at EU level)</td>
<td>D5.11, D5.12</td>
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**Project Milestones**

<table>
<thead>
<tr>
<th>WP</th>
<th>Milestone</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>WP1</td>
<td>System ready</td>
<td>MS1</td>
<td>MS2</td>
<td>MS3</td>
</tr>
<tr>
<td>WP2</td>
<td>Requirements complete</td>
<td>MS4</td>
<td>MS5</td>
<td>MS6</td>
</tr>
<tr>
<td>WP3</td>
<td>Partners Trained</td>
<td>MS7</td>
<td>MS8</td>
<td>MS9</td>
</tr>
<tr>
<td>WP4</td>
<td>Pilot Users Group formed</td>
<td>MS10</td>
<td>MS11</td>
<td>MS12</td>
</tr>
<tr>
<td>WP5</td>
<td>Pilots Launch</td>
<td>MS13</td>
<td>MS14</td>
<td>MS15</td>
</tr>
<tr>
<td>WP6</td>
<td>Business Plan(s) Ready</td>
<td>MS16</td>
<td>MS17</td>
<td>MS18</td>
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<td>WP7</td>
<td>Data Protection Policies (Legal and Regulatory Requirements at EU level)</td>
<td>MS19</td>
<td>MS20</td>
<td>MS21</td>
</tr>
</tbody>
</table>
Work Package List

The work scope for INCA will be split into six Work Packages (WP1 to WP6). Each of the individual work packages will have its own objectives and deliverables as set out below. Each Work Package (WP) will have its own WP leader and all the INCA participants will contribute to the WP’s related to their core development areas.

In order to achieve the research objectives, the project is organized in one Work Package focusing on project management (WP1), one dissemination work package (WP2), one technical work package, including standardization and interoperability issues, (WP3), one use cases and validation (WP4), one sustainability work package (WP5) and one work package dealing with the Ethical and Legal issues (WP6).

The overall work package structure and the relationships and dependencies between the Work Packages are represented next. All the deliverables run from M1 in a continuous cycle that goes until the end of the project, except for WP5 that ends at M28.

Project Management (WP1): This work package is responsible for ensuring that the project has an effective project management structure, ensuring compliance with project plans and that project activities meet appropriate quality levels, checking and validating the correct scheduling of tasks, and managing risk within the project.

IDI EIKON as the project Coordinator and WP1 leader will be responsible to maintain an overview and to ensure that the WP administration and the deliverables are achieved. The Consortium has the responsibility for the success of the project and each work package (WP) will be led by the listed partner.

WP2: Dissemination Activities. Consortium will act to promote awareness in the appropriate stakeholders groups chosen as the project main targets. This also implies the exchange of information and the establishment of relationships with other ongoing projects and networks thus achieving a lively dialogue with key stakeholders.

For the Dissemination Activities (WP2) INCA Consortium will use, among other strategies, SEED (ICT PSP project nº 297192) innovative solutions. SEED is a tool for raising the awareness of useful contents and services previously invested by European Public Sectors, including European projects (FP7, CIP, ...) that is showing effective and impacting results. INCA will take advantage of SEED project by reusing its awareness strategies and applying them for an INCA sound dissemination.

WP3: Service Adaptation and Customization will especially address the “technical” aspects of the project, providing the basics for the technical infrastructure supporting INCA connectivity and interoperation between different tools and services in order to ensure a seamless experience for INCA stakeholders while providing the user with access to a variety of tools and services. The outcomes of this WP are technology system ready for welcoming the different pilot scenarios chosen by the different partners. The work package has as main objectives the definition of user needs and system requirements and the identification of the requirements and constraints for the successful adoption of INCA solution. An internal evaluation will be carry out supported by pilot partners’ feedback before opening the system to the general public.

WP3 will include also a Technical Training Programme to be developed and established for using the INCA solution. Training material will use only digital means (Wiki and alike). Training impact will be evaluated with all stakeholders; individualisation; collaboration; creativity; design of new and/or improved features, if required, overall transformative effect...

Standardisation tasks are included within WP3 and have as its aim to ensure that the project is aligned with key accepted industry standards and is able to provide, through them, the necessary connectivity to make the project run properly with independence of manufacturers and hardware.
WP4: Deployment and Operation, aims to measure ‘buy-in’ and ‘uptake’ of INCA by end-users and decision makers, providing objective measurable evidence of the interest in the project outputs by including summary outcomes on system usage. The report will also evaluate the benefits and usefulness of specific project objectives via the dissemination strategy and the interest groups.

Developing a set of relevant and convincing scenarios to help refine and later promote the INCA concept will be key:

- Understand the data sources needing to feed the chosen scenarios, their availability and quality.
- Understand how multi-professional decisions utilising INCA will be best captured, preserved and shared.
- Identify the requirements and constraints for the successful use of INCA to empower patient.
- Leveraging and supporting Communities of Interest to help steer future work on INCA.
- Produce Reports and Recommendations.

Demonstrators’ pilots (WP4) will be produced, assessed and tested as part of the INCA deliverables with the selected results disseminated both within the partners and externally as part of the exploitation and dissemination plan agreed with all partners.

WP4 will include also a Service Coaching Programme to be developed and established for using the INCA solution.

WP5: Planning for Sustainability. The aim of this work package is to execute exploitation activities to maximise the impact of the results of the INCA project. Activities will include the identification and exploration of perceived barriers to widespread uptake and acceptance of the INCA the vision for all levels of ambition.

WP6: Data Protection Policies. The objectives of this task regard observing the requirements of national laws of each participant and safeguarding the adherence to the legal stature of each country where pilots will be held. The challenge for the project is to ensure that the availability of electronic information and the use of ICT are handled in an ethical manner.

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### Milestones

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Dependencies between Deliverables
The following PERT diagram shows the dependencies between deliverables.

Project PERT Diagram

Relationships between Deliverables

All the work packages run from month 1.

Milestones

In INCA milestones are critical points that need to be monitored throughout the life of the project. They highlight important interim events, such as the completion of a phase. It is important to note that milestones are not work activities but rather significant events.

| Project Milestones               | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|----------------------------------|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| System Ready                     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Requirements completed           |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Partners France                  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Partners Group selected          |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Pilot Launch                     |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Business Plan(s) Ready           |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| Pilot Validation                 |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
Work Package Description

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### Objectives

The aim of this WP is to provide the internal project management and the overall co-ordination of activities, financial- and technical- planning and control. It ensures that the project objectives are met and represents the contact point of the project to the Commission and the external world. It also addresses any issues concerning access rights, including cases where partners join or leave the project during its duration. It is assisted in its tasks by other bodies established as part of the management structure. The Management structure proposed for INCA aims at facilitating co-operation between partners while maintaining a strict control of gradual achievements of the actions objectives.

Management of INCA will be carried out during the project life. IDI EIKON will be in charge of the overall work of this package and the managerial tasks of the project (administrative management, financial management and technical management). It will be of special relevance (and will be considered as such) the quality assurance of the project (that will have special measures and procedures).

The objectives of this work package are:

- To achieve project objectives on time
- To ensure the fulfilment of project objectives and submission of project deliverables to the European Commission on time
- To develop management and communication mechanism whereby the other participants could equitably contribute to and benefit of the project
- To manage the funds related to the project, authorise payments, submit deliverables and report to the Commission

### Description of Work

Project Management is a critical component of the INCA project, and its purpose is to ensure the quality of results of the project activities and tasks and target dates for deliverable deadlines are achieved.

**T1.1 Management Activities** (M1 to M30)

Consortium management activities include:

- Project Standard Procedures
- Planning
- Document Distribution
- Delivery Preparation
- Project Reporting
- Meetings
- Supervising corresponding sub-contracts
- Quality control
- IPR Management
- Monitoring Ethical aspects of all the other work packages

That will be provide by the Project Manager in collaboration and in consultation with the bodies established.
Management will monitor the project progress and will organize reports and meetings throughout the duration of the project. Reports will be submitted to EC after 12-24-30 months. Coordination (and the Steering Committee) will provide a mechanism through which all partners will be kept informed about the general progress of the project and about deliverables and milestone achieved.

Coordination will sustain the Administrative Support and will establish detailed financial reports, collects cost statements and certificates and will administer funds according to the rules set in the Consortium Agreement. The Project Coordinator will verify that cost statements are in line with the work performed, and will assure partners compliance with the DoW and audit certificates.

**T1.2 Establishment of a management structure & Communications Strategy** (M1 to M4)

The Management structure proposed for INCA aims at facilitating the co-operation between partners while maintaining a strict control of gradual achievements of the action objectives. Responsibilities are clearly defined and the management structure with well defined roles is as follows: **Steering Board**, chaired by the Project Manager and consisting of the Partner’s Leaders.

To identify and set the means/medium and frequency of communication between the different parties, documenting how information will be disseminated to, and received from, all stakeholders in the INCA activity.

Effective communication flow will be established between consortium members. This will be handled via meetings scheme and an electronic information exchange scheme.

- Communication and information flow will generally involve IDI EIKON, which will be a leading partner in this WP. The other participants of the project will also be actively involved in communication and information flow of the project by the means of email, audio and video conferences, telephone and Internet, which will play a key role for the information exchange between partners and the Commission.

The main information exchange tool will be the INCA web (private side), which will store project deliverables, reports and working documentation and will be established at the working domain of the INCA web. This site will be maintained and up-to-date during the full project and behind.

**Results**

To ensure the project is well and harmoniously managed
To ensure that it respects proper quality standards

**Deliverables**

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<tr>
<th>Nº</th>
<th>Title</th>
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### Dependencies
This is a horizontal work package that has no direct dependencies with the rest of the work packages but is in charge of the good results of the rest and of the general project thus should be considered as linked to all of them.

### Contribution to Project Objectives
This Work-package provides a reporting function for the project and contributes by ensuring the partners take stock of their positions at reasonable periods throughout the project. It also keeps track of expenditures and efforts and it ensures good co-operation and proper handling of risks to success.
**Objectives**

This WP is to ensure the widest possible dissemination and promotion of **INCA** internally (among Consortium members) but also to all European Members States and in particular those engaged in the project.

In **INCA** dissemination is related to making the results / products of the project visible to others, specially the end-users, the target groups and the key-actors that can implement its use.

Dissemination is essential for take-up, and take-up is crucial for the success of the project and for the sustainability of outputs in the long term. In **INCA** Dissemination activities have, as a core objective, the need to disseminate the outcomes of our project to particular communities. We are aware that this will only be achievable and successful if, from the outset, every partner of the Consortium has a shared understanding of exactly what it is we want to disseminate and why. Thus, Consortium sharing vision and common understanding of what we want to disseminate together is essential.

In **INCA** we think about dissemination in at least three different ways:

1) Dissemination for **Awareness** (with the help of **SEED** strategies)
   Making others aware about our work. This is dissemination useful for those target audiences that do not require a detailed knowledge of our work but it is helpful for them to be aware about our activities and outcomes. Creating such an awareness of our project's work will help the "word of mouth" type dissemination and help build an identity and profile within nearest communities around us.

2) Dissemination for **Understanding**
   Will be targeted directly to the groups of interest, because we believe that they can benefit from what our project has to offer. It is, therefore, important that these groups/audiences have a deeper understanding of our project’s work.

3) Dissemination for **Action**
   Referred to as the change of practice resulting from the adoption of services or approaches offered by our project. These groups/audiences will be those people that are in a position to “influence” and “bring about change” within their organizations and as such will need to be equipped with the right skills, knowledge and understanding of our work in order to achieve real change.
aim to: 1) ensuring a strong, stable and interested reaction of local stakeholders to the implementation of INCA; and 2) searching for an adequate, significant and extended cooperation from external consortia and other “sources” of relevant information and knowledge to be submitted to trial during the project.

The main objective of this work package is to create awareness among the different targets groups identified:

- Medical Personnel (doctors, nurses, administrative and managerial personnel at Hospitals departments, especially decision makers);
- Municipality Services un charge of Health and Social Services Policies (Social Services personnel, especially Social Workers and those responsible of implementing wellbeing policies among citizens);
- Informal Carers (including family, volunteers, neighbours...) and
- Users/Patients themselves (elder people with chronic conditions)

Engaging them will be for sure a costly task consuming a lot of resources. However, counting with tools as SEED (ICT PSP project nº 297192) for raising the awareness of useful contents and services previously invested by European Public Sectors, including European projects), INCA dissemination activities will have realistic possibilities to successfully achieve its purposes (address the identified targets groups and audiences). A template will be created for all partners to follow, helping to keep track of the dissemination activities within INCA.

Beyond specific target groups, WP2 “Dissemination Activities” will expand the dissemination activities to all those that may show an interest in the project, such as Decision Makers, Policy Makers, Private Investors, disadvantaged citizens’ associations, NGOs etc.

INCA Consortium will try to reach an audience as wide as possible and will try to make links to other projects, networks, communities. Moreover, INCA partners, given their composition and profile, will give a European value to the project, using their networks and contacts to make the “voice of the project” grow up.

Dissemination schemas will try to approach the different characteristics of the groups they address.

The Program’s mandatory requirements for dissemination will be fulfilled by this work package, namely:

- Press release and project fact sheet (by end of negotiation time)
- Project website and logo (by month 2) and links to/with Social Networks (by month 4) and others projects (by month 16)
- Project description for the CIP website (by month 4)
- Photos and graphics (continuously updated during the project’s lifetime)
- PowerPoint slides (customized from the CIP template)
- “Success Story” description (by mid- and end- project)
- Public Workshops (one by mid- and one by end- project)
- Brochure and leaflet (by month 8)
- Videos (by M12 and 24)
A plan of dissemination activities and events will be prepared by all the partners (participation in thematic fairs, seminars and workshops...) with the aim of presenting the results of the initial deployment activities and thus eliciting additional involvement. The expected number of public presentations can be estimated now as at least twice per year.

The project will be deeply involved in the roadmap of events related to inclusive eHealthcare and Telemedicine, Social Care, Long-Term care, EHTEL Symposiums, Open Days, European eHealth Forums, eHealth Management, EHR, eHealth IT, connecting eHealth IT..., other projects as SmartCare and Epsos....

**INCA** will join the most related existing communities in the EU ePractice Portal and/or will create a new one if considered convenient.

### Description of Work

**T2.1: Production of a Web site (M2).**

With two differentiated areas: a public and a private one. The private area will serve as a project document repository where partners and authorized users (the Commission, Reviewers, etc.) will be able to access any relevant document/information on the project.

**T2.2: Dissemination Plan Report (M1 to M4).**

Describing all the actions made or to be made. This deliverable will be used as a living internal deliverable to be updated during project meetings, with dissemination activities contained in it being reported in management reports to the EC until the end of the project.

**T2.3: Content Maintenance, Network of Interest & Dissemination Material (M4 to M30).**

Populating the Web site and Maintaining and updating the information. This will be an ongoing task needed to maintain and updating the delivery of information to the different channels of dissemination.

The first step to ensure the success of the proposed work is the creation of a network of contacts for the dissemination of the results and the offered services. By using the contacts capacity of the consortium members, an initial network of interest for the project will be created (this phase has already starting during proposal preparation). The obtained list of contacts will be used as the basis for mailing actions (using the email) including project information, related events and services offered. In the **INCA** web site, a Section will be dedicated to the Network of Interest (NoI) where a form will be made available for all those interested in joining it.

The Network of Interest (NoI) is expected to rapidly become an important Dissemination Tool, as the number of Members increases and the usability of the pilots help to make them more widespread. **INCA** will link with existing subject-specific fora.

The consortium will involve stakeholders in the chain of health and social care (including Public Administrations) and European Commission to disseminate results using their communication channels. This task includes the participation in “concertation meetings” or other bilateral events /exchanges for cooperation with relevant other projects in e-Inclusion (e-Inclusion features prominently in the Digital Agenda for Europe) or more generally in DG CONNECT.

**Project leaflets design and creation; Posters creation; information dossiers, videos, Newsletters, ...**

The Consortium will produce any publicity material needed to present the project at public events and/or helping to better promote it through direct contacts, when convenient but especially in coordination with the Workshops planned. Also Newsletters will be produced (if possible once per quarter). Latest News will be updated at once when happening and the same for events, publications, etc.
T2.4: Workshops Activities (M10 to M16 and M20 to M28)
Among the dissemination activities to be carried out, two main Workshops are foreseen to be held around month 15 and 28.
The goal of these events is to create awareness among socio-health practitioners and caregivers and patients/users (including Public Administration and Private Organizations, Health Managers and Coordinators and Investors), in order to foster the final deployment of the service.
Relevant authorities and/or persons on the subject from different countries, especially new Member States, will be invited.

Results
The main expected result for this work package was presented in the description of the work that is the creation of awareness among European Social and Healthcare professionals, as well as patients/users and caregivers, Investors, Stakeholders, and the General Public. However, there is a set of measurable results that will be obtained from this work package that are summarise in the following list:
- Contacts network
- Project Web site
- Project publicity material
- Two Project Workshops

Deliverables

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D2.1 and D2.2: Project Web Site and Dissemination Plan, after their submission to the Commission in M4, will be used as a living internal deliverables. The dissemination activities will be updated more or less at the time of Progress Reports, but in separate deliverables of their own. (Note: The final project report will list activities (if any) taking place after that).

Dependencies
This is a horizontal work package that not having direct dependencies relates with all the work packages in the sense of being a driver for the consecution of many of its objectives.

Contribution to Project Objectives
Dissemination of project information and of the status of the project is of immense marketing advantage to the project and also is necessary for Commission purposes. No business opportunity exists if no-one knows of it. It will be pursued actively from the beginning of the project.
Work package No. 3 Start date or starting event: M1
Work package title: Service Adaptation & Customization

<table>
<thead>
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<tr>
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<td>INCA DoW v06 accepted on 28/11/2013 Page 58 of 83</td>
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Objectives

The INCA service can be categorized as an organizer of care around the needs of people with the aim of improving the health services through better coordination across different levels of care and from different providers within each level.

This is the WP in charge of providing availability of common ICT-based components/building blocks necessary for the deployment of integrated care services

- Availability of ICT infrastructures
- Knowledge and capacity of using technology
- Level of intrusion the user will allow
- Capacity to follow the protocols established (level of dependence)
- Data retrieval and transformation to get a common view of data able to be shared with third parties
- Alerts configuration
- Dashboards parameters (a unified view of KPI, graphical analysis and business report in a truly interactive environment). Critical metrics to track business performance and help users to answer critical business questions and adapt to the changing market quickly and with confidence in every decision.

INCA dashboard is easy to implement, practical and affordable to use. It requires minimal training. It allows creating a personalized, intelligent environment to enable access to critical information with ease and simplicity.

WP3 regarding service adaptation and customization comprises of:

Providing a list of Services: Appointments, Medication reminders, Vital Parameters Measurements (manual and/or automatic in case of patients with IP connectable devices), PSR (Patient Summary Report) accessibility and/or transferability to be conveniently available to those professionals that may require it, choice of preferred activities, active voting actions, direct surveys...

- Providing the final service operational and technical specifications (setup of the system).
- Internal testing and validation and adaptation of the Services to adjust as much as possible to pilot partners requirements and the afore-mentioned specifications
- Content in INCA can come from internal existing solutions at each of the partners organizations and/or from third parties repositories (considering service providers, but also the data contributed by the own end-users)
- The integration work with existing eServices when required will be done according the types specified in the system integration requirements (mainly XML web services, SSO - SAML 2.0...) without interfering with existing solutions and in parallel to them.
- The adaptation and customisation of the chosen services (localisation work according to the regions where pilots will be held).
- The customization work according to each partner channel delivery
- The Training of Trainers (initially Pilots responsible) and Coaching activities
Description of work

This is the most technical WP of the entire project and is responsibility of partner IDI EIKON that will contribute all the means (technology; technical team for adaptation, support and maintenance; computation resources (owned and/or in the cloud); training and material.. and whichever mean needed) to make possible the INCA services.

One of the main INCA capabilities is its ability to re-use previous investments integrating multiple already existing data sources and show the information in an easier and accessible way to the end-users.

The main aim of this deliverable is to demonstrate that INCA can support the interchange of data among different systems, without interfering with implemented eHealth systems, leveraging and facilitating a better coordination among all the interested stakeholders in the continuum of care and having the patient as the focus of the solution.

INCA is a platform composed by several modules and has much functionality. Its business logic is composed mainly by the following elements: Roles + Modules + User Profiles = Services. All the software currently used and/or, those that could be needed in the future to cover anything not now foreseen is done by the integration of open source software.

T3.1. System Architecture and Users Roles (M1 to M7)

This task involves the definition of all operational and technical requirements of the INCA service. Operational requirements are strongly correlated with chosen Pilot Scenarios by each pilot partner and the integration with their existing systems, affecting directly the integration process design. INCA technical team which possess expert knowledge in the field will provide their insights towards improving the effectiveness of the training programme for the delivered services.

INCA is based on open standards and its envisioned solution would properly address interoperability and scalability issues. INCA flexibility will accommodate any improvement during the pilots’ trial, especially in those cases where trials results advise to do so and/or because there is strong demand from end-user side.

INCA innovative integrated solution will be submitted to internal technical testing and validation by the technical team at IDI EIKON with the collaboration of the pilot’s partners. The technical team will collect all the observations and improvements suggested by the pilots partner and fine-tuned the system with those improvements consider relevant especially in terms of e-accessibility for the end-users. Testing will ensure the correct operation of the service in terms of:

- Matching requirements
- Integration with existing services
- User interaction with the system
- Level of localisation
- Training Programme

Validation against these general and all specific criteria set in the D3.1 deliverable will be the objective of this task. The corresponding changes and adaptations to the system should result into INCA services system that will used in the piloting phase.
**T3.2: Services and Pilots Specifications and Requirements** (M4 to M10)

Defining the Services to deploy in each pilot site and any technical mean needed to make it possible. **INCA** will be mainly served as a **Cloud Computing** application.

This task will include the identification of content and content managers (and/or source of contents) and the definition of the required steps towards the **localization of the service**. IDI EIKON will facilitate the process by indicating the data that has to be translated and the procedures that should take place.

**T3.3: Training, coaching and Training material** (M6 to M11)

Pilots’ partners acting as intermediaries of **INCA** service will be trained together at the facilities of partner IDI EIKON, technical provider of the solution (or at partner pilots sites). At least two face-to-face **training** workshop sessions will be held.

**Coaching** will be done online using for it the means most suitable for all (Web tutorials, How-to articles, Wiki, FAQs, Audio&Video-conference(s)...).

**Training/coaching** documentation will be produced and handed to partners in advance to the training sessions. Documentation updates as result of partners suggestions and comments, procedure changes and/or incorporation of additional features, will be delivered to all the partners (once the documentation source is revisited, revised and updated accordingly.

**T3.4: Standards and Interoperability** (M12 to M20)

**Interoperability** is the ability of content or systems to work together through the use of **agreed standards and specifications**. Electronic health information exchange across institutions and borders is increasingly important, in light of the growing global disease burden and a mobile populace. Critical challenges in the process of meaningful data exchange are the **lack of interoperable health systems** and the **lack of consensus** on data standards.

One of the challenges and opportunities of **eHealth** standardization is the proliferation of multitudinous **eHealth** standards developed by numerous standards-setting institutions. One historical challenge is that many of these **eHealth** standards are not interoperable with each other or directly coordinated with each other at an institutional level. CEN/TC 251, DICOM, HL7, ISO/TC 215, ISO/IEEEE, ITU-T...

A specific action of the Digital Agenda is to "Foster EU-wide standards, interoperability testing and certification of eHealth systems. The Commission has funded several projects and studies related to the interoperability of **eHealth** systems: such as **ePSOS**, Calliope, Hitch, eHRQTN, NetC@rds, but also generic projects such as STORK.

**INCA** will take into account assets developed within these projects, and when possible will liaise with them and with related political initiatives (CrossBorder Directive, eHealth Governance Joint Action, etc.)

**T3.5: Continuous maintenance and support tasks** (M12 to M30)

This is a non-stop task undergoing until the end of the project whichever its duration be. As its name indicates this task will run along the project duration, since the technical provider will support, enhance and improve the Services in a continuous way.

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**Results**

WP3 will result into customised and (technically) tested services ready to be used in each of the partner's countries.
Deliverables

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<tr>
<td>D3.5</td>
<td>Report updating maintenance and support</td>
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Dependencies

Results of WP3 (in parallel with T4.1) are the basis for the remaining tasks of WP4.

Contribution to Project Objectives

Running INCA installations are a prerequisite for the establishment of INCA Services.
Objectives

The objectives of this work package are to demonstrate the significant impact potential of INCA service in 4 different countries. INCA main goal is to implement pilots based on interoperability between stakeholders

- Identifying infrastructure requirements
- Defining and closing Scenarios
- Training Professionals
- Meeting with stakeholders to define data interchange
- Selecting User Groups – Agreeing privacy and security levels – getting Consent form signed
- Planning and follow-up of the pilot

INCA pilots are planned to validate the impact, usability and interactivity of the services implemented in each of the pilot sites according to previous definitions, as defined in WP3 (requirements, pre-existing infrastructures adaptation, selection of services and delivery channels) in the various testing sites thus reaching conclusions for the subsequent uptake of the service by whole value chain in the corresponding market (long-term care stakeholders). Finally, the results of the pilots should reach the target goals set for each region as roughly presented in the proposal and elaborated in the deployment plan to be evolved in this work package.

This WP has the responsibilities to:

- Deploy the service to its running environments
- Ensure that user training occurs
- Validate and Evaluate the Service
- Ensure that the business procedures involving the new service are updated to support it.

Description of Work

The overall procedure we will start with the selection and involvement of the user groups participating in the trials. This will include:

1. Decision of the participants inclusion criteria and creation of a list of participants
2. Circulate list between peers and departments involved and a final selection of the participants
3. Introduction of the trials to the participants
4. Coaching of the participants
5. Start of the trials and support
6. Feedback reception and overall impression

The process of the Validation of the Service will include a usability test, user documentation and user satisfaction.
The evaluation methodology task will focus on presenting the approach and the methodology which will guide the validation activities. It will describe the set of actors and stakeholders involved, present the key variables and questions, and define the approach, principles, steps and tools by which quantitative and qualitative data is going to be taken from the trials. Validation will also use the set of indicators suggested by the European Commission to measure the deployment activities.

**INCA** will develop a survey(s) in order to determine the impact of **INCA** that focuses on wellness, prevention, and longitudinal health—on the delivery of patient-centered preventive care by examining the behavior and experiences of both patients and primary care clinicians and the degree to which recommended services were individualized and provided at each pilot side.

Finally, the **Post-implementation review** will gather information during the deployment from multiple sources to effectively measure satisfaction of users and provide for lessons-learned. The deliverable of the Post Implementation Review is a summary of findings and specific recommendations for optimizing business and system performance.

**INCA** Consortium, leaded by INTERFUSION, will categorize and describe “barriers” and “facilitators” to implementation by identifying factors thought to influence implementation processes and their outcomes, locating an appropriate body of evidence in order to determine the relevance of that evidence to their specific circumstances. The review ensures that future projects benefit from the lessons learned during this project.

**T4.1 Deployment Planning** (M1 to M10)

**INCA** deployment plan will include the major tasks and timelines for implementing the solution into production.

**INCA** deployment plan will provide a detailed schedule of events, persons responsible, and event dependencies required to ensure successful cutover to the new service. Its complexity depends greatly on the type of solution being implemented, whether there is one site or multiple sites, or one deployment or a phased deployment planned.

In addition, the deployment planning process will evaluate the potential impacts on end-users subsequent to the end of the pilot, and determine what mitigating actions may be required to ensure that there are no negative consequences of withdrawal of services from the end-users, including either continuation of services or alternatives/substitutes for the services.

**INCA** deployment plan will include any agreement obtained during the project with public administrations of the services committed in each pilot and/or any other type of stakeholder: Insurers, NGO, Consultancies houses, independent content managers, associations of citizens, telcos, etc. Deliverable D4.7: Post Implementation Review will report on their success in ‘signing them up’.

Dissemination of the Deployment document will contribute to increase the chances of private or public-private alliances overtaking our work at regional level, hence augmenting the chances for quick uptake, promotion into a number of local markets and overall wide deployment of the service.

**T4.2: Pilot Evaluation Methodology and Quality of Service Assurance** (M1 to M11)

This task depends on the results of T3.2 (since the setup of the system needs to be first finalized) and T3.3, which will define, formalize and document the training process for each piloting institution and site. Procedures followed and remarks made during the service installation will be documented in a related report to be used as a reference for future **INCA** installations.
T4.3: Pilots ready to run (M5 to M12)

T4.3 relates with deliverable D4.3

D4.3 belong to type “PR” (prototype or demonstrators) and they have to show that INCA Services have been deployed at partners’ pilot sites according to partners’ services selection and requirements.

This deliverable is to show that the services have been deployed and are ready to be run (and/or are already running) at each pilot site. Accessing the service online (pilots launcher) to shown how the service works is one of the best ways to demonstrate that the work has been done.

INCA is scheduled to be piloted simultaneously in all the countries at the same time. Pilots will run at least for 12 months and where and if possible for longer (T4.3) Some services may require authentication and/or strong authentication.

INCA services are of the type:

- Supporting people at home (away from expensive hospital settings) through telemedicine, remote care and mobile health;
- Transforming the role of patients in managing their own wellbeing through shared decision-making, condition monitoring and chronic disease management.
- Providing professionals with a powerful range of analytical and diagnostic tools, and enable managers to coordinate care, target resources and improve public health outcomes.

Partners involved in the coordination of the pilots for each country are:

- Cyprus (Geroskipou, Iasis Hospital, Interfusion)
- Latvia (Ventspils Social Care Board, Northern Kurzeme Hospital
- Croatia (Croatian Health Insurance Fund; Rijeka City)
- Spain 1: Hospital de Manises
- Spain 2: Foundation for Training and Healthcare Research of Murcia Region

Each implicated partner will be responsible for:

- Recruiting and randomising participants according to criteria set in the deployment plan (according to different profiles like age, education, social status, technical capabilities, physical or cognitive disability etc)
- Training the participants on the usage of the system
- Running the INCA service, according to the deployment plan and the training procedure received in WP3.
- Monitoring the procedure for the entire 12 months period
- Noticing problems especially in ease-of-use, general usability, motivation effectiveness and general interest shown to the service by people with any kind of impairment or difficulty – for medium and wide scale deployments

Measuring Users impact y using different means (qualitative and quantitative) as holding interviews and handing out questionnaires to acquire the direct opinion of the system’s users

T4.4: Pilots Testing and Validation (M13 to M28)

The piloting phase includes, first, the definition of the methodology to follow; second (and once the pilots are running for enough time to be tested by the users), the evaluation and results coming out of such running. Adaptation of the services will be done on the fly; this is, immediately the fault, correction or improvement is informed to the technical team. The trial evaluation will be based on the predefined deployment plan targets and expected goals for each region as documented by task T4.1.

In addition, user satisfaction with the service will be measured by surveying users – end users and system administrators involved – on a number of parameters measuring compliance with treatment regimen, satisfaction with individual service components, clarity of instructions and
ease of use, as well as general ideas for improvement of the service. Meanwhile, all pilot organizing institutions will report their conclusions to the representatives of those partners, conveying the remarks from their notes and the questionnaires from the end-users. The collaborating partners will then evaluate the comments and decide on whether any alteration/improvement of the service is feasible within the required time frame. To realize this prospect, it is imperative that the results of T3.2 on the technical specifications of the service are clear and concise, facilitating an early contingency intervention if needed.

In short, pilot(s) evaluation will reach the overall conclusions of the process, underlining points of interest that need to be taken into account during the wider deployment of the service after the project’s conclusion.

Public and private “business stakeholders” (with potential role of “clients” or “investors” beyond the project phase) will be specially consulted during this task (pole) about the viability of INCA as a business (including specific questions/answers to the engagement of market stakeholder, related to exploitation aspects). This feedback of WP4 will be combined with the feedback of WP5 related to sustainability and scalability of INCA in a competitive environment.

**T4.5: Post-implementation report** (M19 to M29)
Upon conclusion of the final iteration of the trial, the INCA solution will be fully evaluated across a range of criteria, with an expectation of the following key outcomes:

- Efficacy of the technology solution
- Effective supporting processes
- Ability of the INCA solution to be competitive in the market as a solution for delivering inclusive eHealth services (in connection with feasibility and exploitation aspects)

The final results of this post review evaluation will be reported in the final deliverable of this work package which will be used as success indicator and reinforcing evidence for the effectiveness of the INCA service after the completion of the project. Providing measurable and quantifiable results will be essential in reaching our objective which regards convincing public authorities and private stakeholders for the efficacy of our solution and thus inciting new prospects of cooperation.

**Results**

- The expected result of this work package is to obtain the maximum commercial alliances and supporting action from engaged/interested stakeholders and potential investors/customers
- Teams supporting running services trained and prepared.
- End-to-end Service Quality
- A clear deployment plan to be used as the first information to provide to all those interested in the business potential of INCA.
- A functional validation of the deployed service(s)

**Deliverables**

<table>
<thead>
<tr>
<th>Nº</th>
<th>Title</th>
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<td>Pilots: Ready to run</td>
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<td>Pilots: Trials Testing &amp; Validation</td>
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<tr>
<td>D4.5</td>
<td>Post Implementation Review</td>
<td>M29</td>
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</table>
Dependencies
T3.2 of WP3

Contribution to Project Objectives

The deployment is a key cornerstone for the sustainability of the service during all the life of INCA (from the Initial to the Full Phase)

The deliverable produced in this WP is a pre-requisite for a professional implementation of the INCA service and for efficient, automated operation of the service.
Objectives
The aim of this work package is twofold: on one hand, departing from the Business Plan outcomes from the Market Validation phase, to address the iterative work of rewriting/organizing Business Plans, according the requirements of different investors. On the other hand, ensuring the sustainability of the services once that the project itself has ended.

Business Plan of INCA
The Business Plan of INCA wants to be realistic and feasible, and able to adapt to any country or situation requirement. This means great doses of flexibility and a focus in the vision of the USER NEEDS.

INCA Business Plan will include the Socio-Economic Impact Assessment (SEIA) and Cost Benefit Analysis (CBA) of INCA, coming from the main feedbacks of WP4. The Deliverable D5.3 will have a PUBLIC separata for SEIA and CBA (D5.4).

Socio-Economic Impact Assessment (SEIA) of INCA
SEIA will describe the effects which INCA will have on social and economic conditions in each given community or region where the pilots are in place. The awareness of SEIA effects of INCA will be important so that local planners can be prepared for changes that are likely to arise in the community as a result of the project. Furthermore, the local result will be disseminated through all Europe at Regional, National and European level (Deliverable D5.4 PUBLIC separata); an assessment of socio-economic impacts will give decision makers information which they can use in weighing the potential positive and negative consequences of deploying INCA in their respective areas of influence.

Among the Economic effects which will be considered in the SEIA INCA will be included the changes in employment and associated earnings (mainly in small local SMEs, acting as “near” providers of public authorities), net effects on government revenues, and, at the provincial or national level, impacts on gross domestic product. Some of the Social impacts considered will include the demand for inclusive eHealth services addressed at the patients without exception. Some effects have both a social and an economic component such as population and demographics, cost of living, opportunities for local or regional involvement, and income distribution. Effects may arise from INCA in itself or in combination with other policies or developments. SEIA of INCA will include these potential cross-fertilization effects and the respective "cumulative effects assessment" in addition to the assessment of project-specific impacts.

Cost Benefit Analysis (CBA) /Feasibility studies
The aim of this section is to communicate to non-specialists the key intellectual underpinnings in INCA project from the point of view of its monetary evaluation. INCA CBA should cover all the steps needed to contribute to its appraisal, that could help decision makers to find answers to their questions:
- A presentation and discussion of the socio-economic context and the objectives
Cost-Benefit Analysis (CBA) of INCA will attempt to determine whether INCA constitutes an efficient use of resources either from the point of view of society as a whole, or from the perspective of the Consortium. The latter (also called "feasibility analysis") reflects a "private" CBA of utmost relevance as input in the Business Plan. Whether from a private or a social perspective, INCA CBA will compare streams of benefits and costs that result from the project, intended or otherwise, that occurs over “the two years period” of time (INITIAL deployment) and expresses them in "present value" terms. Decision criteria will include measures reflecting "internal rate of return", "net present value", or "benefit-cost ratio." In cases where some of the benefits and costs of the project can not easily be put into EURO terms, "critical value analysis" may be useful in providing an indication of how significant the non-monetized effects of the project must be in order to overcome the quantified values. Sensitivity analyses will be an important component of INCA CBA as alterations in the key assumptions used in the analysis may produce quite different results.

**Business Plan Structure**

We want it to be simple enough since we are aware that when beginning nothing is that marvellous and at the stage of setting up a venture, assumptions are just that: assumptions. We will intend to describe the problem and the opportunity, the business model chosen to go out to the market, will take into account the market analysis undertook in D5.1 (mainly competitors), the operational strategies (sales, prices...) to execute/deliver the solution, the team supporting it (human resources), the financial objectives and projections...

INCA Business Plan should serve the business well as a working document – as well as to articulate to third parties the benefits of the business return on capital invested, risk management and other concerns of stakeholders and partners.

But the business plan is not a sacred document and we want to keep it versatile. The problem addressed is not an easy one and it is very likely (as business plan always do) that it will change, and moreover, given Consortium diversity, business strategies may require different views to approach the different market situations we may encounter.

*Ensuring the sustainability of the INCA services.*

In order to make this possible, it is necessary to ensure financial contributions and real customers for the service. The identified customers and investors are divided into Public and Private Initiatives and the goal is to have them as customers or collaborators for the service.
### Potential risks from the dependency of the sustainability on the technology of owner’s business plan

This will be dealt with in a Consortium Agreement to be signed by all the Consortium Partners.

To avoid jeopardising the course of the project, in case the technology owner leaves the project, the following will apply:

(a) The remaining partners will have the option to substitute the contributed technology, being property of the departing partner, by an alternative technology. In this case, the departing partner will be released from any previous granted rights and obligations.

(b) In case the remaining partners wish to continue to use and access the technology of the departing partner, the leaving partner will sell at market prices its rights to the other partners, or gain a percentage of the licences that the final product will bring. This deal will include the necessary support to guarantee the smooth running of the project during the market validation. This agreement will be expanded in the case of starting the deployment of the INCA services.

### Description of Work

**T5.1: Market Trends Overview** (M1 – M12)
- Analysis of existing statistical data on the current evolutions in the eHealth market
- Analysis of the publicly available business plans of R&D or market validation projects (eTen, CIP ICT PSP) and evaluation of their effectiveness
- Utilise questionnaires and interviews of the end-users in terms of service feature expectancy to money spent for that service

This task shall provide a service market report that will be referenced during the business plan implementation.

**T5.2: Sustainability Strategies (Public and Private)** (M9-M20)
During the project duration, the Consortium will create links to Public Administrations in order to foster the collaboration of these institutions to reach the project objectives. INCA Consortium will search for financial contributions coming from the Public Administrations in order to make them the natural user of the service. Public Administrations are not supposed to pay high amounts of money for the service but small fees for certain features. The final exploitation results will come from the Public Administration recommendation of service adoption and commercial alliances with private companies that will be the real users and will pay for software licenses.

Equally, INCA Consortium will search for private initiatives willing to invest in the project to obtain a future profit from it. These tasks (once started) will become a continuous activity to ensure the final deployment of the service (the more companies want to buy the solution the more countries will be addressed and the more number of citizens will benefit from it).

T5.2 activities should conclude with the signatures of commercial alliances with public and private organizations that will invest on, subsidise for the costs, adopt and build on the INCA service.

The final alliances should be in accordance with the Business Plan of T5.2 and provide evidence for the success of our strategic approach regarding the sustainability of the innovative service.

**T5.3: Producing Business Plan(s)** (M9 – M25)
- Developing business plans
- Creating multi-faceted Value Proposition Business Plans for key regional stakeholders (if needed)
- Creating service blueprint for the business implementation process
- Determining new product positioning relative to the technology market
- Mapping decision making channels of major stakeholders to develop further business opportunities
- Researching competitor’s software usage
- Researching market trends
- Rewriting/organizing business plans

**T5.4: Socio-Economic Impact Assessment (M9 – M28)**
- Producing a Summary report on deployment feasibility of INCA. A SEIA and BCA to enhance the INCA effectiveness and efficiency will be produced in this final report as a *separata* section.

**Results**
The expected result of this work package is to obtain the maximum commercial alliances and supporting action from Public Administrations.

**Deliverables**

<table>
<thead>
<tr>
<th>Nº</th>
<th>Title</th>
<th>Month</th>
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<td>D5.1</td>
<td>Market Trends Overview</td>
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<td>D5.2</td>
<td>Sustainability Strategies (Public and Private)</td>
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<td>D5.3</td>
<td>Producing Business Plan(s) production</td>
<td>M21</td>
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<tr>
<td>D5.4</td>
<td>Socio-Economic Impact Assessment (Public <em>separata</em> for SEIA and BCA)</td>
<td>M28</td>
</tr>
</tbody>
</table>

**Dependencies**
This work package is directly related to the results of the dissemination activities. It is also related to the results coming out from work packages 3 and 4.

**Contribution to Project Objectives**
The contribution of the activities of this work package to the project is to make real alliances for the final deployment of the services or in other words, get investors to support financially the go-ahead and full deployment of the Service.
**Work package No.** 6  
**Start date or starting event:** M1  
**Work package title:** Data Protection Policies

<table>
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<tr>
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<th>P2</th>
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<th>P5</th>
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</table>

**Description of Work**

**T6.1: Data Protection Policies (Legal and Regulatory Requirements at EU level) (M1 to M30)**

The objectives of this task regard observing the requirements of national laws of each participant and safeguarding the adherence to the legal stature of each country where pilots will be held. The challenge for the project is to ensure that the availability of electronic information and the use of ICT are handled in an ethical manner.

INCA will create the **Ethical Advisory Group** (formed by a responsible of the different leading partner pilots) that will be the responsible for reviewing and approve this document that will be the basis of the handling of ethical and legal issues during the course of the project.

Each state and territory regulates the collection and handling of personal information either by legislative or administrative regimes. The **Ethical Advisory Group** shall ensure that implementation meets all relevant regulatory and administrative requirements for their country, as well as community expectations.

Moreover, EU directives will be researched as an effort to guarantee up-front legal adherence to the largest possible scope.

INCA will fulfil all legal or ethical requirements of the member states where the pilot programmes are carried out. Personal information will be collected, used and disclosed in accordance with privacy laws or schemes in each pilot country.

Despite the fact that health services are excluded from the application of the Directive on Services in the Internal Market (Directive 2006/123/EC of 12 December 2006), it is obvious that the Commission has enacted many rules related to health care and that these rules have an important impact on health care systems, including the creation of an EU legal framework for **eHealth**.

Within the scope of INCA project, ethical guidelines will be established and applied consistently, and will:

- Recognise the primacy of the views, choices of users and respect of their dignity;
- Operate according to universal principles of bioethics (Universal Declaration on Bioethics and Human Rights of UNESCO, 19 Oct. 2005; The Charter of Fundamental rights of the EU, 2000);

Particularly, the ethical guidelines will be established in accordance with the following key European legislation:

- The **Charter of Fundamental rights of the EU**, approved by the European Parliament, Nov. 14th 2000;
The E-Commerce Directive 2006/123/EC on services in the internal market does not apply to non-economic services of general interest and to health care services. Nevertheless, health care actors that utilize e-health may be considered to be providing information society services and may have to comply with certain legal aspects of information society services. The E-commerce Directive may apply to online medicine purchases, as well as to services consisting of the transmission of information via a communication network...


Directive 2012/52/EU of 20 December 2012 laying down measures to facilitate the recognition of medical prescriptions issued in another Member State.

INCA Consortium will try always to follow EGE (European Group on Ethics) recommendations and will be also watchful about new potential incoming directives on EHR (Electronic Health Records. Since EHRs can include information on patient demographics, treatment progress, problems, medications, vital signs, past medical history, immunisations, laboratory data and radiology reports ....they may boost the efficiency of health markets but also pose major challenges regarding interoperability and safeguarding patient privacy.

Initiatives on e-Identity will be also closely followed by the INCA Consortium, since having as objective to maximise the cross-border potential of electronic identities, medical patients will be without doubt among the groups that could benefit from them.

Results
The expected result of this work package is to cope with the most relevant legal questions relating with personal data protection across the different participating countries having as an underlying reference the European Directives compliant for all MS.

Deliverables

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</thead>
<tbody>
<tr>
<td>D6.1</td>
<td>Data Protection Policies</td>
<td>M27</td>
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</table>

Dependencies
The Digital Agenda for Europe (DAE) emphasises that ethical considerations should be built into the various technologies as they become available.

Since similarities in the ethical issues arising from the use of ICT, independently of specific sectors, impact on society and individuals, this work package affects the entirety of the project.

Contribution to Project Objectives
The contribution of the activities of this work package to the project is to ensure the project meets all legal requirements. It works to ensure that the project does not encourage or tolerate misconduct. It also works to identify and reduce the risk to face when going to the market.
Summary Effort table

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**B3.2c. Project management**

The INCA Consortium has designed an analytical and detailed project management / co-ordination approach to ensure project’s successful and on time implementation. Under this context the project management has been built in such a way so as to (i) address effectively all major particularities – characteristics of the project and to (ii) optimize the utilisation of the project consortium resources and experience. In the beginning IDI EIKON, responsible for the Project Management Office, will develop an Operational Handbook tailored to project’s size, complexity and particularities.

**ICT and Ethics**

The Consortium is very concerned with Ethical issues that at the request of the Commission have been included within WP1. The nature itself of the project services bear intrinsically the gathering of Personal Data (gathering, use and storage of such information), therefore all aspects of the Data Protection Acts must be adhered to with respect to this. It should be borne in mind that Privacy usually refers to people while confidentiality usually refers to information.

Monitoring Services are also affected by ethical issues. A balance must be made between safety and intrusion of privacy.

All participants in the project will be fully trained in all aspects of Ethical behaviour and be familiar with the different legislation in the area.

**Privacy Issues**

The INCA Consortium will ensure that fundamental rights and freedoms of natural persons, and in particular their right to privacy with respect to the processing of personal data are protected. The project will conform to the charter of Fundamental Rights of the European Union (article 8, protection of personal data) and the Directive 95/46/EC on data protection. Article 6(1)(b) of this Directive states that personal data must be “collected for specified, explicit and legitimate purposes“ and not be further processed in a way that is “incompatible with those purposes”. Further processing of personal data (like the building up of a survey database) for “historical, statistical or scientific purposes” is not considered as incompatible, “provided that Member States provide appropriate safeguards”.

**B2.3 Resources to be committed**

A detail breakdown of efforts and resources can be seen in the next tables. In summary: Human efforts represent the **72,50%** followed by Overheads (21,75%). Other Costs 5,75%.
Equipment:

No durable equipment for partners is allocated.

Software:

Neither server-side nor client-side software is needed for the common activities of INCA. Only standard web browsers are used in INCA.

Personnel:

Some INCA partners may contract external experts for helping them in the undertaking of project tasks. In these cases, people from outside contracted for the project, will act as “in-house” consultants and will be assimilated to internal personnel.

This is a procedure covered in the Programme and any partner could do it at a given moment, even if initially more likely partners to make use of it could be pilots’ partners, given that they may need to collaborate with external stakeholders for the performance of their work. However, if needed for the project consecution, any partner could apply to it.

Overheads:

All the partners use 30% as a flat rate for overheads.

Other Costs (Travels and Others):

Each partner has allocated a budget in “Other Costs” including costs for travels and also for tackling contingencies like “invitations” to relevant stakeholders to assist workshops in any place of the European Union. This will cover the cost of hosting them in a “case by case” approach. Or participation costs in exhibitions or dissemination costs not included in travels.

Also Other Costs will cover the auditory expenses, if needed.

Travel costs for project participants have been estimated according to the involvement of each participant in the different work packages and workshops, in relation to the place of meetings and the country of origin of each one. Some additional travel costs were foreseen for participants that need to conduct national travel during the pilots. Finally, some additional travel costs were foreseen for participation in selected European events and conferences.

This category will include also the costs related to hardware/devices (that could be needed) to be purchased by the project partners in order to run the trials.

Steering Board meetings and Working meetings: Exception done of the kick-off meeting that will take place in Valencia, where Project Coordinator IDI is located, and will set the basic project management specifications and rules, the rest of meetings will be held at the most convenient location for all the partners at that time, considering the issues to be discussed and will be decided during the course of the project.

Costs for the organisation of the meetings include renting and organisation of event venue, preparation of documentation, renting and use of technical and audio-visual equipment, translation (if needed), local transportation, catering, meeting recording and reporting, visits to pilot facilities, etc. will be included either under Travel and/or Other specific costs, according to how each partner will handle the organisation of the meeting for which the partner is responsible.

Workshops: Major workshops are foreseen to be held around months 15 and 28. One of the workshop locations is foreseen to be Brussels while the other, if possible, will be the location of one of the pilots’ sites.

The Consortium will consider and look for, the possibilities of carrying out the workshops within and/or in parallel to other big events in the sector, especially those promoted by the Commission or big recognised organizations, to take advantage of the impact of such events that tend to attract.
The costs for the organisation of the workshops include identification and invitation of chairpersons, speakers and participants, advertising of the workshop in local and national media, preparation of the workshop documentation, organisation of event venue, renting and use of technical and audio-visual equipment, technical on-site support, event translation (if needed), registration of participants, local transportation, catering, workshop recording and reporting, workshop materials, etc. Workshops costs will be included under “Other” specific costs.

### Subcontracting: No subcontracting for partners is allocated.
## B2.4 Indicators

### Performance Monitoring

The Performance Monitoring Plan can be summarized in the table listed below, where indicators, its impact and its evolution in project’s timeframe (in achievement percentage and in relation with Key Deliverables) is presented:

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<th>Nº</th>
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<th>INDICATOR</th>
<th>GOAL</th>
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</thead>
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<tr>
<td>A1</td>
<td>Deploying inclusive e-Health integrated care services in INCA pilots. Pilots should proof INCA’s 4 main pillars:</td>
<td>• INCA cloud-based structure ready to deploy services across Europe</td>
<td>• By month 0</td>
</tr>
<tr>
<td></td>
<td>• Being a Patient-Centric model</td>
<td>• Every INCA pilot deploys a “better coordination” scenario using several pre-existing ICT socio-sanitary services or systems</td>
<td>• 100% of INCA pilots have an “inclusive e-Health integrated care services” scenario where at least 1 social area and 1 sanitary area services are integrated to result in a “better coordination” pilot</td>
</tr>
<tr>
<td></td>
<td>• Being an Inclusive e-Health solution</td>
<td>• INCA Pilots, based on pre-existing investments, are successfully deployed</td>
<td>• By month 12</td>
</tr>
<tr>
<td></td>
<td>• Providing Personalised Integrated Care Pathways solutions</td>
<td>• Number of sub-services offered in INCA deployment</td>
<td>• At least 5 different sub-services coming from the chosen pre-existing socio-sanitary services above will be part of INCA pilots covering educational issues, engagement issues, user’s empowerment issues, better coordination issues and increasing quality of services perception issues</td>
</tr>
<tr>
<td></td>
<td>• Being a cloud-computing based solution</td>
<td>• Pre-Existing Back Offices integrated services</td>
<td>• 80% of the services come from pre-existing investments, Back-Offices or sources of content are successfully integrated with INCA, at least to have any relevant information sharing data with INCA’s Patient Health Repository</td>
</tr>
<tr>
<td></td>
<td>INCA expanding epSOS and SMARTCARE</td>
<td>• Integration with pre-existing relevant socio-sanitary projects</td>
<td>• 20% of the services are new services relying of capabilities INCA platform offers</td>
</tr>
<tr>
<td></td>
<td>• Being ready to expand epSOS and SMARTCARE goals and demonstrate it</td>
<td>• Every service deployed in INCA pilots is an Inclusive integrated socio-sanitary e-Service</td>
<td>• 100% of INCA pilots are ready to receive and reuse information from epSOS and SMARTCARE projects to be used where these pilots have not yet been implemented</td>
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<tr>
<td></td>
<td></td>
<td>• ICT skills of End Users empowerment</td>
<td>• Every service integrated in a INCA pilot should be available for its usage in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accessibility of INCA pilots is guaranteed</td>
<td>• Keyboard and mouse based environments</td>
</tr>
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<td></td>
<td>• Touch based interfaces</td>
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<tr>
<td></td>
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<td></td>
<td>• Gesture-navigation based interfaces</td>
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<tr>
<td></td>
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<td></td>
<td>• Smart Phone as a remote control of other devices</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>• Every INCA pilot will add the following Accessibility tools: font size adapter, contrast colour adapter, text-to-speech, voice navigation (ASR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• ~ 800.000 citizens</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Impacted citizens: 125.250</td>
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<td></td>
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<td></td>
<td>• Average 15% of the population of the pilot areas (&gt;65 years)</td>
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<td></td>
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<td></td>
<td>• 100%</td>
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<tr>
<td></td>
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<td></td>
<td>• At least all these alternatives to conduct Citizens – Socio-Sanitary Providers Interactivity will be piloted:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Patient-centric network of an integrated circle of</td>
</tr>
<tr>
<td><strong>A2</strong> Localisation:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>INCA</strong> fits customisation requirements and is replicable across all EU-27</td>
<td>% of interfaces in local languages</td>
<td>100% - 4 Member States and 2 Pre-Accession Languages English (per default) + as many as different participants’ languages.</td>
<td></td>
</tr>
<tr>
<td>Pre-existing socio-sanitary services and systems delivering info into INCA’s Personal Health Repository</td>
<td>100% of pre-existing systems in INCA Pilots are re-used and integrated to ensure local socio-sanitary needs are observed in all INCA pilots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customized set of KPIs developed to fit the needs of different pilot sites and their target audiences</td>
<td>100% of INCA pilot sites develop their own set of KPIs, ensuring there are measurable and comparable among other pilot sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cross-Border</strong> service deployment</td>
<td>100% of INCA pilots are ready to be deployed in cross-border scenarios at local, regional, national and trans-national level. This includes INCA pilots being ready to expand impact of pre-existing projects like epSOS and SMARTCARE.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>A3</strong> INCA Validation:</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>INCA</strong> is easy to deploy, access, learn and use by all type of patients and providers along the care provision chain</td>
<td>Average time to make INCA run over pre-existing investments</td>
<td>2 months as a maximum</td>
</tr>
<tr>
<td></td>
<td>Average time to train socio-sanitary providers since INCA deployment</td>
<td>1 week (working days)</td>
</tr>
<tr>
<td></td>
<td>Average time for patients and relatives to learn how to use and interact with INCA</td>
<td>1-5 hours with basic training / up to 10 hours without any kind of training</td>
</tr>
</tbody>
</table>

| **INCA** is known and accepted among citizenship | % of citizens that know INCA exists after 1 month | 50% of pilot population |
| | % of citizens that interact with INCA at 12 months | 80% of pilot population |
| | % of users that do not understand services workflow or are unable to access, learn and use it (potential abandon rate for INCA pilots) | Less than a 20% of pilot population |

<table>
<thead>
<tr>
<th><strong>A4</strong> INCA Acceptance:</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>INCA</strong> is recurrently used and stopping the service would be a loss for its</td>
<td>Average volume of socio-sanitary health condition self-management in INCA pilots</td>
<td>At least 30% of pilot users self-manage their socio-sanitary condition actively measuring (manually or with any device) socio-sanitary parameters</td>
</tr>
</tbody>
</table>

- Number of citizens engaged with **INCA** Services
- % of improvement in getting **patients engagement** with socio-sanitary services
- Engaged citizens: 1550 active users
- % of improvement in engaging citizens: 5%
<table>
<thead>
<tr>
<th>A5</th>
<th>INCA Viability: INCA has demonstrated its benefits and initial deployment goes to full deployment phase</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>users</strong></td>
</tr>
<tr>
<td></td>
<td>- Average volume of <strong>socio-sanitary</strong> transactions done</td>
</tr>
<tr>
<td></td>
<td>- % of end users (patients and providers) that consider their needs are properly attended</td>
</tr>
<tr>
<td></td>
<td>- % of additional users engaged with INCA</td>
</tr>
<tr>
<td><strong>INCA Cloud Computing platform deployed and running</strong></td>
<td>At a European scale since month 5</td>
</tr>
<tr>
<td>**INCA working over <strong>pre-existing services and systems</strong> deployed and running</td>
<td>For every pilot after month 12</td>
</tr>
<tr>
<td>Providers along the care provision chain willingness to be Customer for INCA</td>
<td>Achieved for all pilots in the consortium</td>
</tr>
<tr>
<td></td>
<td>Achieved for at least 5 partners/providers in <strong>INCA Network of Interest</strong></td>
</tr>
<tr>
<td><strong>INCA achievements demonstrated (in terms of using resources more efficiently)</strong></td>
<td>Number of routine visits for the target audience per pilot are reduced at least between a 1% and a 2%</td>
</tr>
<tr>
<td></td>
<td>Number of emergency visits for the target audience per pilot are reduced at least a 1%</td>
</tr>
<tr>
<td></td>
<td>Number of hospital admissions for the target audience per pilot are reduced at least a 1%</td>
</tr>
<tr>
<td></td>
<td>Hospital stay length for target audience per pilot are reduced at least a 2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A6</th>
<th>Sustainability: INCA is a moderate-profitable business across Europe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>INCA network of providers around the patient concept</strong> proofed</td>
</tr>
<tr>
<td><strong>Prices Acceptance</strong></td>
<td>By using INCA all providers in the care provision chain piloting INCA have access to new sources of socio-sanitary indicators allowing them to make better decisions in a preventive way</td>
</tr>
<tr>
<td><strong>Willingness to pay</strong></td>
<td>Achieved for at least 5 Partners/Providers in <strong>INCA Network of Interest</strong> (initial estimations is that price will be established as a % of the generated savings)</td>
</tr>
<tr>
<td></td>
<td>At the end of year 5th (2021) more than 5,000,000 users among European Regions will have access to commercial INCA services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A7</th>
<th>Scalability: INCA can replicate initial deployment efforts easily in order to create a sustainable business</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>INCA Cloud Computing Platform running</strong></td>
</tr>
<tr>
<td>**INCA working over <strong>pre-existing services and systems</strong> deployed and growing</td>
<td>Pilot scenarios able to use INCA cloud-based structures to deploy Services since Month 5</td>
</tr>
<tr>
<td><strong>Initial structure of INCA pilots relying on pre-existing investments available in month 5 with no cost</strong></td>
<td><strong>INCA working over additional pre-existing services and systems outside INCA pilots</strong> according to new potential customers / partners / providers budgets availability</td>
</tr>
<tr>
<td>Average time to start deploying services in new EU member state or region</td>
<td>1-6 months, depending on pre-existing services and systems</td>
</tr>
<tr>
<td>Number of targeted European regions in the Full Deployment Phase</td>
<td>All: 268</td>
</tr>
<tr>
<td>Average time to integrate new pre-existing services and systems outside INCA pilots</td>
<td>2 months; even less depending on existing (or not) collaboration from third parties (if needed)</td>
</tr>
</tbody>
</table>
B2.5 Security, privacy, inclusiveness, interoperability; standards and open source

INCA believes that for the success of any application or service, the user must be in the focus and therefore has to try very hard to hide to the user as much as possible all technical requirements.

Interoperability means the ability of information and communication technology (ICT) systems, and of the business processes they support to exchange data and to enable the sharing of information and knowledge and it is essential to maximise the social and economic potential of information and communication technologies (ICT) and as such has been identified in the Digital Agenda for Europe, one of the flagship initiatives of the Europe 2020 Strategy.

As for Usability, INCA services have been thought with the user in mind, hiding the technology from the user and making sure there are no barriers for users to find their services. A transparent approach to security benefits the user since data exchange, communications and access to services and data are reliable and confidential in all situations and use scenarios without any special effort or training.

Users do not have standard technology, neither standard characteristic. Therefore, to ensure the universal access of different users (with or without disabilities), INCA complies with the guidelines of the W3C Web Accessibility Initiative (WAI).

Security

Security issues, both, data transferred and information stored are taken into account by INCA and private information is secured in accordance with European Data protection Directives.

The platform encrypts all the internet transaction through HTTPS protocol and uses OpenSSL, to encrypt and generate certificates and ModSSL to allow Apache to work with OpenSSL.

Privacy

Information Privacy is the interest an individual has in controlling, or at least significantly influencing, the handling of data about themselves. It is this aspect of privacy that is of primary concern in INCA.

Considering the sensitivity of the data exchanged careful preservation of the information privacy and authorized access to data is of great importance. Therefore, in the infrastructure, in addition to the user authentication and communication security, proper definition of information access rights and authorization rules are mandatory. To properly preserve the definition of adequate levels of information privacy, the platform also supports a federation layer that extends the functionalities of standard database management systems. Furthermore, proper settings of information visibility and access rights of different sites involved will be supported through the federated information management layer, and in particular through the definition of export schemas.

The privacy rights of the users are completely preserved by the federated information management approach in the sense that the proprietary and confidential information about the stakeholders involved can only be accessed by authorized users. Furthermore, special focus is given to the security of interactions.

Interoperability

In the INCA case, although dealing with health that is understood in Europe as a universal right under, most of the times, the responsibility of public bodies, interoperability is considered inside the European Commission’s eHealth Action Plan 2012-2020. The Plan is in line with the objectives of the Europe 2020 Strategy and the Digital Agenda for Europe, encouraging Member States and stakeholders to work together.

Standards specifications

INCA follows the Digital Agenda for Europe (DAE) adopted in 2010, as an integral part of the Europe 2020 strategy, to stimulate the digital economy and address societal challenges through ICT.
Interoperability and standards are Pillar II among EU targets. The European Commission has reached an agreement with the World Wide Web Consortium (W3C) on the sustainability of key specifications to facilitate interoperability, across borders and sectors, between public administrations in Europe and beyond.

APPENDIX I: Ethical Screening

Ethical Screening

<table>
<thead>
<tr>
<th>Privacy</th>
<th>Does the proposal involve processing of genetic information or personal data (e.g. health, sexual lifestyle, ethnicity, political opinion, religious or philosophical conviction)?</th>
<th>Yes</th>
<th>Check our approach about Privacy below</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does the proposal involve tracking the location or observation of people?</td>
<td>Yes</td>
<td>Check our approach about Privacy below</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>Does the proposal involve adult healthy volunteers, children, or patients or persons not able to give consent?</td>
<td>No</td>
<td>Check our approach about Privacy below</td>
</tr>
<tr>
<td></td>
<td>Does the proposal involve Human data collection?</td>
<td>Yes</td>
<td>Check our approach about Privacy below</td>
</tr>
<tr>
<td></td>
<td>Does the proposal involve Human genetic material or Human biological samples?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>ICT Implants</td>
<td>Does the proposal involve clinical trials of ICT Implants?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Other Ethical Issues</td>
<td>Are there other aspects of the proposal that may raise ethical issues?</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Coverage of Ethical Issues (only to be completed if there are 'Yes' responses above)</td>
<td>Are the ethical issues raised above adequately dealt with in the proposal?</td>
<td>Yes</td>
<td>Check our approach about on Informed Consent and Privacy below</td>
</tr>
</tbody>
</table>

INCA Ethical Screening

The underlying principles

INCA code of practice will be based on two main principles:
a) The informed consent of their participation and b) the personal data protection of the end users.

1. Informed consent
The INCA Project will fully respect the provisions of the Charter of Fundamental Human Rights in this respect also and more specifically article 3: “Right to the integrity of the person”, where everyone has the right to respect for his or her physical and mental integrity. The project will also address the EU Directive on clinical trials (2001/20/EC) and more specifically the following provisions on informed consent:

A person gives informed consent to take part in a clinical trial only if his decision:
- is given freely and of course that person will be informed of the nature, significance, implications and risks of the trial
- is evidenced in writing, dated and signed, or otherwise marked, by that person so as to indicate his consent, or
if the person is unable to sign a document so as to indicate his consent, is given orally in the presence of at least one witness and recorded in writing.

The same provision will apply in the case of informed consent by a legal representative, on behalf of the trial subject. Specifically, in the case the elderly person cannot give his/hers consent for using his/hers personal data due to a specific disability say dementia the consent of a capable adult or legal representative is needed and will be sought.

Therefore, specifically, under Article 3(2) of the EU Directive the following conditions will apply to reaching the informed consent by a capable adult:

- The subject (end user in our case) has had an interview with the investigator, or another member of the investigating team, in which he has been given the opportunity to understand the objectives, risks and inconveniences of the trial (research activity in our case) and the conditions under which it is to be conducted.
- The end user will be informed of his right to withdraw from the trial (research activity) at any time.
- The end user will be given his informed consent to taking part in the trial (research activity).
- The end user may, without being subject to any resulting detriment, withdraw from the clinical trial (research activity of INCA) at any time by revoking his informed consent.
- The end user has been provided with a contact point where he may obtain further information about the trial (the INCA research activity).

All researchers involved in the INCA project will seek the informed consent of the test user, only under circumstances that provide the prospective participant sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. Also, the information that is to be given to the end user participating in the research or his representative will be in a language understandable to him/her.

Based on the above, the Informed Consent form that potential end users should complete in order to participate in any research related to INCA will contain all the information that a person could reasonably need to know in order to decide whether or not to participate in a research project. Also the informed consent form will include

- how can end users/human subjects help to contribute to science and/or public health and farewell services through INCA Project. It is crucial to explain the impact of the planned research for society and for the individuals involved: to describe the potential and direct benefits of the research as well as the side effects.
- How will researchers work to protect subjects and their data? Researchers will explain what happens to data collected at the end of the research period. If the data are retained for further research they need to ensure that the informed consent form indicates this clearly.

Therefore, an Ethics committee will be established in the early stage of the project and ensure that all the staff involved in the research with end users as well as all the methods, information forms, tools, consent forms are adequate and proper to reflect that prior to consent, each end user in the research activities of INCA is clearly informed of its goals, its possible adverse events, the security measures to protect confidentiality and personal data and the possibility to refuse to enter or to retract at any time with no consequences. Moreover, no inducement should justify participation in a research activity.

It is apparent that certain information should be provided to research subjects/end users of INCA before they participate in a study, including the following checklist:

- a statement that the study involves research subjects/end users, an explanation of the purposes of the research and the expected duration of the subject’s participation, a description of the procedures to be followed, and identification of any procedures which are experimental
- a description of any reasonably foreseeable risks or discomforts to the subject/end user
- a description of any benefits to the subject/end user or to others which may reasonably be expected from the research
- insurance guarantees provided to participants/end users
for research involving more than minimal risk, an explanation as to whether there are any treatments or compensation if injury occurs and, if so, what they consist of, or where further information may be obtained

- a disclosure of appropriate procedures in case of incidental findings
- a disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject/end user
- a statement describing the extent, if any, to which confidentiality of records identifying the subject/end user will be maintained
- an explanation of whom to contact at any time for answers to pertinent questions about the INCA research and research subjects’ rights, and whom to contact in the event of a research-related injury to the subject/end user
- a statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject/end user may discontinue participation at any time without penalty.

2. Personal data protection

All activities involving end users in INCA will comply with the requirements of the Charter of Fundamental Human Rights of the European Union, and more specifically to article 8 “protection of personal data”. Furthermore, the INCA project will comply also and apply the provisions of

a. Directive on the processing of personal data [Directive 95/46/EC],
b. Directive on the protection of personal data in the telecommunications sector [Directive 97/66/EC], and

Therefore, the Consortium will ensure that anyone from the INCA Research Team that is processing personal data must comply with the eight enforceable principles of good practice. Data must be:

- fairly and lawfully processed
- processed for limited purposes
- adequate, relevant and not excessive
- accurate
- not kept longer than necessary
- processed in accordance with the data subject’s rights
- secure
- not transferred to countries without adequate protection.

Researchers should describe the procedure for obtaining informed consent from persons to whom the information relates, and describe the arrangements for protecting the confidentiality of the personal data of the individuals concerned.

If the data are retained for further research, the INCA project will ensure that the informed consent form explains and justifies it. The INCA researchers will inform in detail about all the measures taken to encode or anonymise the collected personal date. Even where only anonymous data are used, adequate security for storage and handling of such data will be applied. The ethics leader with the support of the scientists- researchers involved in INCA will ensure before the advancement of any information to others (internals or externals), and before the publication of any information – that this information under no circumstances leads to identification of individuals that have participated in the INCA project as end users.

Privacy issues exist in INCA Project since uniquely identifiable data relating to a person or persons like health information, location information, cultural information are collected and stored, in digital form or otherwise.

The challenge in data privacy is to share data whilst protecting personal identity in the information. The idea of sharing the data in this way is to ensure that only non-identifiable data are shared. In this respect, the following checklist of actions will be applied.

- Examine which national law applies, especially in international co-operations
Determine who will be the person responsible for the processing (in this case it is already determined, since it will be the technical provider the responsible for the data processing, thus it can be said that in INCA the controller is the technical coordinator along with the ethical committee and the ethical leader)

Collect the data only for specified, explicit and legitimate purposes

Collect only data that are adequate, relevant and not excessive with regard to the purpose of the processing

Keep the data accurate and, where necessary, keep them up-to-date

Process the data fairly and lawfully

In general, data will not be kept longer than necessary according to the purpose of the processing and once achieved, they will be destroyed or render the data anonymous. In some countries, where personal data may be kept for longer periods for historical, statistical or scientific use, partners could keep them longer if all the conditions for this longer storage are fulfilled.

Not further process the data in a way incompatible with the initial purpose(s). If the data are further processed for scientific or statistical purposes, partners should comply with requirements regarding the re-use of personal data.

Respect the conditions regarding the legitimacy of the processing, bearing in mind that to qualify as legitimate it must meet one of the social justifications laid down by the law

Comply with the information duty towards data subjects to provide information on the identity, address of the controller, purpose of the processing, and other information stipulated by law unless an exemption is provided by the law

Comply with duties towards National Data Protection Authorities by providing the required information regarding the planned processing and, where relevant, obtaining prior consent, unless an exemption is provided by the law

Respect the rights of data subjects to access personal data, rectify incomplete or inaccurate data, and to object to the processing under the stipulated circumstances

Take technical and organisational measures to ensure the security and confidentiality of personal data (including encryption where necessary)

Comply with the conditions for communication of personal data to third parties or recipients, bearing in mind that it is only lawful to transfer data if the purpose is compatible with that for which the data were originally collected

Refrain from transferring personal data outside the European Economic Area except where an adequate level of protection has been acknowledged by the European Commission or if not, except if the legal conditions provided by the relevant law are respected.