TABLE OF DELIVERABLES FROM COMMITMENTS ACCEPTED FOLLOWING-UP TO THE FIRST & SECOND INVITATION FOR COMMITMENTS

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Establishment of risk definitions to tailor interventions	1,00 heart failure; 1,00 COPD; 1,00 Parkinson's disease	Heart failure, COPD, Parkinson's disease	2013-Q1	2014	To evaluate adherence rates to therapies used for treatment of chronic diseases in older patients. To evaluate the correlation between poor adherence and patients negative outcome. To improve adherence to chronic diseases treatment.	The IRCCS San Raffaele Pisana will contribute epidemiologic and statistic expertise. Inpatients and outpatients affected by Heart failure, COPD and Parkinson's disease and afferent to the San Raffaele facilities will be selected for evaluating adherence	IRCCS San Raffaele Pisana, Rome
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Questionnaires development and administration	100 heart failure; 100 COPD; 100 Parkinson's disease	Heart failure, COPD, Parkinson's disease	2014	2014	To evaluate adherence rates to therapies used for treatment of chronic diseases in older patients. To evaluate the correlation between poor adherence and patients negative outcome. To improve adherence to chronic diseases treatment.		IRCCS San Raffaele Pisana, Rome
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Evaluation of adherence-patients clinical outcome correlation	100 heart failure; 100 COPD; 100 Parkinson's disease	Heart failure, COPD, Parkinson's disease			To evaluate adherence rates to therapies used for treatment of chronic diseases in older patients. To evaluate the correlation between poor adherence and patients negative outcome. To improve adherence to chronic diseases treatment.		IRCCS San Raffaele Pisana, Rome
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Implementation of Interventions addressed to improve poor adherence	100 heart failure; 100 COPD; 100 Parkinson's disease	Heart failure, COPD, Parkinson's disease	2014	2015	To evaluate adherence rates to therapies used for treatment of chronic diseases in older patients. To evaluate the correlation between poor adherence and patients negative outcome. To improve adherence to chronic diseases treatment.		IRCCS San Raffaele Pisana, Rome
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	Monitoring adherence through the utilization of observatories and databases		65+ years old patients affected by chronic diseases	2013-Q1		To evaluate adherence rates to therapies used for treatment of chronic diseases in older patients. To evaluate the correlation between poor adherence and patients negative outcome.		The Division of Geriatric Medicine and Cardiology, the University of Florence, Italy

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AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	Monitoring adherence through the utilization of observatories and databases		65+ years old patients affected by chronic diseases	2013-Q1		Prescriptions, health outcomes and dispensing data utilization for testing various methods of rational drug use evaluation, including medicines prescribing and medication adherence.		University Medical Center Groningen, The Netherlands
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	Monitoring adherence through the utilization of observatories and databases (1) and through electronic tools and alerting systems (2)	1. to be defined 2. 100 patients	65+ years old patients affected by hypertension, hart failure, dyslipidaemia, diabetes, COPD, depression, Parkinson's disease	2013-Q1	2014-Q4	To evaluate adherence rates to therapies used for treatment of chronic diseases in older patients. To evaluate the correlation between poor adherence and patients negative outcome. Improvement in adherence rete, fostering business environment and implementation of innovative solutions through implementation of the Health-KIT system.		Università Cattolica del Sacro Cuore at Policlinico Gemelli of Rome
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Monitoring adherence through electronic tools and alerting systems		65+ years old patients affected by chronic diseases	2013-Q1		Improvement in adherence rate, fostering business environment and implementation of innovative solutions by making available for implementation the Health-KIT system.		GESI Gestione Sistemi per l'Informatica srl, Rome
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	Piloting adherence programs with use of elderly-friendly devices and medicinal products.		65+ years old patients affected by chronic diseases	2014		Improvement in adherence rate and associated health outcomes		Philips Research, Eindhoven, The Netherlands
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Piloting adherence programs with use of elderly-friendly devices and medicine products and development of information/awareness and health literacy strategies, including life-style recommendations		65+ years old patients affected by chronic diseases	2013-Q1		Improvement in patient's adherence to treatment.		European Generic medicines Association-EGA; European Patients' Forum –EPF
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Piloting adherence programs with use of elderly-friendly devices and medicine products and development of information/awareness and health literacy strategies, including life-style recommendations and Public-Private collaborative and innovative organizational models for pro-active care		65+ years old patients affected by chronic diseases	2013-Q1		Improvement in patient's adherence to treatment.		GlaxoSmithKline-GSK, European Office, Brussels, Belgium

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AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	Monitoring adherence through electronic tools and alerting systems and piloting adherence programs with use of elderly-friendly devices and medicine products and development of information/awareness and health literacy strategies, including life-style recommendations		65+ years old patients affected by chronic diseases	2013-Q1		Improvement in patient's adherence to treatment.		Merck Serono Rome, Italy and Merck Serono Geneva, Switzerland
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	ICT tools to monitor and identify causes of poor adherence (e.g. video cameras, electronic surveys and questionnaires through Smart TV sets etc.) will be developed and be validated. Implementation of older person's friendly packaging and formulations.	This will be defined within next months	65+ years old patients affected by hypertension, depression	2013-Q1	2014	Improvement in patient's adherence to treatment.	Within the realm of running projects such as the http://www.usefil.eu project NCSR in cooperation with its partners will work with elderly people and chronic patients suffering from hypertension, diabetes and depression among the others	National Centre for Scientific Research-NCSR, Greece
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Decision support tools	Improve compliance through a toolkit of interventions: Simplified medication schedule; Medication changes (dosage, scheme, etc.); Pro-active monitoring on dispensing scheme; Consultations; Interventions (when deviations from prescribing scheme is being identified);	385.000 patients 65+	Asthma/COPD, diabetes and cardiovascular conditions,	On-going (The Netherlands)	2016	Improvement in patient's adherence to treatment. Educate and support patients to stay on therapy & gain control over their diseases.	To be achieved through: Patient outcome measures; Medication evaluation profiles; Evidence based prescribing; Dispensing schedule schemes; Medicines and Home Use Reviews; Chronic disease care programs; Taylor-made compliance programs; Cost-effectiveness of medical treatment (model/evidence of reduction in cost of hospitalization); Pharmaceutical care tool: Tool which scans the population based on the clinical rules	GIRP-European Association of Pharmaceutical Full-line Wholesalers, Brussels, Belgium

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
									and medication history resulting in proposed interventions; Trainings for pharmacists and caretakers: The pharmacists and assistants in the program are trained on communications skills	
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring/Review	Monitoring adherence through the utilization of observatories and databases and through electronic tools and alerting systems	385.000 patients 65+	Asthma/COPD, diabetes and cardiovascular conditions, Osteoporosis	On-going (The Netherlands)	2016	Improvement in patient's adherence to treatment.	To be achieved through: Medication review tool: Tool which automatically generates a questionnaire for the pharmacist as basis for the medication review; Field study: Study focusing on the impact of the program to hospitalizations. A scientific committee will be set up consisting of university professors to approve the clinical rules used by the program. An observational study will be set up.	GIRP-European Association of Pharmaceutical Full-line Wholesalers, Brussels, Belgium
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Dispensing	Expertize in evaluation of adherence-patients clinical outcome correlation and in implementation of interventions addressed to improve poor adherence	385.000 patients 65+	Asthma/COPD, diabetes and cardiovascular conditions, Osteoporosis,	On-going (The Netherlands)	2016	Improvement in patient's adherence to treatment.	To be achieved through: Repeat Prescription Service: monitoring on dispensing scheme, in combination with consultation, and if necessary interventions, when deviations from	GIRP-European Association of Pharmaceutical Full-line Wholesalers, Brussels, Belgium

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									prescribing scheme is being identified; Clinical rules: The clinical rules to generate the interventions on the target group, continuously need to be adjusted and expanded to the most up to date insights and national guidelines.	
AIFA (Italian Medicines Agency)	2. Empower the patients and care givers	Education Monitoring	1a) Development and implementation of education programs for patients and their careers on actions to improve adherence. 1b) Implementation of other specific device (PD objective monitoring system): An ad hoc hardware platform with proper processing capability, a variety of connectivity options (including web communication between the patient and the health care provider), and a wide touch-screen interface. 2a) Identification of indicators 2b) Progress monitoring 2c) Identification of key gaps and difficulties	250	Parkinson's disease	2013-Q1	2015-Q4	Improvement in adherence rate and implementation of innovative solutions through ICT-based at-home systems for quantitative measurement of Parkinson's disease symptoms and related treatment effects.		Department of Biomedical and Neuromotor Sciences, University of Bologna and IRCCS Institute of Neurological Sciences of Bologna; Department of Electrical, Electronic, and Information Engineering, University of Bologna
AIFA (Italian Medicines Agency)	3. Deliver improvements in the health care system	Service models	Public-Private collaborative and innovative organizational models for pro-active care		65+ years old patients affected by chronic diseases	2013-Q1		Improvement in patient's adherence to treatment.		ASL Brescia
AIFA (Italian Medicines Agency)	1. Improve patients' adherence	Monitoring	Support in development of the next stages of the project and in taking the task of coordinating the EIP on AHA Joint Action on prescription and Adherence at regional level	Up to 25.000 patients	Mostly affected by chronic disease 35% of them 65+	2013-Q1	2014-Q4	Improvement in patient's adherence to treatment.	Real World Data Acquisition	Pfizer Italy
Andalusian Regional Ministry of Health and Social Welfare	3. Deliver improvements in the health care system	Electronic prescription	XXI prescription allows all pharmacies in the region to access centrally stored electronic prescriptions directly, and to share information on patients' current and long-term medications with doctors in public healthcare settings. GPs can prescribe for periods of up to one year, and pharmacists' can cancel prescriptions and send them back to the relevant GP for revision. Integrated prescribing decision support tools enable the application of regional standards and facilitate			On-going since 2000 in PHC				

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			prescribing procedures.							
APSS	1. Improve patients' adherence	Interventions	Prototyping and lab testing of mobile and web applications for diabetes management		65+ years old patients with diabetes	2013-Q3				
APSS	1. Improve patients' adherence	Interventions	System piloting	60 patients	65+ years old patients with diabetes	2013-Q4				
APSS	1. Improve patients' adherence	Interventions	Rolling out of the system and testing in real life conditions; early validation of disease management program (results, satisfaction, feasibility)		65+ years old patients with diabetes	2014-Q1				
APSS	1. Improve patients' adherence	Interventions	Service piloting to assess organizational, economic and clinical impact. Service policy validation with stakeholders		65+ years old patients with diabetes	2014-Q4				
APSS	1. Improve patients' adherence	Interventions	Program deployment to target population	260 patients	65+ years old patients with diabetes	2015-Q2				
APSS	3. Deliver improvements in the health care system	Service models	Hospital Specialist and MMG shared management of diabetic patients by using of telemonitoring technologies	100 patients	Cohort of MMG's patients with diabetes and comorbidity	2013-Q1				
APSS	4. Research and methodology	Evidence	Context analysis (qualitative and quantitative analysis of network of care) aimed at designing an integrated pathway for diabetes management		65+ years old patients with diabetes	2012-Q4				
Aston University	4. Research and methodology	Evidence	Development of an up-dated scale to assess anti-cholinergic burden (which may be associated with confusion and reduced adherence) in older people.			2013-Q4				
CIRFF (University of Naples)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Algorithms will score persistence and adherence for chronic diseases of interest using the information from established databases.	800,000 (citizens); 120,000 (patients)	Patients with diabetes, hypertension, heart failure, osteoporosis/refracture		2014-06	1) Develop an algorithm to identify indicators of levels of adherence and predictors of discontinuation, which will result in a score for intervention in patients. 2) Allow a more efficient use of resources and enhance efficacy of	The target population is about 15% of the total population of the Campania Region	

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								health interventions		
CIRFF (University of Naples)	2. Empower the patients and care givers	Online services	Web Application to show appropriate information about adherence levels. This software will grant access to each stakeholder to information of their interest. Interface will be designed to maximize accessibility to contents. This software will also provide instruments of communication, creating a social network among stakeholders. It will finally provide analysis tools to allow efficient monitoring of system activities.	800,000 (citizens); 120,000 (patients)	Patients with diabetes, hypertension, heart failure, osteoporosis/refracture		2014-12	1) Implement new information tools for patients and health care professionals: Telematic health counselling device, Remote warning system for adherence. 2) Develop a Web Application linked to prescription databases to pull out appropriate information about adherence levels for different type of stakeholders. 3) Develop a content-share platform to allow future information campaigns and formative interventions. 4) Design specific content to support informative campaigns aimed to patients and carers.		
CIRFF (University of Naples)	3. Deliver improvements in the health care system	Best practices	Develop and test guidelines for improving adherence to medical plans for diabetes, hypertension, heart failure, obesity, osteoporosis/fracture, dementia, depression, falls etc. This document will provide integrated care and communication protocols for patients, GPs, pharmacists, specialists and local authorities and can be used as a working draft in clinical audit.	800,000 (citizens); 120,000 (patients)	Patients with diabetes, hypertension, heart failure, osteoporosis/refracture		2014-12	1) Allow a more efficient use of resources and enhance efficacy of health interventions; 2) Deliver efficient and sustainable pharmaceutical care		
CIRFF (University of Naples)	4. Research and methodology	Evidence	Document that analyses and describes our current situation using information from administrative databases (drug prescriptions, hospitalizations, ambulatory procedures) to describe current adherence of patients for chronic diseases. Identify predictive factors for good and poor adherence and attempt to correlate these factors with particular outcomes e.g. hospitalization, institutionalization or death.	800,000 (citizens); 120,000 (patients)	Patients with diabetes, hypertension, heart failure, osteoporosis/refracture		2013-12	1) Population risk stratification for specific target population; 2) Evaluate rational use of medication and estimate outcomes in real-world conditions.		
CIRFF (University of Naples)	4. Research and methodology	Evidence	Data Analysis to outline the results obtained	800,000 (citizens); 120,000 (patients)	Patients with diabetes, hypertension, heart failure, osteoporosis/refracture		2015-12	1) Evaluation of results achieved		

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CIRFF (University of Naples)	5. Foster communication	Data repository	Database containing clinical information including drug prescriptions, hospitalizations, outpatient procedures will be designed for access by IT platform tools (Web Application, analysis tools etc.).	800,000 (citizens); 120,000 (patients)	Patients with diabetes, hypertension, heart failure, osteoporosis/refracture		2014-06	1) Develop an early warning system on poor adherence to treatment resulting in an integrated adherence monitoring system; 2) Implement new information tools for patients and health care professionals; Evaluate rational use of medication and estimate outcomes in real-world conditions		
Colegio Pharmacysts Valencia, Spain	1. Improve patients' adherence	Decision support tools (including mobile devices)	3,000 mobile-phone with warning signals for medicines intake		65+ years old diabetic patients		2013			
CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Develop and testing apps for mobile devices specially conceived for the elderly to help facilitating adherence and assess the impact		65+ years old patients with chronic diseases, taking multiple medication	Feb 2013		Measurement of the impact of remote warnings through mobile devices) in the improvement of adherence -Enhance communication and empowerment of patients		
CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Benchmarking of the program in provinces with e-prescription implemented and provinces without e-prescription		65+ years old patients with chronic diseases, taking multiple medication	Sept 2013		-Measurement of the impact e-prescription in the improvement of adherence -Develop new collaborative practice model to enhance communication among professionals (therefore to be considered also as improvement in the health care system)		
CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Develop and testing of Personalised dosage systems + IT tools associated		65+ years old patients with chronic diseases, taking multiple medication	March 2013		-Measurement of the impact of personalised dosage systems in the improvement of adherence -Enhance communication with patients		
CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Implement protocols of Pharmaceutical Care		65+ years old patients with chronic diseases, taking multiple medication	Sept 2013		-Disseminate evidence of best practice -Consolidate results of previous pilot (AFADEP 2010) on effectiveness of Medication Review with Pharmacological Follow Up on improvement of adherence		

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CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	1. Improve patients' adherence	Decision support tools (including mobile devices) and Monitoring	IT platform as a decision support tool (info on medicines, alerts on interactions, etc for dispensing process)		65+ years old patients with chronic diseases, taking multiple	Jan 2013		-Tool for community pharmacists in the dispensing process and to facilitate patient monitoring		
CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	3. Deliver improvements in the health care system	Training	Training programmes for pharmacists on Pharmaceutical Care considering the specific characteristics of target population		65+ years old patients with chronic diseases, taking multiple	May 2013		-Implementation of protocols of Pharmaceutical care and specific knowledge on the target population and on the IT tools to be used		
CGCOF (Consejo General de Colegios Oficiales de Farmacéuticos de España)	5. Foster communication	Networking	Final report on results		65+ years old patients with chronic diseases, taking multiple medication	March 2014				
Department of Health and Consumer Affairs of the Basque Government	2. Empower the patients and care givers	Education	Expert Patient Programme for type 2 diabetic patients	500 patients (pilot); 3,000 'activated' by the end of 2014	Diabetic (type 2) patients	2011	2014-Q4	Evaluate the effectiveness of the "Diabetes Self-Management Programme" (DSMP) on the metabolic control, cardiovascular risk reduction, quality of life and self-efficacy in adult patients with type 2 diabetes, compared with current standard care of patients with type 2 diabetes, in the context of the Primary Care network of the Basque Health Service. By December 2012 a total of 61 courses on the “Diabetes Self-Management Programme” had been organised and 720 diabetic patients (and carers) had been trained. The evaluation of the effectiveness of this programme through a randomised controlled trial on a sample of 556 type 2 diabetic patients is under way.		

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Department of Health and Consumer Affairs of the Basque Government	2. Empower the patients and care givers	Education	Implementation of a personal health folder and other online health services	Pilot on 500 users on-going (Total population: around 2,200,000) Progressive extension to the whole Basque population.		On-going	2012-10	Improved access to his/her own health information by the citizen and improved interaction between users and health professionals. It will contribute to the population's health empowerment and capacity to self-care. It will also contribute to the coordination of care, though the access to more complete information on the patients' health and healthcare by different health provider/professionals.	First version released by October 2012. Second version released by December 2012. Regular updates with progressive deployment of services during 2013.	
Department of Health and Consumer Affairs of the Basque Government	2. Empower the patients and care givers	Social network	(Development of a) Social network for patients with chronic conditions, their relatives and caregivers.	1,000 users currently. The target for 2013 is 5,000 users.	Persons with chronic conditions, their relatives and caregivers	2012-04		Improve the quality of life of persons living with chronic conditions, their relatives and caregivers, through the development of relationships that provide emotional support and empower them to better deal and live with their conditions.	On-going	
Department of Health and Consumer Affairs of the Basque Government	3. Deliver improvements in the health care system	Electronic prescription	Implementation of the electronic prescription in the Basque Country	Whole Basque population.		2011	2013-Q4	It will boost the safe and efficient use of medicines. It will contribute to: improve the quality of the pharmaceutical provision, enhance knowledge by the patient about his/her treatments, improve safety in the use of medicines, and contribute to sustainability of the healthcare system.	On-going: in a first phase, all prescriptions by the public health service (Osakidetza). In a second phase, it is planned to include all medication provided to a patient/user.	
Department of Health and Consumer Affairs of the Basque Government	4. Research and methodology	Evidence	Evaluation of the effectiveness of the Expert Patient Programme for type 2 diabetic patients			2011	2014-Q4		On-going	
Department of Health and Consumer Affairs of the Basque Government	4. Research and methodology	Evidence	Evaluation of the effectiveness of a programme for primary prevention of diabetes type 2 through changes in lifestyle implemented by primary care professionals.	1,008 patients	45-70 years old patients, without diabetes, but with high risk of developing DM type 2 (FINDRISC score higher than 14), consulting primary care	2011	2013	Improving adherence to healthy habits by patients at risk of developing a chronic condition such as diabetes mellitus type 2. Through this change of habits, it is expected to reduce diabetes risk by 35% in the intervention group versus the control group.	On-going	

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Department of Health and Consumer Affairs of the Basque Government	1. Improve patients' adherence	Dispensing and prescribing	Review of medication and patient education on type 2 diabetes Polimedicated patients – pilot project	Pilot on 552 patients is on-going. Total population will be around 1,000 patients.	Polimedicated diabetic patients 40+	2011	2013-Q4	The program has been implemented in 100% of the primary care health centres included in the pilot phase, showing a satisfactory patient inclusion evolution. Preliminary results indicate that pharmacotherapeutic intervention has an impact on reducing the number of drugs that patients are prescribed and especially in those patients whose degree of polypharmacy is 9 or more medications. Likewise it has been observed that adherence of intervention group patients relevantly improved (from 71% to 97.8%). An improvement in the perception of the quality of life of patients in the group compared to the control intervention has also been observed		
Department of Health, Social Services and Public Safety Northern Ireland (MAP commitment)	1. Improve patients' adherence	Decision support tools (including mobile devices)	Pilot test an adherence assessment tool for identifying problems with medicines adherence for individual patients who are identified as having problems with their medicines.	4,000 patients (approximately)	65+ years old people taking 4 or more medicines	2012-10	2013-09		The draft tool which has been designed will be tested by clinical pharmacists in hospital and community settings. The aim of the pilot will be to test feasibility and refine the tool and assessment processes for wider application. The pilot will operate in two HSC Trusts.	
Department of Health, Social Services and Public Safety Northern Ireland (MAP commitment)	3. Deliver improvements in the health care system	Service models	Pilot testing of service models for community pharmacy to deliver adherence support for individual patients who are identified as having problems with their medicines and have been assessed as part of the assessment tool pilot in hospital and community settings in two HSC Trusts.	4,000 patients (approximately)	65+ years old people taking 4 or more medicines Mental health patients	2012-10	2013-09		The pilot will test the feasibility of particular solutions including Medicines Administration record charts and medicines reminder cards which are not routinely used at present. The draft tool which has been designed will be tested by clinical pharmacists and the aim of the pilot	

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									will be to test feasibility and refine the tool for wider application. The pilot will operate in two HSC Trusts.	
Department of Health, Social Services and Public Safety Northern Ireland (MAP commitment)	3. Deliver improvements in the health care system	Service models	Commission adherence support services from community pharmacy based on the outcomes of pilots of a medicines adherence assessment tool and community pharmacy service models to deliver medicines adherence support for patients.	30,000 patients (approximately)	65+ years old people taking 4 or more medicines Mental health patients	2013-09	2014-04	an assessment tool which can be rolled out across NI		
Department of Health, Social Services and Public Safety Northern Ireland (MAP commitment)	3. Deliver improvements in the health care system	Service models	Commission adherence support services from community pharmacy based on outcome of pilot of service models		65+ years old people taking 4 or more medicines Mental health patients	2013-09	2014-03			
Department of Health, Social Services and Public Safety Northern Ireland (MAP commitment)	3. Deliver improvements in the health care system	Service models	Develop a business case for IT enabled adherence support which could be deployed as part of a medicines adherence support service	30,000 patients (approximately)	65+ years old people taking 4 or more medicines Mental health patients	2013-04	2014-03	contracted medicines adherence service	The business case will be required to secure funding for roll-out of an IT based solution across Northern Ireland. The development of the business case will require development of a specification for an IT based solution to meet the needs of the potential patient groups.	
Department of Health, Social Services and Public Safety Northern Ireland (MAP commitment)	3. Deliver improvements in the health care system	Best practices	Develop a specification for training domiciliary care workers who assist patients with taking medicines or administer medicines	10,000 patients (approximately)	Domiciliary care workers providing services to older people and mental health patients	2012-10	2014-03	regional specification for training for domiciliary care workers to assist patients with taking medicines	The specification will support Trusts in ensuring appropriate governance arrangements for medicine management in domiciliary care provided by Trust staff and private	

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									care agencies.	
Department of Health, Social Services and Public Safety Northern Ireland (TTVC)			Provision of therapy through video conferencing (VC)	30-50	Patients with chronic conditions (e.g. stroke and COPD)	2012-12	2013-12		Please kindly check this deliverable	
Education, Health and Society Foundation Murcia	5. Foster communication	Networking	Presentation of the project: event and mass media campaign. Static web page for the project		Diabetic, 65+, Polimedicated high cardiovascular risk patients	2012-11	2014-03			
Education, Health and Society Foundation Murcia	3. Deliver improvements in the health care system	Best practices	Report on public interventions in adherence at the Murcia Region and integration with this project			2013-01				
Education, Health and Society Foundation Murcia	3. Deliver improvements in the health care system	Training	Training following CDSMP (Stanford SMS program)			2013				
Education, Health and Society Foundation Murcia	5. Foster communication	Networking	Benchmarking and validation of the project to other countries. Spread though conferences			2014-01				
GIRP (European Association of Pharmaceutical Full-line Wholesalers)	1. Improve patients' adherence	Dispensing	Support for improvement of adherence through individual patient packaging of medicines (weekly or daily doses) in an older persons-friendly manner and user-friendly devices to improve adherence (reminders and alerts)		Elderly patients affected by chronic diseases	on-going	2016	1. Optimize medication therapy and improve ‘quality of life’; 2. Reduce the incidence of medication related hospital admissions; 3. Reduce of medication costs by supporting prescribers to prescribe more cost-effective		

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GSK	1. Improve patients' adherence	Decision support tools (including mobile devices)	Patient adherence screening tool		Metastatic RCC patients.	2013-Q1/2	2013-Q3	Appropriate support programmes, tools, materials for patients, physicians and other HCPs (e.g. Pharmacists)		
GSK	2. Empower the patients and care givers	Education	Tools/training to support effective patient / HCP communication		Metastatic RCC patients.	2013-Q1/2	2013-Q3	Appropriate support programmes, tools, materials for patients, physicians and other HCPs (e.g. Pharmacists)		
GSK	3. Deliver improvements in the health care system	Service models	1) To improve quality of care following the clinical audit approach and to provide an integrated set of data for HCPs involved in the disease pathways, to payers and to health care managers; 2) To obtain new real practice data on epidemiology, diagnosis, care, use of drugs and costs of the disease at regional and local levels and make them available to the communities of professionals, health care managers and scientists; 3) To allow Local Health Units to experience new multidisciplinary way of working (including pharmacists, physicians, health care managers, budget holder, specialists) based on common data, methodology, knowledge; 4) To build specific way of working based on continuous improvement while implementing performance indicators that include clinical, economical and organizational outcomes; 5) To recognize and immediately implement the best practices from local health care units to all other units; 6) To identify and discuss with EEs the principal topics of COPD management to identify possible solutions based on the consensus conference methodology and to promptly publish available results; 7) To maintaining and exploit the F2F communications and “on line” discussions of the Scientific Network including all 55 participants units	All patients referring to 53 Italian local health units	COPD patients	2011	2013-Q4	1) Decrease and subsequent elimination of interventions by local units that are not evidence based by providing guidance on COPD treatment, in particular pharmacological, when the quality of management of the disease not appropriately addressed; 2) Increase the knowledge of the GPs and Pharmacists regarding of COPD problem and improve collaboration across those professionals; 3) KPIs e.g.: reduction of the hospital admission rate; reduction of the exacerbation of COPD, etc.;		

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
GSK	4. Research and methodology	Evidence	Carry out market research with renal cell cancer (RCC) patients and physicians treating RCC patients to understand behaviours that lead to non-adherence. This research to be published and to help develop appropriate programmes to support patients and pharmacists looking after those patients.	84 patients 36 physicians	metastatic RCC patients	2012-Q3	2012-Q4	to gain insight into adherence and non-adherence issues with patients with mRCC		
Hospital de Getafe	1. Improve patients' adherence	Decision support tools (including mobile devices)	Disseminate the use of STOPP START criteria between physicians to avoid the inappropriate polimedication		70+ years old	2013-End		Disseminate the use of STOPP START criteria between physicians to avoid the inappropriate polimedication is one of the most important contributions and along with the conciliation program will contribute to avoid inappropriate medications following STOPP START criteria and we have disseminated these criteria through services involve. The clinical pharmacology department and pharmacy department in our hospital are working together in this way.		Region de Madrid-Consejería de sanidad-Hospital de Getafe
Hospital de Getafe	1. Improve patients' adherence	Decision support tools (including mobile devices)	Implementation at the hospitals computer tools or algorithms to prospective detection of serious adverse reactions in elderly population		70+ years old	2015-End		The Research Unit of the Hospital of Getafe (HUG) in Madrid has implemented a Pharmacovigilance program for hospital-in patients based laboratory signs (PPLSH) that certain analytical parameters may be associated with altered ADRs. We have carried out an epidemiological registry of automatic laboratory signals (ALSs) generated of patients with signal with/without SADRs of PPLSH in HUG since its creation. This program has proved its effectiveness and we hope that this program will be used in other hospitals in Madrid		Region de Madrid-Consejería de sanidad-Hospital de Getafe
Hospital de Getafe	1. Improve patients' adherence	Dispensing	Try to outfit to the hospitals clinical pharmacologist that know the differential properties in metabolism and management of drugs in aging		70+ years old	2018-End			The Department of Pharmacology in Getafe (Region de Madrid) is working together pharmacy service in this way from 2010. A clinical pharmacologist is responsible for conciliation program and for clinical research in	Region de Madrid-Consejería de sanidad-Hospital de Getafe

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
									geriatric patients.	
Hospital de Getafe	4. Research and methodology	Guidelines	Recommendation on new guidelines performing RCT in older people before marketing new drugs intended for consumption.		70+ years old	2014-End			This commitment is o going and we are working on publications in Spain (in contribution with European experts) We are working on publications that promote the realization of ECCE in elderly patients	Region de Madrid-Consejería de sanidad-Hospital de Getafe
Hospital de Getafe	5. Foster communication	Networking	Develop and implement a network in EU of clinical trials unit with the necessary tools to carry out RCTs in old people (similar SOPs, protocols templates and information sheets, outcomes and recruitment strategies). In this, Spain there is a Clinical Trial Unit that meet these requirements, and it could be used as a model to implement it in the other European countries.		70+ years old	2017-End			The clinical trial unit for old people in Spain (Hospital universitario de Getafe) is running since 2010. The unit currently has four beds and a room for exploration. In human resources, we have qualified staff as clinical pharmacologist and a team of geriatricians and nurses. At this time, we have designed general and specific SOPs of our unit as well as protocols and information sheets adapted to our population. Currently we are coordinating the MID Frail trial, one large European multicenter trial funded by 7th Framework Programme for	

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
									Research and Innovation. Nine European countries are involved in this project, with a substantial contribution of highly-qualified human resources. All those potential partners are specialized in doing research in aging and frailty. In some of our current projects we are working with the most important people in treatment of old people in EU.	
LST, Universidad Politecnica Madrid	1. Improve patients' adherence	Interventions	Software programmes to help 65+ people suffering with diabetes and multi-morbidities to achieve specific and measurable lifestyle goals (i.e.: losing weight through healthy diet and physical activity, improving education literacy in specific hot topics	To be defined (50-200)	diabetes & multi-morbidity patients 65+	2014-01	2014-06	Goal Achievement (Weigh t loss, increased Physical Activity, Increased Education)	On-going Project	
LST, Universidad Politecnica Madrid	1. Improve patients' adherence	Interventions	Lifestyle intervention plans fostering a tight glycaemic control and encouraging the adoption of healthy behaviours through achievement of measurable goals.	To be defined (50-200)	diabetes & multi-morbidity patients 65+	2014-01	2014-06	Reduced complications and hospitalizations, improved main clinical outcomes (hba1C, Glucose variability, etc.)	On-going Project	
LST, Universidad Politecnica Madrid	1. Improve patients' adherence	Decision support tools (including mobile devices)	Novel methods and procedures for the continuous stratification of the population at risk of diabetes and related complications.	To be defined (50-200)	diabetes & multi-morbidity patients 65+	2014-01	2014-06	Discovery of main risk factors affecting health status and to be included in adherence care plan	On-going Project	
Medical university of Warsaw	1. Improve patients' adherence	Monitoring	Design and manufacture of the sensor prototype along with the prototype of the central computer system for planning and monitoring the medicine intake		65+ years old patients with chronic diseases, taking multiple medication and with some degree of disability	2013-Q1	2014-Q1	Create a prototype for monitoring and improving adherence	3 types of prototype	
Medical university of Warsaw	1. Improve patients' adherence	Monitoring	Create IT system for monitoring elderly patients' medicaments intake, along with the integration with sensor and subsystem for doctors and supervisors to monitor the treatment		65+ years old patients with chronic diseases, taking multiple medication and with some degree of	2013-Q1	2014-Q1	Create a simple-to-use system for elderly patients		

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
					disability					
NHS Scotland	1. Improve patients' adherence	Decision support tools (including mobile devices)	To develop decisions support tools that patients can use to help them manage their medication for their LTC that patients can use with mobile technology. Examples to date include tele monitoring of COPD and Heart failure but mobile technology could help patients manage medication in exacerbations.		Patients with one or more LTC	2012-12		Development of mobile technology solutions.		
NHS Scotland	1. Improve patients' adherence	Interventions	Collaboration in working on polypharmacy and pharmaceutical care for patients still living at home to improve appropriate prescribing and patient decision making. Outcomes from work where pharmaceutical care issues are being addressed by pharmacists who are identified through social work will highlight how to best support these patients in their own homes.		Patients with one or more LTC supported to live at home.	2012-12		Solutions to provide support/assistance to patients in their own homes.		
NHS Scotland	2. Empower the patients and care givers	Social network	Adopting patient e-health and social media innovations to support self-management (e.g. patient portals)		all patients	2015-12		Use of ICT solutions as well as use of self-management/behaviour changing tools.		
NHS Scotland	2. Empower the patients and care givers	Education	Implement use of a health literacy tool ("Teachback") to improve adherence and concordance		all patients	2015-12		Use of ICT solutions as well as use of self-management/behaviour changing tools.		
NHS Scotland	3. Deliver improvements in the health care system	Service models	Using ICT and portal communication to maximise clinical communication. Roll out of Emergency Care Summary , key information summary and pilot of sharing of pharmaceutical care records within the Chronic Medication Service across primary and secondary care		Patients with LTCs	2013-12		More timely and appropriate information sharing leading to improved appropriate prescribing.		
NHS Scotland	3. Deliver improvements in the health care system	Electronic prescription	e-health strategy- electronic prescribing capture by all clinicians in primary and secondary care will allow for accurate picture of medications patients are taking. This will allow for monitoring not only of adherence but of safe and effective prescribing. Examples include electronic prescribing and HEPMA		Patients with LTCs	2012-10		Reduced harm to patients through inappropriate prescribing or due to communication/cognitive issues for patients. Integrated medicines management system implemented across Scotland.		

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
NHS Scotland	3. Deliver improvements in the health care system	Best practices	Investment in the development of a research-informed national toolkit to support the sharing of good practice and the promotion of literacy sensitivity in health and social care organisations		Patients requiring support to improve their health literacy	2012-12		Patients are able to be lead partners in their care and treatment.		
NHS Scotland	3. Deliver improvements in the health care system	Service models	Investment in the development of a robust national demonstrator programme to ensure consistent provision of personalised communication to enable effective participation in health care		Patients requiring support to improve their health literacy	2012-12		Evaluated materials that can be rolled out across Scotland.		
NHS Scotland	4. Research and methodology	Evidence	Guidance on dealing with appropriate prescribing and initial outcome data from Boards addressing Polypharmacy and value of risk of admissions data to inform which patient groups to target.		Patients on complex or inappropriate drug regimens	2012-12		Reduction in inappropriate prescribing and number of patients identified as being inappropriately polymedicated.		
ParkinsonNet (Radboud University Nijmegen Medical Centre)	3. Deliver improvements in the health care system	Service models	Establish a multidisciplinary expert centre for Parkinson's care (international up-scaling of Nijmegen Centre of Excellence), forming a cross-border collaborative care model		Parkinson's disease: patients and providers	2013-01	2015-01	Cross-border collaborative care model for Parkinson's disease		Klinikum Niederrhein Duisburg, Germany
ParkinsonNet (Radboud University Nijmegen Medical Centre)	3. Deliver improvements in the health care system	Service models	Reorganisation of care: selecting and training physiotherapists to work according to evidence-based guidelines. Improve communication and collaboration with and between physiotherapists, neurologists and patients. ICT supported.		Parkinson's disease: patients and providers	2013-01	2015-01	Reduce costs, while improving quality of care and accessibility to all patients in the region		Klinikum Niederrhein Duisburg, Germany
ParkinsonNet (Radboud University Nijmegen Medical Centre)	3. Deliver improvements in the health care system	Best practices	ParkinsonAtlas, which is a web application that shows quality of care in Parkinson's disease in the Netherlands, including guideline adherence, offering the opportunity for regional benchmarking		Parkinson's disease: patients and providers	2012-06	2014-06			
ParkinsonNet (Radboud University Nijmegen Medical Centre)	4. Research and methodology	Guidelines	European Clinical practice Guideline for physiotherapy in Parkinson's disease		Parkinson's disease: patients and providers	on-going	2013-Q4			Physiotherapy professional associations of 18 European countries
ParkinsonNet (Radboud University Nijmegen Medical Centre)	4. Research and methodology	Guidelines	Implementation European Guideline for Physiotherapy in Parkinson's disease (2013; 18 countries involved)		Parkinson's disease: patients and providers	2013				Physiotherapy professional associations of 18 European countries

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
Perugia University	2. Empower the patients and care givers	Education	Development of "healthy trails"		Operators and guides of local mountain community office Exercise physiologists, personnel of receptive structures along the two trails	2014-01	2014-12		Siena-Assisi Italy's coast to coast	
Perugia University	3. Deliver improvements in the health care system	Training	Training of care givers from other European countries		Personnel involved in diabetes care and prevention	2014-03	2014-12			
Perugia University	4. Research and methodology	Evidence	Validation of the efficacy of an innovative model to improve lifestyle		Type 2 diabetic patients	2013-01	2013-12			
Perugia University	4. Research and methodology	Evidence	Cost-effectiveness analysis and HTA of the model		Type 2 diabetic patients	2013-12	2014-03			
UCC Cork	2. Empower the patients and care givers	Counselling	Piloting the implementation of the *'Let Me Decide'* advance care planning programme in long-term care residences in Ireland. Development of educational resources on advance care planning for residents and families	Pilot Study on 430 patients. Eventual target population includes 4,000+ residents in LTC in Cork & Kerry	Long-term care residents	2012	2014-Q3	**1) Acceptability** and **uptake** of the *'Let Me Decide'* advance care planning programme among long-term care residents and their families.		Irish Hospice Foundation (IHF); All Ireland Institute of Hospice and Palliative Care (AIIHPC); Health Service Executive (HSE); Specialist Palliative Care (PC) Marymount University Hospice; School of Medicine UCC; School of Nursing & Midwifery UCC; Dept. General Practice UCC
UCC Cork	3. Deliver improvements in the health care system	Training	Development of online e-learning resources for advance care planning education and general palliative care education for staff in long-term care facilities		Long-term care staff	2013	2013-Q4	**Flexible** and **standardised** delivery of online training programmes on advance care planning and general palliative care for staff in long-term care residences		IHF; AIIHPC; HSE; Specialist PC Marymount University Hospice; School of Medicine UCC; School of Nursing & Midwifery UCC; Dept. General Practice UCC
UCC Cork	3. Deliver improvements in the health care system	Best practices	Piloting the implementation of the *'Let Me Decide'* advance care planning programme and a palliative care educational programme in long-term care residences in Ireland.		Long-term care residents	2012-07	2014-Q3	1) **Feasibility** of implementing the *'Let Me Decide'* advance care planning programme and a palliative care educational programme in long-term care residences in Ireland.		IHF; AIIHPC; HSE; Specialist PC Marymount University Hospice; School of Medicine UCC;

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
			Completion of advance care plans for competent residents and completion of End-of-Life Decisions Care Plans for residents lacking capacity.					2) **Compliance** of healthcare staff with residents' expressed wishes. 3) Effect of programme implementation on the **quality of death & dying** as assessed by relatives using the QODD questionnaire.		School of Nursing & Midwifery UCC; Dept. General Practice UCC
University Coimbra	2. Empower the patients and care givers	Education	Program of public lectures and round-table discussions in museums and other public spaces addressing healthy and active ageing and adherence to care plans	1000	65+ years old healthy population; patients with chronic diseases and their relatives; health sector professionals and carers	2013-01	2015-12	Seminars, round tables and exhibitions		
University Coimbra	2. Empower the patients and care givers	Education	Implementation of Social network to monitor adherence to prescription	1000	65+ years old; General population; high-risk patient groups; family members (younger generations); Health professionals	2012-12	2015-12	Published/posted comments and documents		
University Coimbra	2. Empower the patients and care givers	Education	Combined cultural and physical fitness/training medically-assisted tailored programs, targeting +65 old or patients suffering from chronic diseases, joining sport faculty members, nurses and psychologists	200	65+ years old healthy population, patients with chronic diseases (with a focus on patients suffering from cognitive deficit or dementia; Parkinson's disease; Epilepsy, Vision deficit; rheumatism/arthritis; cardiovascular diseases; stroke; diabetes) and their relatives/or carers	2013-06	2015-12	Implementation of a scientifically-validated approach for maintenance of active and trained body for healthy ageing, physical/living independence and adherence to medical/care plans		
University Coimbra	3. Deliver improvements in the health care system	Service models	Implementation of ICT-based programs for remote monitoring of health status and adherence to care/medical plans in +65 people and chronic disease patients in their homes/institutions Development of software and ICT devices	200	65+ years old; patients with chronic diseases (with a focus on patients suffering from cognitive deficit or dementia; Parkinson's disease; Epilepsy, Vision deficit; rheumatism, arthritis; cardiovascular diseases; diabetes)	2013-06		Implementation of a scientifically-validated approach for auto-maintenance of active and trained body and adherence/monitoring of adherence to care/medical plans		

Commitment owner	Objective	Action Area	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partner
University Coimbra	4. Research and methodology	Evidence	High-level interdisciplinary education and training of health care personal through the PhD program on ageing with adherence-specific education and training modules	90	PhD and master students; professional seeking for advanced training/scientific upgrade	On-going	2015-12	Number of students/professionals attending the courses; Number of original manuscripts and research communications o Ageing/adherence; Number of new PhD thesis on Ageing/adherence		
Veneto Region;	2. Empower the patients and care givers	Counselling	Service of individual counselling to orient aged people toward an active and healthy aging and voluntary service.		60-75 years old	2013-Q2	2014-12	Implementation of a counselling public service; Number of people living in Mogliano Veneto and surroundings who attended this service; Satisfaction about the service measured by a questionnaire and involving in voluntary activities.		AUSER; U.L.S.S.9 Public Health; Mogliano Veneto Municipality
Veneto Region	2. Empower the patients and care givers	Education	Educational programme in Veneto Region, to promote health literacy, active and healthy aging and social involvement.		60-75 years old	2013-Q4	2015-12	Implementation of “guida al benessere nel tempo” classes; Number of retirees attending these courses; Satisfaction about classes, measured by a questionnaire; change for a more active and healthier daily life.		U.L.S.S.9 Public Health; Mogliano Veneto Municipality

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Agenzia sanitaria e sociale regionale dell'Emilia-Romagna	1. Improve patients' adherence	To reduce inappropriate prescription and, in general, the number of patients inappropriately polymedicated	Development of novel technological individual packaging and older friendly medication devices	Novel technological individual packaging and older friendly medication devices	several hundreds	Patients with all major ageing diseases (from neurological to cancer and finally orthopeadic ones)	01/07/2014	31/12/2015	Novel Individual Packaging older friendly. RFID devices for environmental data monitoring		IRCCS Istituto Ortopedico Rizzoli; Alma Mater Studiorum University of Bologna; IRCCS Arcispedale S.Maria Nuova; IRCCS Istituto delle Scienze Neurologiche di Bologna; IRST Istituto Scientifico Romagnolo per lo Studio e la Cura dei Tumori
Agenzia sanitaria e sociale regionale dell'Emilia-Romagna	1. Improve patients' adherence	To improve adherence to treatment, protocols in dispensing, used medicines review and pharmaco-therapeutical follow up, and personalized dosage systems	Development and implementation of pharmaceutical care services	Pharmaceutical care services	several hundreds	Patients with all major ageing diseases (from neurological to cancer and finally orthopeadic ones)	01/04/2013	31/03/2016	Prototipe of New Logistic Integrated model for Pharma		as above
Agenzia sanitaria e sociale regionale dell'Emilia-Romagna	2. Empower the patients and care givers	To promote exchange of information between patients, hospitals and pharmacists.	Development of IT tools	IT tools for exchanging information in real time between patients, hospitals and pharmacists	several hundreds	Patients with all major ageing diseases (from neurological to cancer and finally orthopeadic ones)	01/10/2013	31/03/2016	IT Platform for clinical genetic and imaging data. IT Architecture integrated with existing database.		as above
Agenzia sanitaria e sociale regionale dell'Emilia-Romagna	3. Deliver improvements in the health care system	To develop innovative personalized therapy programme using IT databases and novel methods for population stratification.	Development of IT databases	Personalized therapy programme	several hundreds	Patients with all major ageing diseases (from neurological to cancer and finally orthopeadic ones)	01/04/2015	31/03/2016	IT Architecture integrated with drug delivery chain.		as above
Agenzia sanitaria e sociale regionale dell'Emilia-Romagna	5. Foster communication	To address adherence for different target groups.	Implementation of appropriate support programmes, tools and educational materials		several hundreds	Patients, hospital and primary care physicians, pharmacists, caregivers	01/07/2014	31/03/2016	Health Literacy implementation by Smart IT tools. Customer satisfaction analisys by Smart IT tools		as above
Amsterdam Center on Aging	3. Deliver improvements in the health care system	Development of a patient centered method that better aligns medication prescription with the principles of geriatric-palliative care. This method will combine structured multidisciplinary medication review with advance care planning (ACP).	1) Interviews with older persons to elicit their views on participating in discussions on medication appropriateness in the context of ACP; 2) consensus meetings with geriatricians and pharmacists on the concept method for patient centered medication prescription as developed by experts within ACA integrated with the results of patient-interviews. 3) cluster randomized trial in which the method will be tested (primary outcomes: adverse effects; quality of life)	Patient centered method that better aligns medication prescription with the principles of geriatric-palliative care		Older people with multimorbidity in their last stage of life				This method will combine structured multidisciplinary medication review with advance care planning (ACP).	Amsterdam Innovation Motor (AIM); Amsterdam Knowledge Network; Amsterdam University Medical Center
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To evaluate adherence to treatment, in the context of a national project involving several regions	Build the Aragón patients' cohort on ischemic coronary diseases	Aragón patients' cohort on ischemic coronary diseases		Patients' cohort on ischemic coronary diseases	2013-Q4	2015-Q2			Bio-Med Aragón is an association is integrated by: Aragon Health Science Institute (IACS): including the following parties: Aragon Primary Care Research; Telemedicine and Health innovation in Sector Barbastro; Research in Health Services and Policies group (ARiHSP); Multidisciplinary Research Group on Chronic Diseases (EpiChron); Telemedicine and Mental Health research; FOCUSS programme; Nursing Care Mental Health Group; ZARADEM group; Blindness Prevention research group; Multidisciplinary group in orthopaedics research; Multidisciplinary group in Cardiovascular research (Aragon Workers Health Study) project; University of Zaragoza: including Health Services Research Group; Telemedicine I3A group; Tecnodiscap I3A group; GENUD(Growth, exercise, nutrition
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To assess adherence to preventive treatment of CV diseases	Analysis of adherence using Pharmacies DB & General Motors regestry	Analysis of electronic databases performed	Aragon´s Workers Health Study (AWHS) (cohort study)	Patients 49+ years old in Aragón	ongoing	2016	Prevalence and incidence of cardiovascular preventive treatment. Adherence and effectiveness in intermediate outcomes	AWHS cohort study from 2008. Collaboration between epidemiological, clinical groups. Multidisciplinary team (cardiologist, laboral doctor, epidemiologist, pharmacologist,…)	AWHS, University, Hospital Miguel Servet and General Motors.
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To improve adherence	Implementation of Guidelines & training workshops in improving adherence for patients, nurses, caretakers, pharmacists & physicians	Update clinical practice guidelines	Chronic polypharmacy patients	Polypharmacy patients	2013	2015	Implementation of clinical practice guidelines	Within the context of the REAP & redIAPP networks, for a population of polypharmacy patients	
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	Collection of evidence of cost-effectiveness of adequacy in the prescription		update clinical practice guidelines and implementation of workshops	Chronic polypharmacy patients	Polypharmacy patients	2013	2014	Implementation of clinical practice guidelines		
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	Analysis of adherence variability in relation to sociodemographic characteristics, in rural and urban areas, across socioeconomic levels	Analysis of databases and analyze reasons for the variability	In case the results advices, modification of the variability in adherence through specific training to health professionals, and implement programs to improve adherence to specific population.	Depending on the results	Polypharmacy patients	ongoing	2015	Implementation of clinical practice guidelines		
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To support personalised intervention plans for chronic patient supervision & their adherence to care plans.	Design of an ontology-based telemonitoring system	Ontology-based telemonitoring system	chronic and multi-chronic patients	patients	ongoing	2015	An ontology model used to design generic monitoring profiles will be developed. Furthermore, an application based study to monitor patients with specific chronic conditions and multi-chronic conditions will be conducted.		
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To monitor patients' activities in hospitals, patients' agenda	Development of ICT tools for monitoring patients' activities in hospitals, patients' agenda. Pilot proofs during 2013-2014. final ITC tool "patinet agenda" 2014-2015. implementation in 2014 in different hospitals	ICT tools for monitoring patients' activities	patients	Polypharmacy patients	ongoing	2015	computer tool		

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To improve health outcomes & adherence.	Development of a collaborative digital platform	Collaborative digital platform		Polypharmacy patients	2013-2015			Commercial platform already working in USA for Haemophilia (400 users, 70% patients, 25% family caregivers, 5% professionals)	
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To track remote rehabilitation exercises for patients	Development of commercial platform to track remote rehabilitation exercises for patients in terms of quantity and quality of exercises performed			Specific Chronic diseases, Rehabilitation patients, and patients in general	2013				
Asociación Bio-Med Aragón (BMA)	1. Improve patients' adherence	To improve and monitor adherence to treatment	Development of aService to show graphical & audible reminders	Service to show graphical & audible reminders on the TV screen (HbbTV)		Specific Chronic diseases, Rehabilitation patients, and patients in general	2013-2015				
Asociación Bio-Med Aragón (BMA)	2. Empower the patients and care givers		Seminars & capacitating training sessions for caretakers, including on-line services, advices & health education (healthy aging & personal well-being)	Seminars & capacitating training sessions for caretakers	caretakers, students	caretakers	ongoing	2014	reports and training material		
Asociación Bio-Med Aragón (BMA)	2. Empower the patients and care givers	To empower patients & their careers to take more responsibility & control of their own health care. Identification of key gaps & difficulties.	Adherence workshops, informing patients about their disease, health education (medication management, information on side effects & consequences of leaving medication). Implementation of training tools/materials to carry out the activities.	Seminars & capacitating training sessions	patients	Polimedicated patients, Polypharmacy patients	2014-2015		reports and training material		
Asociación Bio-Med Aragón (BMA)	2. Empower the patients and care givers	To monitor patients' progress, giving feedback & performing rapid interventions, users' engagement.	Development of a a collaborative digital health platform	Collaborative digital health platform	Patients, tutors and health professionals	People with haemophilia and other bleeding disorders	2013-2015			Commercial platform already working in USA for Haemophilia.	
Asociación Bio-Med Aragón (BMA)	2. Empower the patients and care givers	To track remote rehabilitation exercises for patients, allows creating exercises & rehabilitation programmes through the network.	Implementation of a Commercial web based platform	Commercial platform letting caretakers lead patients rehabilitation programs		Specific Chronic diseases, Rehabilitation patients, and patients in general	2013				
Asociación Bio-Med Aragón (BMA)	2. Empower the patients and care givers	To provide information about treatment adherence	Development of HbbTV audiovisual content & questionnaires to be depicted on the TV screen	HbbTV audiovisual content & questionnaires to be depicted on the TV screen			2013-2015				
Asociación Bio-Med Aragón (BMA)	3. Deliver improvements in the health care system	Deployment of Aragón Electronic Prescription system in Primary Care centres.		Deployment of Aragón Electronic Prescription system in Primary Care centres.		The population of Aragon	2012	2014		Deployment started in 2012; Zaragoza city coverage expected during 2013; Aragón coverage expected by 2014	
Asociación Bio-Med Aragón (BMA)	3. Deliver improvements in the health care system	To evaluate the effectiveness of electronic prescribing to improve rational prescribing & prescription adequacy, targeting primary care physicians in Spain. To evaluate if the access to the healthcare system influences the improvement of the prescription		Evaluation of the effectiveness of electronic prescribing to improve rational prescribing & prescription adequacy		The population of Aragon				Within the context of the REAP & REDIAPP networks	
Asociación Bio-Med Aragón (BMA)	3. Deliver improvements in the health care system	To enhance medication adherence, including personalised dosing systems, medication review & health education	To develop & implement pharmaceutical services for aged patients	report of results about the service implementation	patients	Aged patients	2014-2015		reports and training material		
Asociación Bio-Med Aragón (BMA)	3. Deliver improvements in the health care system	To improve the adherence of telemonitoring systems in healthcare domain	Application of alignment theories (five steps)	Study of evaluation methodologies to set-up telemedicine services.		Patients associated to the studied teleservice.	2014-2015		Development of a methodology to evaluate and align telemedicine services		
Asociación Bio-Med Aragón (BMA)	3. Deliver improvements in the health care system	To monitor patients, connecting them to their care team & health professionals	Development of a collaborative digital health platform	Collaborative digital health platform	Patients, tutors and health professionals	People with haemophilia and other bleeding disorders	2013-2015			Commercial platform already working in USA for Haemophilia	
Asociación Bio-Med Aragón (BMA)	3. Deliver improvements in the health care system	Deployment of APPs to improve adherence	Development of APP to improve the adherence to the treatment (at this moment for psichological treatment)	APP for mobile devices to remind and guide de treatment (mainly in psichological treatments)		Inhabitants of Aragon (and others communities) who could benefit from these treatments	2012	2014	APP for mobiles.		
Asociación Bio-Med Aragón (BMA)	4. Research and methodology	Know-how & evidence on the analysis of unwarranted geographic variations in Avoidable Hospitalizations in Chronic Conditions in several European Countries		Report on the in-country and cross-country variation in the hospitalizations of six chronic conditions deemed as potentially avoidable		Two subgroups of population: patients aged 60 and over, patients aged 75 and over.	2014-Q2			As part of deliverables from the FP7 ECHO project on international healthcare performance assessment	
Asociación Bio-Med Aragón (BMA)	4. Research and methodology	To evaluate adherence to treatment & clinical & patient-referred outcomes	Analysis of electronic databases: Pharmacies DB & Primary Care DB, General Motors database.	Analysis of electronic databases performed	Aragon´s Workers Health Study (AWHS) (cohort study)	Patients 49+ years old in Aragón	0ngoing	2016	Link several data bases.To evaluate adherence of treatment using different methodologies.Efectiveness analysis using electronical DB.	AWHS cohort study from 2008. Collaboration between epidemiological, clinical groups. Multidisciplinary team (cardiologist, laboral doctor, epidemiologist, pharmacologist,…)	AWHS, University, Hospital Miguel Servet and General Motors.
Asociación Bio-Med Aragón (BMA)	4. Research and methodology	Polipharmacy and Multimorbidity Patterns	Identification of polypharmacy & multimorbidity association patterns to facilitate the desig of clinical guidelines unravel potential synergistic effects & causal relationships between diseases and/or medications. Data-mining statistical techniques in longitudinally gathered large DB.	Scientific papers	Spanish Health System population	Polimedicated patients, Multi-morbidity patients, Specific Chronic diseases, and patients in general	2012	2014	Scientific papers on polypharmacy and multimorbidity patterns and adverse drug events.	Scientific papers based on comparative European data (e.g. Dutch and Spanish population).	Spain, Holland.
Asociación Bio-Med Aragón (BMA)	4. Research and methodology	To provide prescription adherence & healthy prescriptions, avoiding unnecessary prescriptions & self-medications	Development of a simple guide for professionals & patients	Guide for professionals & patients		professionals & patients	2014-2015				
Asociación Bio-Med Aragón (BMA)	4. Research and methodology	Research on effective interventions to promote adherence to changes in lifestyle and healthy habits. Economic viability evaluation of health interventions and drugs		Economic viability evaluation of health interventions and drugs		patients aged 65 and over.	2014	2015			
Asociación Bio-Med Aragón (BMA)	5. Foster communication	Integrated Data Repository (IDR)	Creation and validation of an Integrated Data Repository (IDR) including anonymised patient-level information from primary, specialized and emergency care, based on electronic medical records and pharmacy dispensation system (1.3 M inhabitants of the Aragón Health System). This repository is the base to perform observational studies on specific issues related to polypharmacy and multimorbidity patients, and will allow targeting patients with high risk of low adherence.	An Integrated Data Repository, and a document with the validation proccess and description of the included variables, and their operativization process.	Aragón Health System population	Polimedicated patients, Multi-morbidity patients, Specific Chronic diseases, and patients in general	2012	2015	An Integrated Data Repository, and a validation proccess document.	The Spanish database will be available by middle of 2014. Comparative studies with health information contained in databases (from the UK Department of Primary Care and Public Health of Imperial College London) are envisaged.	Spain

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Asociación Bio-Med Aragón (BMA)	5. Foster communication	Know-how on building data infrastructures based on real world data, while providing insight on its better use for healthcare performance evaluation		Seminar explaining the ECHO knowledge infrastructure and its potential on health services and policies evaluation		EIP members	2014-Q1			Big-data structures coming from: −AltasVPM, nation-wide project on Variations in Medical Practice, gathering the universe of hospital discharges produced in Spain since 2002 onwards −ECHO, a FP7 healthcare performance evaluation project gathering the universe of hospital discharges in 6 European countries –around 200 M discharges, from 2002 to 2009	
Aziende Chimiche Riunite Angelini Francesco (spray platform)	1. Improve patients' adherence	To improve the adherence to care plans through the development of spray platform for poorly soluble drugs, to develop a suitable formulation for patients with difficulties in swallowing	Phase 1 - Selection of candidate Active Principle/s (API) solvents selection -target concentrations /volume of administration	Candidate Active Principles Selected, volume of administration selected, solvent selection completed.		Elderly patients	2013-Q3	2014-Q3	Stable forlmulation at ICH conditions, packed in the marketing device.	Stability studies will be performed in house for at list 3 months before enter clinical dev.	Aziende Chimiche Riunite Angelini Francesco (A.C.R.A.F); Agenzia Italiana del Farmaco (AIFA)
Aziende Chimiche Riunite Angelini Francesco (spray platform)	1. Improve patients' adherence	To improve the adherence to care plans through the development of spray platform for poorly soluble drugs, to develop a suitable formulation for patients with difficulties in swallowing	Phase 2 - Taste-masking to solve the bitter taste of the API -stabilization of the formulation	Completed		Elderly patients	2013-Q4				
Aziende Chimiche Riunite Angelini Francesco (spray platform)	1. Improve patients' adherence	To improve the adherence to care plans through the development of spray platform for poorly soluble drugs, to develop a suitable formulation for patients with difficulties in swallowing	Phase 3) Finalization of the development (stress tests etc.); Development of the device	On going		Elderly patients	2014-Q1		A suitable device will be selected to perform stability studies abd clinical trials		
Aziende Chimiche Riunite Angelini Francesco (spray platform)	1. Improve patients' adherence	To improve the adherence to care plans through the development of spray platform for poorly soluble drugs, to develop a suitable formulation for patients with difficulties in swallowing	Phase 4) Clinical Development	Planned		Elderly patients	2014-Q3	2015-Q2		The activities will be conducted at national level, the clinical development will be carried out on study population adequate to demonstrate the clinical effectiveness of the platform	
Aziende Chimiche Riunite Angelini Francesco (new food for special needs)	1. Improve patients' adherence	1) Development of innovative foods for special medical needs	1a) Analysis of unmet medical needs by focus groups involving patients, caregivers, medical staff, payers	Completed the focus group involving caregivers and medical staff. Focus group with patient and payers planned		Elderly patients	2013-Q4		Definition of unmet needs for food for special medical needs		Università di Roma La Sapienza
Aziende Chimiche Riunite Angelini Francesco (new food for special needs)	1. Improve patients' adherence	1) Development of innovative foods for special medical needs	1b) Definition of requisites for innovative foods for special medical needs	Stable formulation with low osmotic properties. Industrialization of formulation and clinical trial			2014-Q1	2015-2Q	Formulation studies and stability studies ongoing		
Aziende Chimiche Riunite Angelini Francesco (new food for special needs)	2. Empower the patients and care givers	2) education and training for patients with nutrition disorders and their caregivers	2b) Definition of a pilot program of education and information	Pilot educational program planned		patients, nutritionist, medical staff and caregivers	2013-Q4	2014-Q1			
Aziende Chimiche Riunite Angelini Francesco (new food for special needs)	2. Empower the patients and care givers	2) education and training for patients with nutrition disorders and their caregivers	2c) Pilot educational program in a selected area	Pilot educational program planned			2014-Q4	2015-Q4		Pilot phases will be conducted in specific regions/areas. The areas will be defined after the phase of additional partner selection	
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	1. Improve patients' adherence	Design, test and evaluate an intervention on patients' treatment adherence which will be supported on ITCs and professionals/patients/caregivers education	1. Define and create a chronic disease management program	Chronic disease management program	All oder than 65 y. with/without a chronic disease	Patients with a) chronic diseases (around 33%), most aged 65+, and taking at least one drug and b) with at least one chronic disease risk factor	2013	2013	Chronic disease management program aproved and published.	Specific locations will be determined later on but will include rural and urban areas.	Department of Health and Social Policy of the Region of Murcia; University of Murcia; CIBER Epidemiología y Salud Pública (CIBERESP);
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	1. Improve patients' adherence	Design, test and evaluate an intervention on patients' treatment adherence which will be supported on ITCs and professionals/patients/caregivers education	2. Identify health educational needs across all actors, design materials and educational platforms, implement and evaluate improvement in self efficacy	2a. Health educational needs across all actors identified; 2b. materials and educational platforms designed; 2c. evaluation in improvement in self efficacy completed	50000 older than 65 yr. with/without a chronic disease	Patients with a) chronic diseases (around 33%), most aged 65+, and taking at least one drug and b) with at least one chronic disease risk factor	2013	2015	a) to set up 4l focus groups to assess perceived health educational needs: 1. older than 65 yr , 2. DM2 older diseased people, 3. caregivers, 4. health personel); b) platform with educational materials designed and tested; c) Quetionnaire of self-efficay pre-post intervention identified/designed/tested/evaluated in representative samples of target population.		Department of Health and Social Policy of the Region of Murcia; Department of Health and Social Welfare of the City Council of Murcia; University of Murcia; CIBER Epidemiología y Salud Pública (CIBERESP); FAMDIF/COCEMFE-MURCIA; Ami2; ORIONHEALTH, IBERICA; STACKS; Murcia Medical Association; Murcia Pharmacists Association; Murcia Nurses Association; Murcia Family Medicine Association; Murcia Primary Care Nurses Association; Consumur
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	1. Improve patients' adherence	Design, test and evaluate an intervention on patients' treatment adherence which will be supported on ITCs and professionals/patients/caregivers education	3. Design and set up the intervention and evaluation	Intervention designed and evaluated	Senior citizens older than 65 yr. with/without a chronic disease	Patients with a) chronic diseases (around 33%), most aged 65+, and taking at least one drug and b) with at least one chronic disease risk factor			Final report on the intervention including methods & result's evaluation. We have chosen DM2 as a case of chonic disease clustered aroud olders. The results will be measured as (pre-post intervention) as: a) improvement of DM2 control according Int'l guidelines; b) improvement in quality of life; c) improvement in health and social services (medical consultation, emergency visits and hospitalization; d) use of social resources.		as above

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	1. Improve patients' adherence	Design, test and evaluate an intervention on patients' treatment adherence which will be supported on ITCs and professionals/patients/caregivers education	4. Develop and test a web platform to facilitate adherence of chronic/aged patients	Web platform develped and tested	50000 older than 65 yr. with/without a chronic disease	Patients with a) chronic diseases (around 33%), most aged 65+, and taking at least one drug and b) with at least one chronic disease risk factor			a) Web platform develped and tested on improvin patient's adherence; b) Library with visual and written educational material, tested and evaluated, available for disemination		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	2. Empower the patients and care givers	1. Develop education programmes for patients and caregivers	1. Design and implement educational programs for patients and caregivers following the PRECEDE model; 2. Apply lifestyle intervention plans encouraging the adoption of healthy behaviours in patients groups	Educational programs for patients and caregivers designed and implemented; 2. lifestyle intervention plans applied	50000 older than 65 yr. with/without a chronic disease	Patients with a) chronic diseases (around 33%), most aged 65+, and taking at least one drug and b) with at least one chronic disease risk factor	2013	2015	Educational program and lifestyle plans evaluated and tested according and intervention pragmatic trial		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	2. Empower the patients and care givers	2. Design a health literacy tool to support self-management	2. Develop / adapt a health literacy tool to support self-management and adherence	healthy literacy tool to support self-management and adherence developed/adapted	50000 older than 65 yr. with/without a chronic disease		2013	2015	Through IROHLA (UE funded) project health-literacy materials tested and final program applied & evaluated		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	2. Empower the patients and care givers	3. Facilitate social network to monitor adherence, to stimulate support and mutual help to dealing with adherence to treatment in chronic diseases	3. Support and extend networks already existing by improving educational competences of all participants		50000 older than 65 yr. with/without a chronic disease		2013	2015	Number of older/caregivers sharing experience and knowledge though social network (in person and through electronic platforms)		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	4. Research and methodology	Develop new food products better adapted to older needs	To set up several focus groups with older citizens, with & without chronic diseases, their caregivers, managers from older's residences, food industry representaives and academics from food sciences University Department in order to identify a) perceveid needs in specific food products better adapted to older citizens needs & b) opportunities to design, test and comercialize new food products devoted to older citizen needs	Report of specific food needs od senior citizens, their caregivers and responsibles of senior citizens residences	Senior citizens older than 65 yr. with/without a chronic disease	Patients with a) chronic diseases (around 33%), most aged 65+, and taking at least one drug and b) with at least one chronic disease risk factor	2013	2015	Report of specific food needs od senior citizens, their caregivers and responsibles of senior citizens residences		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	4. Research and methodology	Validation of the efficacy and cost-effectiveness of an innovation model to improve lifestyles in chronic diseases taking as starting point type 2 diabetic patients.	1. Set up indicators and methods for evaluation	Validation of the efficacy and cost-effectiveness of an innovation model to improve lifestyles in type 2 diabetic patients.	50000 older than 65 yr. with/without a chronic disease	Type 2 Diabetic patients	2015	2015	Inform on cost-effectivness analysis for DM2 innovative model of care		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	4. Research and methodology	Validation of the efficacy and cost-effectiveness of an innovation model to improve lifestyles in chronic diseases taking as starting point type 2 diabetic patients.	2. Evaluate and disseminate results	Results evaluated and disseminated	50000 older than 65 yr. with/without a chronic disease	Type 2 Diabetic patients	2015	2015	a) Draft for a scientific public policy journal ready; b) Good practices disseminated through UE platform		as above
Consejería de Sanidad y Politica Social, Region de Murcia, España/Department of Health and Social Policy	5. Foster communication	Develop, test and expand current web applications with information about adherence levels in order to embrace bidirectional information from patients and caregivers to health professionals and social workers and back.	Development of web applications containing information on adherence levels	Web applications with information about adherence levels	50000 older than 65 yr. with/without a chronic disease	health professionals, patients and caregivers.	2015	2015	Example of Good Practices (protocol & result) and the selection of some reference sites for teaching & learning to other health ansd social centres available in the public health web in Murcia (www.murciasalud.es)		as above
Daiichi Sankyo Italia	1. Improve patient adherence to care plans, including medication and healthy habits. 2. Empower the patients and care givers	Development of a web-based program (**My Hypertension care**: *www.it.myhypertensioncare.eu)* designed to assist physicians in the management of patients with hypertension and to assist patients in helping them achieving their health targets	Development of a website containing: patient-friendly information about hypertension and its management, a fully interactive ***Healthy Lifestyle Planner*** to help patients identify personal lifestyle goals and support them in achieving sustained lifestyle changes, an innovative patient segmentation, allowing elements of the programme to be tailored to a patient's personality type, in order to maximise individual impact, a robust evaluation of programme outcomes against predefined objectives (assessed at baseline, 3 months and 6 months) to help measure the success of the programme and improving patient engagement and adherence. The interactive ***Healthy Lifestyle Planner*** is a key and innovative feature that enables patients to track their blood pressure readings on a regular basis, as well as set their own realistic goals for initiating and maintaining healthy lifestyle changes. After selecting goals based on 7 healthy lifestyle choices the patient will be able to pick from a menu of activities in order to tailor their own plan in a way that matches their personal preferences. On the *My Hypertension Care* website, patients will have the opportunity to	Web-based tool to assist physicians in the management of patients with hypertension and to help patients in achieving their health targets: Guidance on practical issues related to life with high blood pressure, a range of support and information designed to motivate patients, encourage them to stick with prescribed medication, and help them maintain healthy lifestyle changes, an improved understanding of disease and commitment to their treatment, a service of text message (SMS) and/or email messages to engage and support patients to achieve sustained lifestyle changes and adherence to the treatment prescribed by their physician.	18 millions of hypertensive patients; 5.000 Cardiologists	Patients with hypertension, physicians	ongoing	31/03/2014	By helping to improve patient engagement and adherence to treatment, this programme is expected to result in better blood pressure control. As a result of improved blood pressure control and better patient adherence, it is anticipated that clinical outcomes may improve. Through participation in this programme, patients will gain: - An improved understanding of what it means to have high blood pressure - Guidance on practical issues related to life with high blood pressure - A range of support and information designed to motivate patients, encourage them to stick with prescribed medication, and help them maintain healthy lifestyle changes - An improved understanding of, and commitment to their treatment.		

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Daiichi Sankyo Italia	2. Empower the patients and care givers	Development of the *My Hypertension Care* **Facebook** fan page to make awareness about the program and drive patients to *My Hypertension Care* webpage, improve awareness about hypertension and its risks, improve awareness about the beneficial effects of a healthy lifestyle and reaching blood pressure target, create and support a community of people with hypertension:	Development of a **Facebook** fan page of *My Hypertension Care* Program. Create a comunity of hypertensive patients (FB users) INTERESTED IN: • Being INFORMED about the disease and related risks • SHARING experiences and opinions, influence • TALKING to other patients • Finding SUPPORT • Improving CONTROL of BP through the adoption of healthy lifestyles and adherence to treatments prescribed	Facebook Fan Page to mobilize, engage, inform, empower and provide support to hypertensive patients in order to improve adherence to treatments and healthy lifestyles	3,5 million hypertensive facebook users	Patients with hypertension, physicians	15/09/2013	31/03/2014	Create a comunity of hypertensive patients, engaged, empowerd, emancipated in the management of their disease. Increase number of patients subscribing to *My Hypertension Care* Adherence Program. By improving patient engagement and adherence to treatment, this programme is expected to result in better blood pressure control among patients. As a result of improved blood pressure control and better patient adherence, it is anticipated that clinical outcomes may improve.		
Fondazione Salvatore Maugeri, IRCCS	1. Improve patients' adherence	To promote team teaching/problem solving, protocols use, clinical triage, clinical decision support flow charts	Meetings, multidisciplinary group interventions	Guidelines revision, Decision support chart, Clinical risk cards	nurse, physioterapist, MD	health care	october 2013	1 year	continous medical education	4 meetings/year	Fondazione S. Maugeri networks (12 hospitals)
Fondazione Salvatore Maugeri, IRCCS	1. Improve patients' adherence	To evaluate incidence of Drugs prescription as potentially inappropriate (DPPI) at time of Hospital admission. During in hospital stay, drugs prescription will be optimized. To verify in hospital drugs changes	Drugs prescription optimisation; Drugs rationalisation (reduction in number of medications to be taken, inappropriate prescriptions). Disease educational intervention (disease knowledge, therapy management, poor patient's awareness on utility, effectiveness and timing). Reinforce on drugs adherence; assessment of drugs modification by different actors at home.	Adherence interventions programs.	1000 patients	Patients consecutively admitted to hospital (aging > 70 years old) In hospital and home settings: aged people with chronic disease, with cognitive disorders, with comorbidities, frequent health care users	January 2014	2 years	reduction in DPPI, patients' health care education improvment, patients'self managemnet improvments	4 lessons of 60 minutes per hospital stay 30 minutes tailored lessons according to necessities	Fondazione S. Maugeri networks (12 hospitals)
Fondazione Salvatore Maugeri, IRCCS	1. Improve patients' adherence	Patients will be monitored by a tele-support (phone and video) multidisciplinary team, mainly managed by a nurse, to reinforce H program on prescribed therapy.	phone/video communication web-based platform with: i) scheduling phone/video sessions; ii) managing drugs sessions; iii) recording and archiving; iv) creating and managing of case studies library with educational and training purpose.		1000 patients	Patients consecutively admitted to hospital (aging > 70 years old) In hospital and home settings: aged people with chronic disease, with cognitive disorders, with comorbidities, frequent health care users	January 2014	2 years	Drugs number, side effects, avoided mistakes reduction; Health care utilisation and mortality reduction	Drugs number and dosages prescription, changes, change's responsible, side effects, drug prescription and avoided mistakes, drug adherence, clinical conditions, number of DPPIs pre hospital admission, at discharge, at 6 and 12 months of follow up, Health care utilisations, mortality and death causes will be collected	Fondazione S. Maugeri networks (12 hospitals); Health telematic network company
Fondazione Salvatore Maugeri, IRCCS	2. Empower the patients and care givers	To educate and reinforce patients in hospital and at home. During the hospital stay, patients will be submitted to a structured educational program.	Dedicated educational sessions on: unnecessary drug use inappropriate drug choice dosing regimens difficulty to manage multiple drugs patients' support and safety	Multi-component structured educational programs on life styles, drugs, physical activity, rehabilitation, nutrition.	1000 patients	Patients consecutively admitted to hospital (aging > 70 years old) In hospital and home settings: aged people with chronic disease, with cognitive disorders, with comorbidities, frequent health care users	January 2014	2 years	patients and caregiver self managemnet improvement	4 lessons of 60 minutes per hospital stay 30 minutes tailored lessons according to necessities	Fondazione S. Maugeri networks (12 hospitals);
Fondazione Salvatore Maugeri, IRCCS	2. Empower the patients and care givers	During next 12 months following their discharge, patients will be monitored by a tele-support (phone and video) multidisciplinary team, mainly managed by a nurse, to reinforce hospital program on prescribed therapy.	Clinical observation and monitoring with phone/video communication web-based platform with: i) scheduling phone/video sessions; ii) managing drugs sessions; iii) recording and archiving; iv) creating and managing of case studies library with educational and training purpose.	A specific phone/video communication web-based calls with: i) scheduling phone/video sessions; ii) managing drugs sessions; iii) recording and archiving; iv) creating and managing of case studies library with educational and training purpose.	1000 patients	In home settings: aged people with chronic disease, with cognitive disorders, with comorbidities, frequent health care users	January 2014	2 years	Drugs number, side effects, avoided mistakes reduction; Health care utilisation and mortality reduction	Patients assigned to the nurse tutor receive, before hospital discharge, a phone call number available 24 hours, 7 days/week. Total duration 6-12 months;	Fondazione S. Maugeri networks (12 hospitals); Health telematic network company
Fondazione Salvatore Maugeri, IRCCS	3. Deliver improvements in the health care system	Promotion of: Guidelines, Protocols use, Clinical decision support flow charts (hopsital setting); Promote the spread of e-health adoption best practices (home setting)	Meetings, Multi-component structured educational programs, Conferences (hospital setting); A specific phone/video communication web-based calls with: i) scheduling phone/video sessions; ii) managing drugs sessions; iii) recording and archiving; iv) creating and managing of case studies library with educational and training purpose (home setting)			GPs Patients Caregivers Patient's association	January 2014	2 years	Drugs number, side effects, avoided mistakes reduction; Health care utilisation and mortality reduction	4 lessons of 60 minutes per hospital stay 30 minutes tailored lessons according to necessities. Patients assigned to the nurse tutor receive, before hospital discharge, a phone call number available 24 hours, 7 days/week. Total duration 6-12 months;	Fondazione S. Maugeri networks (12 hospitals); Health telematic network company
Fondazione Salvatore Maugeri, IRCCS	3. Deliver improvements in the health care system	Continuity of care model (hospital setting); Telesupport, telerehabilitation, Continuity of care model (home setting)	In-patient rehabilitation, Outpatient rehabilitation (hospital setting). A specific phone/video communication web-based calls with: i) scheduling phone/video sessions; ii) managing drugs sessions; iii) recording and archiving; iv) creating and managing of case studies library with educational and training purpose (home setting)			GPs, Patients/caregivers, payers	January 2014	2 years	Drugs number, side effects, avoided mistakes reduction; Health care utilisation and mortality reduction	5 lessons of 60 minutes per hospital stay 30 minutes tailored lessons according to necessities. Patients assigned to the nurse tutor receive, before hospital discharge, a phone call number available 24 hours, 7 days/week. Total duration 6-12 months;	Fondazione S. Maugeri networks (12 hospitals); Health telematic network company
Fondazione Salvatore Maugeri, IRCCS	5. Foster communication	Promotion of linkages between rehabilitation settings and other key sectors; sharing of information on funding resources, policy updates, and best practices	linkages between rehabilitation settings and other key sectors promotion of improved reimbursement for new chronic health activities up-to-date information on funding resources, policy updates, and best practices			Hospitals GPs Payers (Regions) Private Industries Politicians Patients' associations Patients/caregivers	January 2014	2 years	new reimbursement packages for chronic health activities. best practices standards	expert opinions meetings; workshops	Fondazione S. Maugeri networks (12 hospitals); Others Private and Public Italian Hospitals, Regional health politician stakeholders

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Government of Catalonia, Department of Health	2. Empower the patients and care givers	To promote and train old people on the correct use of medicines	Carrying out workshops as a continuous health education and training addressed to older people on the correct use of medicines	Workshops and training addressed to older people on the correct use of medicines		Older people				Each session is conducted by a community pharmacist, who has been previously trained on communication to patient techniques	Department of Health of Catalonia; Professional pharmacists association of Barcelona; Professional pharmacists association of Girona; Professional pharmacists association of Lleida; Professional pharmacists association of Tarragona; Rural pharmacists association of Catalonia.
Hospital Clinic	1. Improve patients' adherence	Pharmaceutical care program to provide medication information, prevention and resolution of medication-related problems, improved outcomes and increased patient satisfaction.	Pharmaceutical care program which includes: 1) ensure the appropriateness of medication therapy and patients' understanding of their therapy; 2) promote patients adherence helping to develop a daily medication schedule, identifying barriers and educating and motivating them; 3) provide information about prevention, early detection and management of adverse effects; 3) identify potential and actual drug-drug interactions and make recommendations for dosage modification or alternative therapies; 4) provide information, education, and counselling to patients about medication-related care.	Pharmaceutical care program	4.000	HIV patients (at present); (in the future) chronic patients (congestive hearth failure, oncologic patients treated with oral chemotherapy)	ongoing		In 1998-2000 we developed a pharmaceutical care program that increased by 11% the number of HIV patients with an adherence rate ≥90%. Since the implementation of this program, patient satisfaction has been >9 out of 10 every year.	We will describe the pharmaceutical care programme in place at our institution, following the template provided ("good practices"). We will expand the target population to other chronic conditions.	
Hospital Clinic	1. Improve patients' adherence	Development of a new ICT enabled strategy for medication adherence in chronic diseases involving mobile phones devices to help patients taking their medication. The mobile devices used for the patients' follow-up will incorporate: 1) bidirectional communication between patient, carer and pharmacists; 2) applications to monitor adherence in combination and to manage reminders of medicine intake.	Design and develop a mobile application helping patients to take their medication and monitor adherence in combination with electronic alarm systems which will facilitate medicine intake. Development of a communication tool between patients and caregivers and of an innovative remote patient's care model.	Mobile application helping patients to take their medication and monitor adherence in combination with electronic alarm systems which will facilitate medicine intake. Communication tool between patients and caregivers and of an innovative remote patient's care model	104	HIV patients (at present); (in the future) chronic patients (congestive hearth failure, oncologic patients treated with oral chemotherapy)	2013	2015	To increase by 10% the current adherence rate of patients with HIV, COPD and CHF in a 3 year period. This improved adherence will have a first impact on other measurable indicators (use of resources – Δ -15% , quality of life scores Δ +15%, less medication use Δ-20%)	We will provide the details of the research protocol to be started that develops and validates an app (to be used on mobile phones) for the follow-up of therapeutic adherence.	
Hospital Clinic	3. Deliver improvements in the health care system	To develop consistent frameworks to ensure smooth management of patient adherence	1) reallocation of tasks for pharmacists, involvement in integrated care programmes, establishment of links across different levels of care (organisational aspects); 2) investigation and deployment of new educational approaches that can be packed as a mainstream service in the delivery of care; 3) development of a model ensuring the viability and sustainability of services	New educational approaches that can be packed as a mainstream service in the delivery of care. Model ensuring the viability and sustainability of services		Polymedicated patients	2014			We will explain and detail how the patient adherence programme is a part of the overall integrated care policy being deployed at Hospital Clinic and in connection to the area of influence (primary and secondary care)	
IDIAP Jordi Gol	1. Improve patients' adherence	Factors related to the control and intensity of treatment in patients over 65 years of age with type 2 diabetes in primary care	Descriptive study on the spanish population based on the SIDIAP database.	Report with results. Recomendations for clinical guidelines	110.000 patients	Patients over 65 years of age with type 2 diabetes from the SIDIAP database.	2013	2014	Factirs related to the control of HbA1c and complications		Diabetes Research Group of the IDIAP Jordi Gol
IDIAP Jordi Gol	1. Improve patients' adherence	Therapeutic inertia and adequacy of the prescription in type 2 diabetic patients	Descriptive study based on the SIDIAP database	Report with results. Recomendations for clinical guidelines	110.000 patients	Patients over 65 years of age with type 2 diabetes from the SIDIAP database.	2013	2014	Adequacy and inadequacy of diabetes type 2 medicines		Diabetes Research Group of the IDIAP Jordi Gol
IDIAP Jordi Gol	1. Improve patients' adherence	Factors related to the adherence of the tretment in diabetic 2 patients in Primary Care	Descriptive study based on the SIDIAP database	Report with results. Recomendations for clinical guidelines	110.000 patients	Patients over 65 years of age with type 2 diabetes from the SIDIAP database.	2013	2014	Factors related to adherence		Diabetes Research Group of the IDIAP Jordi Gol
IDIAP Jordi Gol	1. Improve patients' adherence. 4. Research and methodology	Alzheimer's disease drugs: an analysis of treatment appropriateness and impact of novel therapies on drug use paterns	Descriptive study on the spanish population based on the SIDIAP database.	Changes in drug use pattern and treatment duration (time until dose change, addition of a second AD's drug or drug withdrawal).	Patients with Alzheimer's disease of the SIDIAP database	Patients with Alzheimer who started treatment in the first half of 2007 and the other in the first half of 2009 (post-marketing of new dosage forms and extension of indication of meantine	2010	2013	To describe AD treatment pattern in Catalonia during two treatment periods (treatment initiated in 2007 and in 2009), analyzing changes in drug use pattern and treatment duration (time until dose change, addition of a second AD drug or drug withdrawal). To describe concomitant treatment with other drugs such as antipsychotics, hypnotics or antidepressants as well as to analyze changes in drug use pattern when the AD drug is prescribed for the first time. To compare the characteristics of patients initiating treatment in Catalan practices with those recruited for the pivotal clinical trials		Research group of the IDIAP Jordi Gold. SIDIAP Database
IDIAP Jordi Gol	1. Improve patient adherence. 2.Empower the patients and care givers	To evaluate the effectiveness of online couching programs for patients with a chronic condition and their caregivers to empower them, to improve quality of life and other health results (pain, HbA1c, physical exercise…) (2013-2015)	Effectiveness and cost-effectiveness of a health coaching intervention on the lifestyle of patients with osteoarthritis of the knee. Cluster randomized clinical trial in primary care.	Evaluation of the effectiveness of online couching programs for patients with a chronic condition (Report)	60 patients with osteoarthritis of the knee (180 for each treatment group).	older population	2014	2016	To analyze the effectiveness, cost-effectiveness and cost-utility of an intervention based on Health Coaching with support phone calls on QOL, pain, overweight/obesity and physical activity in patients with osteoarthritis of the knee from primary care centres (PCC) of Barcelona.	Pending project fundings	Research group on health services research of the IDIAP Jordi Gold. Universitat Autònoma de Barcelona
IDIAP Jordi Gol	1. Improve patients' adherence	Persistence on the osteoporosis treatments and predictors of adherence and persistence	Descriptive study based on the SIDIAP database	Report with results. Recomendations for clinical guidelines	Patients with osteoporosis	Patients with osteoporosis from a population of 5,8 million inhabitants	2013	2015	Persistence and adherence to osteoporotic treatments		Research group on Osteoarticular diseases of the IDIAP Jordi Gold. University of Oxford
IDIAP Jordi Gol	1. Improve patients' adherence	Adequacy of treatments on patients with artrosis: counseling, diet and drugs	Observational study with patients with artrosis	Report with results. Recomendations for clinical guidelines		Patients with artrosis	2013	2015	Afequacy of prescribed drugs and adherence to counseling		Research group on Osteoarticular diseases of the IDIAP Jordi Gold. University of Oxford
IDIAP Jordi Gol	1. Improve patients' adherence	Effectiveness of an intervention to assess polymedication in the elderly and improve the adequacy of prescriptions according to their multimorbidity	Development of the study	Report with results. Recomendations for clinical guidelines		older population; patients with polypharmacy taking more than 5 drugs/day	2013	2015	adequacy of prescriptions according to their multimorbidity		Research group of the IDIAP Jordi Gold and Catalan Institute of Health

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
IDIAP Jordi Gol	1. Improve patients' adherence	Chronicity support and appropiatness of prescribing in nursing homes (NH)	a) Creation and implementation of Therapeutic drug guide. Review adequacy treatment for dementia. b) Creation care units (GP and nursing), with specific competence profile, full-time, integrated in primary care centers. Proactivity care actions. decompensation prevention, palliative care support. Streamlining healthcare resources. Coordination between other levels care. c) Connection computerized medical record from NH. Access to electronic prescribing	a) Therapeutic drug guide for patients in Nursing Homes. b) Review adequacy treatment for dementia. C)Report with results	9.917 elderly residents	45% in clinical risk group (CRG) 6-9	2011-2012	2014	To develop a program based on patient safety, quality of treatments,with efficacy, and efficiency to elderly. To evaluate degree of adherence to therapeutic drug guide.		IDIAP Jordi Gold. Catalan Institute of Health
IDIAP Jordi Gol	1. Improve patients' adherence	To develop a program based on patient safety and quality of treatments to elderly with dementia. This program will evaluate the implementation in nursing homes and adherence to the guidelines.	a) Creation of a guideline on therapeutics recommendations for management of patients with behavioral and psychological symptoms of dementia. b) Creation care units (GP and pharmacist), with specific competence profile in management of patients with dementia and medication review. c) Medication review based on type and evolution of dementia and functional state. Review adequacy treatment for dementia and appropriateness of psychotropic drugs. Individuals and tailored care plans that help physicians address psychotropic drugs in patients with dementia. Coordination between other levels of care (neurologist and geriatrics) d) Access to electronic prescribing. Create health and pharmacologic indicators. Monitoring prescription of psychotropic drugs through the utilization of databases.	a) Guideline based on patient safety and quality of treatments to elderly with dementia. b)Report with results. c) Health and pharmacologic indicators for monitoring in the electroniv health record.	3500 elderly residents	Patients with dementia	2011	2014	a) Adherence to the program and guideline. Follow up recommendations of the individuals and tailored care plans; change on number of psychotropic drugs per patient with dementia and variation on functional state.		IDIAP Jordi Gold. Catalan Institute of Health
IDIAP Jordi Gol	1. Improve patients' adherence	Effectiveness of inhaled medication in elderly in relation to the fragile and cognitive impairment. Implementation of interventions addressed to improve the selection of inhalation devices and adherence in the elderly.	a) Quasi-experimental study to assess the effectiveness of the study intervention. b) Assessment of inhalation technique by scaling the EDEN study. Test cognitive impairment, functional assessment, instrumental assessment, psychic assessment, frail global appraisal. c) Monitoring through the electronic health record.	Report with results. Recomendations for clinical guidelines	436 patients	Patients aged 75 or older with an indication of treatment with any inhaled medication device for respiratory disease	2012	2015	To assess the correct use of various devices for inhaled drug delivery and respiratory therapy in relation to the parameters that measures the age-related deterioration of mental functions, motor and frailty.		IDIAP Jordi Gold. Catalan Institute of Health
IDIAP Jordi Gol	1. Improve patients' adherence 2. Empower the patients and care givers 3. Deliver improvements in the health care system	Experimental study to evaluate the effectiveness of an integral strategy in patients with poor glycemic control in type 2 diabetes mellitus in primary care (INTEGRA study).	a) Development of the research project. b) Evaluate the effectiveness of alerts, reminders and other short programs through mobile technology and a web applications (coaching) to support self-management and change behavior. c) To improve the primary care electronic systems including alerts, online guidelines and other assessment tools for health professionals that improve adherence to clinical guidelines and improve adequacy of prescriptions.	Report with results. Recomendations for clinical guidelines. Validation of tools to support self-management and change behaviour. Improvement of the electronic health record with alerts indicators of good control and online guidelines.	500	Patients with Diabetes Mellitus type 2 with a poorly controlled T2 DM	2013	2016	Determine whether glycemic control, as measured by the mean concentration of the patient's HbA1c poorly controlled T2DM improved when it is evaluated, treated and implemented comprehensive strategy in the primary care setting		Diabetes Research Group of the IDIAP Jordi Gold, research group on health services research of the IDIAP Jordi Gold, Catalan Institute of Health, Catalan Department of Health
IDIAP Jordi Gol	3. Deliver improvements in the health care system	Program on electronic health records to integrate all existing prescriptions among the difrferent care levels in order to coordinate them, improve adequacy of treatments and adherence to clinical pactice guidelines.	Develop the program of collaborative prescription and the program of active inteligence on the electronic health records. Evaluate the impact on some outcomes of different diseases (diabetes, cardiovascular diseases, Alzheimer, , etc)	Development of the programs. Report with results. Recomendations for clinical guidelines	Aprox. 120.000 persons	Older people attended by the Catalan Institute of Health	2013	2015	Coordination of protocols among different levels of care. Adequacy and adherence of treatments		Research group on health services research of the IDIAP Jordi Gold, Catalan Institute of Health
IDIAP Jordi Gol	4. Research and methodology	Develop methods of classification of multimorbidity and polypharmacy in the elderly	Research project to establish Methods of classification of multimorbidity and create a classification in the elderly, based on the SIDIAP database	Methods of classification of multimorbidity and polypharmacy in the elderly developed		population over 65 years old of the SIDIAP database with 5,8 million inhabitants	2013	2015	The study of multimorbidity patterns will facilitate the comprehensive assessment of the burden of multimorbidity in our population and determine how a particular health problem is ascribed to a specific pattern	The study will also identify groups of patients so that specific programmes for people with a particular multimorbidity pattern can be designed and implemented; identify strategies to implement clinical practice guidelines based on patients with multimorbidity to improve their quality of life; contribute to the formulation of health policies that target groups with multimorbidity; identify groups of patients at risk of higher health resource utilization; establish different prognosis for patients according to their multimorbidity pattern	Research group on health services research of the IDIAP Jordi Gold. Universitat Autònoma de Barcelona
IDIAP Jordi Gol	4. Research and methodology	Develop a simple guide for the professional and the patient to provide prescription adherence and healthy prescription, avoiding unnecessary prescriptions and self-medications		Guide for the professional and the patient to provide prescription adherence and healthy prescription		general population and health providers	2014	2015			
IDIAP Jordi Gold	1. Improve patients' adherence	To assess the variability in adherence to preventive services (tobacco, alcohol, obesity, vaccination, cardiovascular risk) in Primary Care based on electronic health records (REGIPREV and SIDIAP databases)(2011-2015)	Specific study related to elderly people in order to know specific factore related to the variability of screening activities.	Report with results	200.000 persons	Persons older than 65 years	2013	2014	Factors related to the prevalence of screening activities. Factors related to the control of the preventable problems		IDIAP Jordi Gol and redIAPP network

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
IK4 Research Alliance	2. Empower the patients and care givers	1. Kronos1: To develop a fully functional home monitoring system for chronically ill patients. The system comprises three main elements: the HIS (hospital information system) which accesses the EHR (electronic health record), the android app and a web interface.	Inside this project we (along with a local company) have developed an android application for the follow up of patients which provides personalized remote follow up for patients of a private clinic in San Sebastian The app provides the following services: 1) personalized follow up via questionnaires. Questions are chosen by the doctor for each patient. 2) collection of vital sign info: weight, pulse (values are inserted by the patient) 3)follow-up treatment via medication: the app reminds the patient what medication to take and when depending on their specific condition 4) Personalised education regarding the condition 5) channels of communication and contact information	Full functional hospital information system and management platform for use at home. Developed for a local private clinic.	30	COPD Diabetes	01/07/2013	01/10/2013	1. Usability. Participants will be asked to fill in a usability questionaire. The SUS - System Usability Scale has been chosen to evaluate the usability of both android app and web interface. 2. Satisfaction. Participants will be asked to fill in a satisfaction questionnaire for both android app and web interface. Satisfaction will be measured in two different level: i) satisfaction with the different service provided (medication reminder, vital signs delivering, contact with doctors, questionnaire about synthoms ...) and ii) general satisfaction with the app or web interface. Other results that can be extracted from the HIS: Adherence to the home monitoring system (to HYGEHOS HOME) *Adherence to medication * Adherence to the different services provided in the system	The three elements are fully integrated and are ready to be used both by doctors in their everyday practice and by patients wherever they are (at home, on travel, ...). The commercial name of the HIS is called HYGEHOS. And the android app and the web interface (the new developments) are branded as HYGEHOS HOME (home monitoring). The android app has been designed for smartphones, but can be run on tablets as well. The web interface has been designed to be used from the PC	clinica Asuncion (private clinic) Bilbomatica (SME) Vicomtech-IK4 (centre within IK4)
IK4 Research Alliance	2. Empower the patients and care givers	2. Kronos2: similar to above but on a grander scale and for the public and private healthcare system.	Kronos is a platform for the follow-up of chronic patients. Mobile devices will be used to provide this service in a variety of environments. This platform is made of 4 pilars: a) education (videogames focused on prevention) b) social networks c) autocontrol of disease d) smart follow up of patients. Alarms, detection of not properly recovering patients ...	The platform consisting of applications and software developed by several companies for the public health system	300	As above	Depends on funding but if approved, it will begin 2014	2015	TBC depending on approval of funding and amount of funding approved	This is a potential commitment - it depends on funding which will be finalised between september and december 2013	
IK4 Research Alliance	4. Research and methodology	Development of guidelines on interoperability and definitions of standards using multimedia and smart devices such as SMART TV and smart phones for adherence	Translate work we are doing in the C2 action group on interoperable refernce architecture and guidelines to A1	Guidelines on interoperability and definitions of standards using multimedia and smart devices			Began in Nov 2012	2015	This depends on the application of the guidlines in new European projects and the uptake of the reference architecture by SMEs	This is a real commitment for C2 and we are willing to make the effort to apply it to A1	C2 interoperability members led by the REAL consortium and TRIALOG
IK4 Research Alliance	5. Foster communication	Development of repositories	As above but for Repositories. Work is currently underway to create a common repository between C2 and B3 that houses good practice information and evidence. Where relevant outcome information from perscription adherance in the A1 group could be added to the same repository. The repository will also be an addition to the EU marketplace and will be a meeting point for supply and demand	Repository, taxonmies			Began in Nov 2013	2015	As above	This is a real commitment for C2 and we are willing to make the effort so results from A1 can be showcased in the repository (therefore work in parallel with A1 regarding taxonomies etc)	C2 coordination and management group led in the case of this deliverable by IK4
Inversión y Desarrollos Socio Asistenciales SL	1. Improve patients' adherence	To implement decision support tools for prescribing applying STOPP START criteria to reduce the effects of polypharmacy.	Specific Focus Group to collaborate in the definition of User Case using Technologies-Tools Requirements Design and User Validation of a basic prototying.	Decision support tools for prescribing applying STOPP START criteria	Polypatjhology assisted	Patients with >5 medications	2013-SEPT	2013-NOV	full specifications, Prototype available for testing.	Patients in Italy and Spain	Inversión y Desarrollos Socio Asistenciales SL; TicTouch (www.tictouch.eu)
Inversión y Desarrollos Socio Asistenciales SL	1. Improve patients' adherence	To design, develop and trials simple monitoring tools to be used both at home and in the clinics to: - Check the correctness of the administered medication versus the planned one; - Check that the administration takes place (mainly in the case of self-administration); - Monitor the time of administration (with provision of alarms and safety blocks in the wrong cases).		Monitoring tools for a) checking the correctness of the administered medication versus the planned one; b) checking that the administration takes place; c) monitoring the time of administration	Elderly patients assisted	Patients with >5 medications	01/08/2013	31/01/2014	full specifications, virtual demonstrator; partial laboratory prototyping.	Patients and Clinicians in Italy and Spain will be involved to design the solution and to evaluate technology acceptance.	Ab.Acus (www.ab-acus.eu); Villa Beretta of the Valduce Hospital from Como;Inversión y Desarrollos Socio Asistenciales SL
Inversión y Desarrollos Socio Asistenciales SL	2. Empower the patients and care givers	To empower chronic patients (e.g. those with diabetes mellitus)	Definition of training modules? Definition of awareness specific campaigns on the importance of adherence (this activity was mentioned under objective 3)	Training modules for patients and caregivers, based on three areas: knowledge about the disease and its treatment, ICT and Social Network generation	Elderly patients assisted		15/02/2014	14/06/2014	Deliverable on training methodology, objectives, monitoring and evaluation of results.	There will be a Knowledge and Adherence Drivers Community (KAdC); this community will include professionals, informal caregivers and patients. A) Knowledge. Aimed at increasing knowledge of the disease and its treatment by the patient and caregivers. This training will be received through the online platform. KAdC members participate as tutors facilitators. B) development of tailored training programs on management tools implemented and based on ICT.	Human Overall (www.humanoverall.com); Inversión y Desarrollos Socio Asistenciales SL
Inversión y Desarrollos Socio Asistenciales SL	2. Empower the patients and care givers	To create a Knowledge and Adherence Drivers Community (KAdC); this community will include professionals, informal caregivers and patients.	Definition of virtual contents, community tool choice and management, usability and accesability validation.	Knowledge and Adherence Drivers Community (KAdC)	Elderly patients assisted		2014-APR	2014-DEC	Social network deployed and validated based on the model of the KAdC	This task requires input from the previous task results.	TicTouch (www.tictouch.eu); Inversión y Desarrollos Socio Asistenciales SL
Inversión y Desarrollos Socio Asistenciales SL	4. Research and methodology			At least 3 scientific publications on the results of the pilots, describing objectives, materials, methods, results, conclusions and discussion.	Elderly patients assisted		2015-MAR	2015-NOV			Inversión y Desarrollos Socio Asistenciales SL and each partner who is involved in each study.
Inversión y Desarrollos Socio Asistenciales SL	5. Foster communication			Report on the adhesion factors identified in the pilots.	Elderly patients assisted		2015-SEPT	2015-OCT			Inversión y Desarrollos Socio Asistenciales SL

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Istituto di Ricerche Farmacologiche Mario Negri	2. Empower the patients and care givers	To foster tailored intervention programmes through the use of a simple and cheap tool to encorauge physical activity in older citizens.	1) produce a systematic review of published studies in order to identify the more cost-effective method to enhance physical activity in the elderly; 2) implement protocols for the validation of personalized walking programmes in older people related to clinical outcomes; 3) promote the use of a simple tool encouraging elderly in engaging and monitoring their exercise over time.	1) Review of published studies to identify the most cost-effective method to enhance physical activity in the elderly;						activities mapped to action plan A1 from those proposed for A3	Istituto di Ricerche Farmacologiche Mario Negri (IRFMN) CSeRMEG (Centro Studi di Ricerca in Medicina Generale) Local Health Authority ULSS 20, Verona Local Health Authority Milano
Istituto di Ricerche Farmacologiche Mario Negri	2. Empower the patients and care givers	To enhance the involvement of the stakeholders in implementing prevention strategies in order to help elderly citizens remain active and involved. it is our commitment to involve older citizens in programmes of healthy lifestyle using simple strategies to enable them to remain active and independent preventing or delaying the onset of chronic cardiovascular diseases.								activities mapped to action plan A1 from those proposed for A3	
Istituto di Ricerche Farmacologiche Mario Negri	4. Research and methodology	it is our commitment to implement strategies for the prevention and health promotion in primary care through a large network of Italian General Practitioners and European General Practitioners involved in EUROPREV network (European Network for Prevention and Health Promotion in Family Medicine and General Practice)								activities mapped to action plan A1 from those proposed for A3; activities under former objective 3 (systematic screening) has been left out. Could it be put under current Objective 4 (Contribute to the research and methodology?)	
Merck Serono SpA Italy	1. Improve patients adherence to care plan	To provide an integrated support set useful to monitoring and detecting adherence levels to DMD therapy (Disease Modifying Drug) for patients affected by multiple sclerosis (MS)	To monitor adherence throught electronic tools and reduce side effects related to therapy	Electronic devices for recording the dosing history and maximizing therapy tollerability	Currently about 5000 MS patients use an electronic device (REBISMART) to administer their therapy	Disable patients with MS; Health professionals; caregivers	2009-Q4	2013-Q1	Monitoring adherance in MS and improve medication persistance		1) CIRFF, University of Naples; 2) Federico II hospital, Campania region 3) Health Authorities of Campania region + additional parteners in other Italian Regions
Merck Serono SpA Italy	2. Empower the patients and care givers	To provide a telephone technical support service carried out by specialized personnel that can be used to empower patients and caregivers to be independent and to take care of their health.	Development and implement of patient support programms in order to optimize involvement and self-management in chronic and disable disease	Telephone technical support service for empowering patients and caregivers to be independent and to take care of their health.	About 12.000 MS patients take advantage by the use of this Call Center	Disable patients with MS; Health professionals	2004	on-going	Provide support and technical assistance in order to decrease inapporpriate care intervention		as above
Merck Serono SpA Italy	3. Deliver improvements in the health care system	Development of new ways to ensure patients follow treatment prescriptions and medical advice and to help caregivers to optimize their intervention into medical care.	To monitor adherence and to create a WEB software platform to optimaze caregivers intervention and to give the opportunity to patients to be pro-active and engage in the manage of their condition.	WEB software platform (MS DIALOG) using a simple wireless techonology (i-cloud) optimizes time visit and caregiver intervention.	Potentially about 12.000 MS patients could be interested to use this WEB tools.	Disable patients with MS; Health professionals	2014-Q1	2016	Adherence and patients related outcomes (quality of life, fatigue, cognition, depression ecc)		as above
Muy Ilustre Colegio oficial de farmacéuticos de Valencia	1. Improve patients' adherence	To help facilitate adherence by using TICs	development of mobile device	Farmamovil, a software application for mobile device (tool for pharmaceutical care adressed to control the adherence of the patiens)	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients	depends on the Sanitary Administration – Valencia Health Agency-	depends on the Sanitary Administration – Valencia Health Agency-	adherence	The Phase 1 pilot of the programm will be placed in the community pharmacies in the following regions and cities: - Region of Valencia: Sagunto - Region of Alicante: Alcoy - Region of Castellón: Onda. The Phase 2, will be extended to the acreditated communitary pharmacies all over the Valencia , Castellón and Alicante Regions. The target population will be extended to all the patients included in the program of pharmaceutical care, home, like polypharmacy, fragile vulnerable, etc.	Foundation of Quality of Life of Elderly People; Association of Pharmacist of Valencia; Association of Pharmacist of Alicante; Association of Pharmacist of Castellón; Spanish Association of Community Pharmacy (SEFAC); Delegación Comunidad Valenciana
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	1. Improve patients' adherence	Using protocols to improve processes	Develop protocols and standard operating procedures in electronic format to facilitate decision-making	Protocols and standard operating procedures in electronic format to facilitate decision-making	Community pharmacies :Sagunto: 34 Onda :8 Alcoy: 34 Total:76 / 3,16% of valencians Community pharmacies	Pharmacyst	depends on the Sanitary Administration – Valencia Health Agency-		degree of implantation of the protocols		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	1. Improve patients' adherence	Improving adhesion treatment by PSD (Personalised Services Dosage)	Development of Personalised services dosage (PSD): the pharmacist will count doses taken and follow-up interviews in the patient's home	Adherence screening tool	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients	depends on the Sanitary Administration – Valencia Health Agency-		adherence		

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Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	1. Improve patients' adherence	DEVELOPMENT AND APPLICATION	Development of drug database, software application for the management of PSD, pharmacotarpéutic history, review of pharmacotherapy	Databases	Community pharmacies :Sagunto: 34 Onda :8 Alcoy: 34 Total:76 / 3,16% of valencians Community pharmacies	farmaceuticos participantes	depends on the Sanitary Administration – Valencia Health Agency-		degree of use / satisfaction survey		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	1. Improve patients' adherence	Establish or implement a pharmaceutical domicilary care service models.Provide pharmaceutical services at home for patients whit special characteristics and vulneravility and allow the patient to live at home.	Pharmaceutical services household:(traducción) a) Improvement treatment adherence by PSD. b) control and review the medicines. c) Collaboration in the detection and reduction of inappropriate medication. d) Health education to the patient on the proper use of medicines and the use of delivery devices. e) Health education to the patient and family caregivers f) Review of the home medicine cabinet	The pharmacist moves to the patientś home to develop actividdes and pharmaceutical services	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients	depends on the Sanitary Administration – Valencia Health Agency-		quality of life / drug related problems / health costs avoided		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	2. Empower the patients and care givers	Improving information patient / caregiver on medications and health problems	Initial interview to the patient to identify patients needs and information gaps . Regular pharmacist home visits for overcoming these shortcomings.	Use the pharmacist as a health advisor	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients for this commitment Pharmaceutical Domiciliary Care			information and knowledge of the patient / caregiver about the medicines you use and health problems		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	3. Deliver improvements in the health care system	development a multidisciplinary team	Meetings of the multidisciplinary commission to develop the protocols of work	Use of protocols and normalized procedures of work		NOT AVAILABLE	depends on the Sanitary Administration – Valencia Health Agency-		protocols and tools developped		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	3. Deliver improvements in the health care system	improve the dispensing process	Joint training courses	Use an electronic prescription/dispensing system	2400community Pharmacies	Pharmacyst / prescribers	depends on the Sanitary Administration – Valencia Health Agency-		dispensing errors		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	3. Deliver improvements in the health care system	Detect inappropriate medication in ederly people	Use tools as criteria STOP-START and BEERS	inappropriate medication in elderly people	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients for this commitment Pharmaceutical Domiciliary Care	depends on the Sanitary Administration – Valencia Health Agency-		Inappropriate medication use in elderly people		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	3. Deliver improvements in the health care system	pharmaceutical drug reviews home service model	Domiciliary visits to evaluate the safety, effectiveness and needless of pharmacotherapy.	Drug reviews	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients for this commitment Pharmaceutical Domiciliary Care	depends on the Sanitary Administration – Valencia Health Agency-		Drug related problems		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	3. Deliver improvements in the health care system	To develop pharmaceutical care	Carry on pharmaceutical care to the patient`s house by assigning him a pharmacist from the nearest community pharmacy patient`s house.	Pharmaceutical care	Polimedicated patients (11,45%) (17379) / dependent patients (9%) 13656 // people; 151779/	Dependent patients (as defined so by the Valencia Health Agency) and crónics polimedicated patients	depends on the Sanitary Administration – Valencia Health Agency-		Drug related problems		
Muy Ilustre Colegio oficial de farmacéuticos de Valencia (MICOF)	3. Deliver improvements in the health care system	Training the pharmacist	Training: Review of the home medicine cabinet , review of pharmacotherapy and Personalised Services Dosage	Training courses for pharmacist about pharmaceutical domiciliary care; accreditation system of the pharmacist`s skill and community pharmacy.	Community pharmacies :Sagunto: 34 Onda :8 Alcoy: 34 Total:76 / 3,16% of valencians Community pharmacies	76 pharmacyst (3,16%) /2400	depends on the Sanitary Administration – Valencia Health Agency-		Number of accredited pharmacists		

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Novartis	1. Improve patients' adherence	Assess elderly Type 2 DM patients' adherence to diabetes treatment in a real-life setting.	Observational study to be conducted in male and female patients aged ≥65 years with inadequately controlled T2DM By evaluating the following topics: - elderly patients' quality of life; - elderly patients' treatment satisfaction; - the perceived burden of physical and psychological symptoms related to T2DM and its possible complications over time; - estimate of hypoglycemia incidence and the utilization of economic resources resulting from emergency access/hospitalization due to hypoglycaemia ; - Gender differences.			Type 2 Diabetic patients					AIFA (Italian Medicines Agency)
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence	To assess the variability in adherence to preventive services (tobacco, alcohol, obesity, vaccination, cardiovascular risk) in Primary Care based on electronic health records (REGIPREV and SIDIAP databases)(2011-2015)	Specific study related to elderly people in order to know specific factore related to the variability of screening activities.	Report with results	200.000 persons	Persons older than 65 years	2013	2014	Factors related to the prevalence of screening activities. Factors related to the control of the preventable problems		IDIAP Jordi Gol and redIAPP network
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence. 2.Empower the patients and care givers. 3.Deliver improvements in the health care system	Effectiveness of a complex multi-risk intervention in primary care to promote healthy behaviours in the population aged 45 to 75 years in order to improve their quality of life and avoid most common chronic diseases and promote a healthy ageing: exploratory multicentre clinical trial in Primary Care	Design of a complex multi-risk intervention in primary care to promote health-promoting behaviours in the population aged 45 to 75 years: exploratory multicentre clinical trial	Implemention of a multi-risk intervention focused in population with risk factors	1.600 persons	people 45 to 75 years attending Primary Health Care with multiple risk factors	2013	2015	improvement on health-promoting behaviours, quality of life and avoidance of most common chronic diseases	This complex multi-risk intervention focused on a population in which concentrate a large number of risk factors and chronic health problems coudd generate health-promoting behaviors that improve their quality of life, avoid the most common chronic diseases and their complications and contribute to active and healthy aging, in line with European Union initiative	All research groups of the redIAPP (8 regions of Spain)
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence	To assess the prevalence of non-initiation of the most prescribed and expensive pharmacological treatments and to determine the factors associated with non-initiation as well as its economic consequences. To identify the factors that determine the behavior of non-initiatiors from the perspective of patients that do not initiate a treatment.	Research Proect: *The problem of non-initiation of pharmacological treatment: mixed-methods evaluation.*	Guideline for the identification of potential non-initiators and management of this problem in primary care.	Aprox. 6 milion	Primary care patients that are indicated to initiate a pharmacological treatment	2014	2016	Prevalence of non-initiation, factors associated and motivations for non-initiation from the patients perspective.		Primary Care Research Group - Cancer in Balearic Islands. (IB Salut) - Mental Health, Services and Primary Care. Andalucía (Andalusia Health Services) - Research in Primary Care and Mental Health. Catalonia. (Sant Joan de Déu)
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence	To describe the delivery of counseling and prescription interventions to promote healthy lifestyles in Primary Care and to assess their associated effectiveness	Dissemination of evidence and know-how from a pilot phase II clinical trial performed in 4 primary health care centres of Spain	Report	Aprox.40.000 patients	Primary care patients attending their health centres during 2 years	2013	2015	Proportion of adressed patients, porportion of counseled patients, porportion of prescribed patients. Estimated effect in healthy lifestyle change		Primary Care Research Unit of Bizkaia
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence	To implement intervention to reduce the over consumption of benzodiazepines	Research Project: *Comparative Efficacy of two interventions to discontinue long term benzodiacepine use in Primary Care*	Report with results. Recomendations for clinical guidelines. On line training on a brief structured interview to gradual benzodiazepine tapering		Patients aged 18 to 80 years old, who were taking bzds for at least 6 months and who do not fulfil any of the exclusion criteria of the study.	2012	2015	effectiveness of a structured educative intervention (SEI) and of a minimal intervention (MI) performed by the family GP (General Practitioner; GP) to discontinue long term bzd use, compared to usual care. To evaluate the safety of these interventions in anxiety and depression symptoms, sleep quality and alcohol consumption		Primary health care services from three spanish regions (Balearic islands, Catalonia and Valencia)
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence	To help general practitioners to identify patients with low adherence to medication	To implement an electronic monitoring system to detect low adherence to medication by a program implemented in the e-clinical records using the automated pharmacy dispensing records.	To give automatic acces to general practitioners to identify patitne with low adherence by e-clinical records		Polymedicated patient	2013	2015	Reduction of low adherence.	on going	Primary Health Care Research Group Balearic Islands (IB-Salut)
redIAPP. Primary Care Prevention and Health Promotion Research Network	2. Empower the patients and care givers	To assess polymedicated patients ' opinion related to medication reconciliation in terms of security, quality of care, ans social and inividual needs	Development of the study	Medical and pharmaceutic guidelines for the management of polymedicated patient.		Polymedicated patient	2013	2015	Improving care coordination among differents health systems assiting levels.		Primary Health Care Research Group Balearic Islands (IB-Salut)
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence	To evaluate the effectiveness of a nurse training programm in motivacional interview to improve patients adherence to medication .	Training workshops in improving adherence targeting patients, physicians, nurses and pharmacists			Patient on pharmacological treatment	2014	2016	patient adherence to medication.		Primary Care Research Group - Cancer in Balearic Islands. (IB Salut) - Mental Health, Services and Primary Care. Andalucía (Andalusia Health Services) - Research in Primary Care and Mental Health. Catalonia. (Sant Joan de Déu)
redIAPP. Primary Care Prevention and Health Promotion Research Network	1. Improve patients' adherence. 3.Deliver improvements in the health care system	To evaluate the effectiveness of APPs, online programs and social networks to improve the adherence.	Development of the study	APPs and technological devices.			2013	2015			All groups of the redIAPP
Region Skåne/Skåne County Council	3. Deliver improvements in the health care system to promote adherence	An up-to date and correct medication list and an individual treatment of the patient	Medication review, medication reconciliation at admission and at discharge (discharge information)	40 % of patients living in nursing homse should recieve a medication review in primary care 40% of all discharged patients ≥ 75 years with ≥ five types of prescribed medicines should receive a medication review (including a medication reconciliation at admission) prior to leaving 70% of all discharged patients ≥ 75 years with ≥ five types of prescribed medicines should receive a discharge information	Patients. 7.8% of 1.2 million inhabitants.	≥ 75 years with ≥ 5 types of prescribed medicines		implemented in the care system in the region	An up-to date and correct medication list and an individual treatment of the patient	Discharged patients will have discharge information containing a medication report, and current prescription list.	hospitals (doctor, pharmacist, nurse), primary care centers (doctor, pharmacist), municipialisis (nurse), patients, academy

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
Royal College of Surgeons in Ireland & HRB Centre for Primary Care Research	1. Improve patients' adherence	Development of decision support embedded in the electronic health record for point-of-care implementation with patient specific recommendations based on knowledge-based algorithms	Joint working with software companies to develop decision support systems and with Health Agencies that collect prescribing data	Decision support systems that enable decision support at point of care with patients	Elderly patiients and patients with multiple morbidities that require multiple medications	older people, pregnant women, children, drug users and homeless patients	2013	2018			Queen's University Belfast, University of Dundee, University of Nottingham, CPRD (UK), Trinity College Dublin0 TILDA (Ireland) Socrates Healthcare, Sligo, Ireland
Royal College of Surgeons in Ireland & HRB Centre for Primary Care Research	3. Deliver improvements in the health care system	Development of and evaulation of decision support systems that enhance the quality and safety of prescribing in the community, with a focus on potentially inappropriate medicines	Randomised controlled trials (RCTs) and cluster RCTs of decision support systems	Evaluation of Decision support systems in RCTs	Elderly patiients and patients with multiple morbidities that require multiple medications	older people, pregnant women, children, drug users and homeless patients	2013	2018			as above
Royal College of Surgeons in Ireland & HRB Centre for Primary Care Research	4. Research and methodology	To Enhance knowledge	Comparative cohort studies in different EU jurisdictions	Comparative cohort studies	Elderly patiients and patients with multiple morbidities that require multiple medications	older people, pregnant women, children, drug users and homeless patients	2013	2018			as above
Royal College of Surgeons in Ireland & HRB Centre for Primary Care Research	5. Foster communication	To increase communication with patients concerning medicines and common medical condidtions	Development of patient information leaflets and other forms of communication that fosters enhanced quality and safety of medicines	Patient information leaflets and other forms of communication (please specify)	Elderly patiients and patients with multiple morbidities that require multiple medications	older people, pregnant women, children, drug users and homeless patients	2013	2018			as above
Sanofi pasteur MSD	2. Empower the patients and care givers	To increase health care practitioners knowledge on existing prevention resources against consequences of immunosenescence through an e-learning and informative web platform To improve patients' health literacy on Immunosenescence, its consequences and prevention means through a highly pedagogical web platform publically accessible.	To develop a web portal for 'Healthy Ageing' which will actively promote prevention starting first with a pilot initiative addressing the important issue of immunosenescence. An e-learning and interactive portal for HCPs and patients will be built through two sub-portals: one for the HCP and one for patients. In order to assess the value of the platform, the following activities will be carried out: - Comprehensive online communication plan - KPIs collection: website performance, impact of the initiative on behaviour towards prevention and health-related outcomes, on health & social care system (reduction health care resource use), and on business growth of SMEs involved in the project. - KPIs assessment tools: website tracking system on visits (number, connection time, ….); Impact on healthcare system assessed via survey prior to and post-launch of the platform; Impact on SMEs activities (turnover, business gross, employment rate);	1- E-learning web platform with 2 sub-portals to pedagogically educate health care professionals and improve patients' health literacy on Immunosenescence, its consequences and primary prevention means through nutrition, immunisation, antimicrobial prescription control. The patient portal will provide Health literacy program on ageing, immunosenescence, infectious disease and prevention means as well as personalised advice on prevention based on patient profile. The health care professional (HCP) portal will provide physicians with reliable information and continuing education through accredited and non accredited e-CMEs as well as a decision making software for personalised advice on prevention based on patient profile. 2- Mobile applications adapted to the customers (e.g. HCP or patients) providing: recall, newsletter; Latest information on innovative prevention means. Sub-Platforms to be used by HCP and their patients in selected healthcare centre in selected member states areas 3- Patient electronic vaccination record / Patient electronic prevention file 4- Possible extension of the project depending on pa		citizens and patients, health care professionals	Q3 2013	Plaform Launch: ' September 2014	- Increase awareness on: - consequences of ageing on immune system and prevention means - vaccination, its efficacy and safety - on immunisation programs for adults/elderly + on available vaccines for vaccine-preventable diseases especially in the elderly - Increase awareness on the importance of adequate nutrition to protect immune system - Increase protection against infectious diseases - Reduce healthcare resource use related to vaccine-preventable diseases	Supplementary Services to be covered by the platform: up to date medical/scientific information thoroughly selected thanks to partners; access to medical references such as EU guidelines on immunisation and nutrition for the HCPs and information pedagogically adapted to the elderly patient population; videos / e-conferences / testimonials; advertisement for specific events (National days of prevention, Congresses; etc); netlinking to relevant websites (EUGMS, twitter, facebook, Linkedin, Medical societies etc.). Impact on healthcare system assessed via survey prior to and post-launch of the platform; Impact on SMEs activities (turnover, business gross, employment rate).	Sanofi Pasteur MSD SYADEM University of Maastricht CHU - Clermont Ferrand
Trinity College Dublin EngAGE Centre for Research on Ageing	4. Research and methodology	To study the effects of non-adherence and non-persistence on health outcomes. The study will examine average levels of adherence (across all chronic medication) and its association with adverse health outcomes, health care utilisation and quality of life. These will include increases in reported disease, hospitalisation, GP consultations, quality of life and death.	Data linkage between two nationally representative studies. One a longitudinal cohort study of adults over 50 years (n=8150) and the other a national pharmacy claims database. The linkage provides details dispensing data for patients linked to outcomes. We will use this linked data to examine prescription refill as a measure of medication adherence and persistence. This will be related to health outcomes, hospitilisations and death.	Longitudinal evidence of the effects of non-adherence and non-persistence on health outcomes	8150: approx 3000 with linked data to pharmacy claims	people aged 50+	2013-09	2014-09	Quantification of the association between non-adherence and non-persistence on specific measured outcomes of health. The information will inform development of interventions to improve adherence 7 persistence. In addition we will examine costs associated with non-adherence, and consider innovative methods of defining adherence/persistence using claims data.	Specific areas of interest will be in medication for prevalent chronic diseases such as hypertension, cardiovascular disease, diabetes and other disease groups where numbers permit.	TCD; Dundalk Institute of Technology; Economic and Social Research Institute; National University of Ireland, Galway; Queen's University Belfast; Royal College of Surgeons in Ireland; University College Cork; University College Dublin; Waterford Institute of Technology.
Universidad de Oviedo	1. Improve patients' adherence	To implement a direct reporting tool of adverse drug reactions open to patients and citizens for collecting reports of side effects and other problems related to drugs and assessment for its viability. This will be done through a website		Reporting tool		elderly population	2012-Q3	2013-Q4		3 regions in Spain will be involved: Basque Country, Castilla y Leon and Asturias (population: 5,8 M). The project started on january 2012 and will finished on december 2014.	Pharmacovigilance Group of Asturias; Pharmacovigilance Unit of Basque Country; Pharmacovigilance Center of Castilla y Leon.
Universidad de Oviedo	1. Improve patients' adherence	Dissemination programme to target populations: patient associations, pharmacists, consumer associations (and including website and Social Networks)		Dissemination programme		elderly population	2013-Q1	2013-Q4			
Universidad de Oviedo	1. Improve patients' adherence	To develop protocols of drug related problems reporting from citizens and data analysis methods		Protocols of drug related problems		elderly population		2015			
Universidad de Oviedo	1. Improve patients' adherence	To carry out comparative analysis of the efficiency of citizen's notifications vs health professional notifications		Comparative analysis of the efficiency of citizen's notifications vs health professional notifications		elderly population		2015			

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
University of Porto	1. Improve patients' adherence	Provide senior citizens with and interactive TV application enabling them to access several health related features such as: medical reminder that seamlessly displays over the TV image; medical agenda (appointments, exams and medication). The technical infrastructure of this application will provide caregivers with monitoring and cross platform access to the senior citizens health related activities.	Elicitation of user requirements through surveys, interviews and focus groups; Development based on user centred design of an interactive TV prototype; In situ evaluation of the application with a sample of senior citizens.	Interactive TV application targeted to older adults and mobile app targeted to the caregivers		Senior citizens (65+ years old) and caregivers		2015	The interactive TV and mobile applications to support and remind health related issues.	The interactive TV application to be developed is supported on a technical system (backoffice) that also supports the caregiver mobile application.	Communication Sciences and Technologies Research Center (CETAC-MEDIA) and Day care centres
University of Porto	2. Empower the patients and care givers	Development of research and education for health programs to empower patients and caregivers.	Development of health programs on environmental risk factors	Health programs on environmental risk factors		Senior citizens and caregivers		2015	Main health problems of elderly people in local communities. Identification of local communities environmental risk factors that impairs an active and healthy ageing. Identification of toxic substances in people. Health literacy improvement of senior citizens and caregivers on environmental risk factors of the main diseases.	The research activities include the identification of environmental sources of toxic chemicals that increase the risk of disease in older humans. The educational activities includes the development of health programs on environmental risk factors	Centre for Research in Chemistry, UP (CIQ-UP) - CIIMAR/FCUP
University of Porto	2. Empower the patients and care givers	Development of a ICT platform (web portal - www.seduce.pt and iTV application - socialitv.web.ua.pt) that provides means for senior citizens to control their social networks, inviting them to join or propose events and activities based on their competences or hobbies.	Development of an ICT platform (web portal and iTV application) to help on senior citizens online activities, such as synchronous and asynchronous technological mediated communication (email or chat), online news, stimulants games, health related issues.	ICT platform (web portal and iTV application) that provides means for senior citizens to control their social networks.		Senior citizens (65+ years old) and caregivers		2015	An ICT platform (web portal and iTV application)	The iNeighbour TV project (PTDC/CCI-COM/100824/2008) (URL: http://socialitv.web.ua.pt/) and the SEDUCE project (PTDC/CCI-COM/111711/2009) (www.seduce.pt) were funded by the Portuguese National Research Agency (FCT and COMPETE).	Communication Sciences and Technologies Research Center (CETAC-MEDIA). The ICT platform is being developed with senior citizens of four residences for the elderly, in the city of Aveiro.
University of Porto	3. Deliver improvements in the health care system	To develop security solutions for managing access to prescription, namely in terms of authentication, monitoring, secure storage and digital signatures.	Development of security solutions for managing access to prescription.	Security solutions for managing access to prescription		Senior citizens (65+ years old) and caregivers		2015	The development of secure solutions for electronic prescription.	Funded by a service contract with Portuguese health authorities (www.healthysystems.pt)	CINTESIS – Center for Research in Health Technologies and Information Systems; Healthy Systems – Start-up
University of Porto	4. Research and methodology	To contribute to a better understanding of the mechanisms by which erythropoietic disturbances develop with ageing, and how inflammation, kidney (dys)function and erythropoiesis are disturbed	Development of knowledge about anemia in the elderly to increase accuracy in prescribing	Peer-review papers		Senior citizens, patients and caregivers		2015	Increased scientific knowledge with a consequent increase in accuracy in prescribing	The prevalence of anemia with aging is about 5% at 65 years of age, to more than 20% at age of 85 years. Aging is characterized by a progressive mild pro-inflammatory state, as shown by the rise in pro-inflammatory markers, which seems to underlie the development of the anemia. Aging has been also associated with physiological, functional and morphological changes in the kidneys, which are similar to those found in the kidneys of chronic kidney disease patients.	Faculty of pharmacy of University of Porto; Institute for Molecular and Cell Biology of University of Porto; IBILI-University of Coimbra;Unidade Multidisciplinar de Investigação Biomédica – UMIB
University of Porto	5. Foster communication	To develop patient records repositories and integration engines based on international communication standards (HL7) and futureproof information architectures (openEHR).	Development of patients record repositories and integration engines.	Patient records repositories and integration engines		Senior citizens (65+ years old), patients and caregivers		2015	The develpment of patient records repositories and integration engines	Virtual Care start-up (WWW.virtualcare,med.up.pt)	CINTESIS – Center for Research in Health Technologies and Information Systems
University of Porto	5. Foster communication	To develop contents and tools to be aggregated in a web platform	Development of contents and tools to be aggregated in a web platform	Contents covering different aspects of the diseases (namelly, allergy and asthma); tools to promote shared medical decisions, to support disease assessment and monitoring		Senior citizens (65+ years old), patients and caregivers		2015	Development of contents and tools to be aggregated in a web platform	The contents, covering several aspects of the diseases, will be created in several formats. For each article, 3 versions will be developed, oriented to physicians/students, patients/public and audiences with limited literacy.	CINTESIS – Center for Research in Health Technologies and Information Systems; UNIFAI – Adult and Elderly Research and Training Unit ; SPAIC - Portuguese Society for Clinical Immunology and Allergology; APAA – Portuguese Association of Patients suffering from Asthma and Allergies; APG – Portuguese Gerontopsychiatry Association; IPA – International Psychogeriatric Association; IFTA – International Family Therapy Association ; Health Centres; Virtual Care – Start-up
University College Cork (establisment of a virtual anticoagulant clinic)	1. Improve patients' adherence	To improve the quality of life of patients prescribed oral anticoagulant therapy by reducing the amount of time the patient spends at the anticoagulant clinic at Cork University Hospital; to improve the patients time in the therapeutic range which in turn reduces the risk of adverse events such as thrombosis or haemorrhage	Development and establishment of the first virtual warfarin clinic in the Republic of Ireland. Development of a toolkit for risk stratification	Virtual warfarin clinic; Toolkit for risk stratification (this toolkit is the measurement of patients therapeutic time in range on a monthly basis within the virtual warfarin clinic)	84 (current)	Chronic patients being prescribed a oral anticoagulant therapy	ongoing	none	Patients TTR measured as part of clinical internal auditing		University College Cork; Cork University Hospital; COLLAGE (Collaboration on Ageing)
University College Cork (establisment of a virtual anticoagulant clinic)	2. Empower the patients and care givers	To empower the patience being prescribed a oral anticoagulant therapy	Implementation of coaching education or approaches that support patients.	Coaching education or approaches that support patients being prescribed a oral anticoagulant therapy	84 (current)	Chronic patients being prescribed a oral anticoagulant therapy	ongoing	none	improved patient knowledge regarding their anticoagulant therapy	Upon enrolment in the clinic, patients are educated with regards to the use of a point of care device, their warfarin therapy and their general dietary and lifestyle. Patients are provided with on-going support from the clinic on a monthly basis also if and when required.	University College Cork; Cork University Hospital; COLLAGE (Collaboration on Ageing)

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
University College Cork (establisment of a virtual anticoagulant clinic)	3. Deliver improvements in the health care system	Development of best practice with regards to the chronic management of patients following an oral anticoagulant therapy		best practice with regards to the chronic management of patients oral anticoagulant therapy; toolkit to enable this change management. Implementation of integrated or coordinated intervention to address pholypharmacy	84 (current)	Chronic patients being prescribed a oral anticoagulant therapy	ongoing	none			University College Cork; Cork University Hospital; COLLAGE (Collaboration on Ageing)
University College Cork (establisment of a virtual anticoagulant clinic)	3. Deliver improvements in the health care system	Implementation of integrated or coordinated interventions to address polypharmacy.	The patients enrolled in the virtual clinic are monitored monthly with regards to their regular medicine usage and are empowered to discuss their regular medicines with their GP and other healthcare professionals		84 (current)	Chronic patients being prescribed a oral anticoagulant therapy	ongoing	none			University College Cork; Cork University Hospital; COLLAGE (Collaboration on Ageing)
University College Cork (health literacy initiative)	1. Improve patients' adherence	To examine the issue of instructions on medication containers	To assess the impact of a standardised, simplified Patient Centred Label (PCL)	Assessment of the impact of a standardised, simplified Patient Centred Label (PCL)		Patients	01/09/2013	01/02/2014	Feasibility of PCL labelling for community pharmacy	The issue of instructions on medication containers is of paramount importance; research to date demonstrates that medication labels can be difficult to comprehend, especially for those with limited health literacy	
University College Cork (health literacy initiative)	2. Empower the patients and care givers	To improve communication between providers and patients, through enhanced awareness of health literacy.	1. To assess the health literacy of patients and to assess knowledge of personal medicines. 2. The ascertain pharmacists' perception of patient knowledge. 3. To identify common areas of miscommunication between patients and pharmacists 4. To develop strategies to improve communication between patients and pharmacists	Assessment and identification of communication gaps between pharmacists and patients		Patients	01/01/2014	01/09/2014	Qualitative assessment of communication in community pharmacy setting		
University College Cork (health literacy initiative)	3. Foster communication	To disseminate results of undertaken studies	To present undertaken studies at international meetings and also to stakeholders in the pharmacy and medical professionals.	Dissemination of results of undertaken studies at international meetings							
University Miguel Hernandez	1. Improve patients' adherence; 2. Deliver improvements in the health care system	To implement a pharmaceutical care plan between GPs, community pharmacists, elderly patients and caregivers that enables pharmacists to assess elderly patients' pharmaceutical care, to withdraw unwanted medicines and to help patients and caregivers to improve patient's adherence.	Training course to community pharmacies in elderly patients. To offer elderly patients pharmaceutical follow-up to address specific problems related with medication	Pharmaceutical care plan between GPs, community pharmacists, elderly patients and caregivers	Elderly patients	Non institutionalized population age 60 and over	October 2013	October 2014	Number of patients included in the intervention; Number of problems related drugs detected and solved.	The program will be established in a sample of community pharmacies in Alicante, Murcia and Albacete (Southeast of Spain) to assess its feasibility. This programme will improve the coordination of pharmaceutical treatments between community pharmacists, medical doctors and nurses, including the identification of patients with undiagnosed or untreated (or over treated) disease and the identification of adverse effects. One of the aims of this programme will cover the improvement of the adherence to the treatment.	University Miguel Hernandez (Dr Elsa Lopez Pintor and Dr Blanca Lumbreras) and community pharmacies in Alicante, Murcia and Albacete
University Miguel Hernandez	3. Empower the patients and care givers	To educate patients and, if appropriate, care givers about the indication for each medication and its use, and withdraw unwanted medicines with patients' consent.	To provide patient and care givers education to enhance compliance with therapy, Community pharmacists will monitor outcomes (at least monthly) in association with care givers, patients and their GPs,		Elderly patients and their caregivers	Non institutionalized population age 60 and over	October 2013	January 2014	Improvement of the patients' and caregivers' knowledge.	Pharmacists will co-operate with doctors, patients and care givers in designing, implementing and monitoring a program of pharmaceutical care in community pharmacies. Pharmacists will educate patients and, if appropriate, care givers about the indication for each medication and its use, and withdraw unwanted medicines with patients' consent.	University Miguel Hernandez (Dr Elsa Lopez Pintor and Dr Blanca Lumbreras) and community pharmacies in Alicante, Murcia and Albacete
University Miguel Hernandez	4. Research and methodology	To evaluate the pharmaceutical care program in terms of efficacy, effectiveness, improve of quality care, adherence and satisfaction.	Patients, caregivers, community pharmacists and GPs will be asked for their satisfaction with the program. Adherence to medication will be evaluated with appropriate tests.	Reporting of guidelines to implement it in other settings.	Elderly patients and their caregivers	Non institutionalized population age 60 and over	October 2013	June 2015			University Miguel Hernandez (Dr Elsa Lopez Pintor and Dr Blanca Lumbreras) and community pharmacies in Alicante, Murcia and Albacete
University Miguel Hernandez	5. Foster communication	Establishment of a website to contact GPs, community pharmacist and patients/caregivers		Website to contact GPs, community pharmacist and patients/caregivers	GPs, community pharmacist and patients/caregivers	Non institutionalized population age 60 and over	June 2015	September 2015	Patients, caregivers, GPs and community pharmacists that actively participate in the website.	In this website, the different actors will be able to know the medication and the problems related with for each patient. Moreover, this site will provide practical information to patients and care givers and a forum to discuss the main concerns about the medication.	
University of Algarve, School of Health	1. Improve patients' adherence	To improve diabetes type 2 patients' self-care by conducting a 12 month longitudinal intervention on adherence to exercise and nutrition and pharmacological therapy.	Assessment of the patient's nutritional and pharmacological stage before and after the intervention, while monitoring the patients during the follow-up period.	Longitudinal intervention on adherence to exercise and nutrition and pharmacological therapy.	90	Independent patients with diabetes type 2	October 2013	July 2014	Improve and motivate patients' adherence to self-care.	The intervention will consist of an initial nutrition and pharmacological therapy assessment, conducted by a dietician and a pharmacist. This interview aims to ensure that patients receive the most appropriate, effective and safe therapy. The objective for the intervention is to allow the patient to gain the skills needed to improve adherence to treatment. During the intervention, patients will be regularly monitored to assess care plan design in order to identify barriers to treatment adherence and encourage proper self-care.	Association for the Study of Diabetes Mellitus and Diabetic Support Algarve- A.E.D.M.A.D.A. (Associação para o Estudo da Diabetes Mellitus e Apoio ao Diabético do Algarve) Regional Health Administration of the region of Algarve - ARS Algarve (Administração Regional de Saúde do Algarve) Sport Division of the Council of Faro (Divisão de Desporto da Câmara Municipal de Faro)
University of Algarve, School of Health	2. Empower the patients and care givers	To provide individual and group education sessions about nutrition, exercise and theraphy adherence.	Carry out sessions for patients and caregivers in order to improve their knowledge in treatment adherence.	Education sessions about nutrition, exercise and theraphy adherence.	90 plus care givers	Independent patients with diabetes type 2	October 2013	July 2014	Improve awareness on diabetes complications and monitoring.	Sessions for caregivers (family, friends or other caregivers) are also planned in order to ensure that they, too, have the knowledge needed to promote treatment adherence.	as above

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
University of Algarve, School of Health	2. Empower the patients and care givers	To promote an online discussion forum to contribute to patients' and caregivers social networking about nutrition, exercise and theraphy adherence.	Create an online discussion forum open to all patients and care givers, moderate by a health professional.	Promote discussion regarding diabetes and provide information to target population.	90 plus care givers	Independent patients with diabetes type 2	October 2013	July 2014	Report on the FAQ on Diabetes.		as above
University of Algarve, School of Health	3. Deliver improvements in the health care system	To establish the best approach to change lifestyle regarding diet and exercise in elderly diabetes patients and to increase adherence to these behaviours.	Develop a multidisciplinary approach to be used in the diabetes treatment.	Best practices Code	90	Independent patients with diabetes type 2	October 2013	July 2014	Improve metabolic control in diabetic patients, using a multidisciplinary patient-tailored care plan.	Intervention management of pharmacotherapy will be part of a separate service offered in a clinical specialty, within an existing multidisciplinary team that provides clinical practice and support for diabetic patients, contributing to increase medication adherence	as above
University of Algarve, School of Health	4. Research and methodology	To contribute to establish a pharmacotherapeutic intervention that help to establish a pharmaceutical care plan specific to diabetes, not only to improve the management of drug therapy for patients (promoting the effectiveness and safety of taking medication), as well as to increase adherence to treatment. To contribute to implement a patient-centered care plan focused on therapeutic adherence, beyond the intervention and counselling by the physician and nurse.	Develop a pharmaceutical care plan specific to diabetes, patient centred. Statistical techniques are used to analyse the database collected along this one year period.	Pharmacotherapeutic intervention that help to establish a pharmaceutical care plan specific to diabetes	90	Independent patients with diabetes type 2	February 2014	September 2014	Improve metabolic control in diabetic patients, using a pharmaceutical care plan specific to diabetes.	If educational, pharmacotherapeutic or diet and exercise interventions show to be efficient in increasing lifestyle quality over the follow up period, it may indicate that support through community settings, namely patient's associations, and public sport facilities may play an important role in managing elderly diabetes.	as above
University of Florence	1. Improve patients' adherence	To monitor prescriptions for anti-osteoporotic treatments in different communities analysing regional/national health registries	To analyse and control quantities, days od therapy for each considered compund and number of patients, calculating frequencies and MPR (medical prescription rate) in general and for each patient use of drugs in time to ccalculat adherence (dynamic analyses: switch of therapy in the general popualtion and in the setting of patients after a hip[fracture	Monitoring of prescriptions for anti-osteoporotic treatments in different communities	General population of a specific regional setting (e.g. population of Tuscany, Italy) and fractured patents after 65 years	Citizens, patients	2013/Q3	2014/Q3	Evaluation of the use of antiosteoporotic compounds (general adherence) and adherence for each specific compound in relation to age groups		University of Florence; University of Liege; Autonomous University of Barcelona; University of Sheffield; University of Ioannina; International Osteoporosis Foundation (IOF); European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO); Fondazione Italiana per la Ricerca sulle Malattie Ossee (FIRMO); Società Italiana di Ortopedia e Medicina (ORTOMED); DIPINT-Tuscany Region; Amgen Dompé; Italy Stroder, EL.EN. Group
University of Florence	2. Empower the patients and care givers	To develop television-based communication systems, internet-based platforms and/or smartphone applications to provide feedback media tools to check adherence and empower both patients and caregivers in active management of the chronic condition (osteoporosis)	Setting-up of videos to be circulated in the hospital (closed-circuit television) in orthopedic departments to show the in-patients the meaning and the consequences of having had a hip fracture; developing of simple internet-based tablet and/or smartphone educational applications on osteoporosis and the importance of a proper treatment, and for feedback systems to be activated by the pharmacists after the first prescription	Television-based communication systems, internet-based platforms and/or smartphone applications to provide feedback media tools to check adherence and empower patients and caregivers	Patients over 65 yrs, having experienced a hip fracture	Patients	2014/Q1	2015/Q1	Increase patient awareness of osteoporosis consequences and increase the understanding that maintaining a good adherence to treatments greatly reduces morbidity and mortality rates; help the process of monitoring (remote control) by health care providers.		University of Florence; University of Liege; Autonomous University of Barcelona; University of Sheffield; University of Ioannina; International Osteoporosis Foundation (IOF); European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO); Fondazione Italiana per la Ricerca sulle Malattie Ossee (FIRMO); Società Italiana di Ortopedia e Medicina (ORTOMED); DIPINT-Tuscany Region; Amgen Dompé; Italy Stroder, EL.EN. Group
University of Florence	3. Deliver improvements in the health care system	To develop physician specific training system to improve efficacy in elderly patient communication at the time of the first prescription in order to underline the long-term benefits of anti-osteoporotic treatment and reassure on possible side-effects	Setting-up of common guidelines for general practitioners to be applied in a regional setting to improve patient understanding of the disease (osteoporosis) and FAQs for the patient to be distributed at the time of the first prescription	Physician specific training system to improve efficacy in elderly patient communication at the time of the first prescription	Patients with osteoporosis requiring therapy	Patients	2014/Q3	2015/Q3	Provide specific information regarding osteoporosis treatment and regarding the importance of a good adherence in the long-term, reassuring about possible side effects		University of Florence; University of Liege; Autonomous University of Barcelona; University of Sheffield; University of Ioannina; International Osteoporosis Foundation (IOF); European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO); Fondazione Italiana per la Ricerca sulle Malattie Ossee (FIRMO); Società Italiana di Ortopedia e Medicina (ORTOMED); DIPINT-Tuscany Region; Amgen Dompé; Italy Stroder, EL.EN. Group

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
University of Florence	4. Research and methodology	To set up validated, evidence-based intervention protocols in the community to be applied also to other chronic conditions to improve adherence and increase HLY	Developing mechanisms(e.g. reward system) to improve adherence for antiosteoporotic medications.	Intervention protocols to be applied also to other chronic conditions (in addition to osteoporosis)	Patients with osteoporosis requiring therapy	Patients	2014/Q3	2015/Q3	Improve adherence for anti-osteoporotic treatments, reducing fracture-related morbidity and mortality		University of Florence; University of Liege; Autonomous University of Barcelona; University of Sheffield; University of Ioannina; International Osteoporosis Foundation (IOF); European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO); Fondazione Italiana per la Ricerca sulle Malattie Ossee (FIRMO); Società Italiana di Ortopedia e Medicina (ORTOMED); DIPINT-Tuscany Region; Amgen Dompé; Italy Stroder, EL.EN. Group
University of Florence	5. Foster communication	To share and suggest tools of intervention between research/academia, care/health providers and public organisms of health	Developing internet-based platforms to share information and feedback systems with territory-based health services and public organisms of health	Shared internet-based platforms for medical staff and administrative/political staff			2015/Q1	2015/Q3	Collection/repository of practices in order to set specific-addressed intervention to improve adherence		University of Florence; University of Liege; Autonomous University of Barcelona; University of Sheffield; University of Ioannina; International Osteoporosis Foundation (IOF); European Society for Clinical and Economic Aspects of Osteoporosis and Osteoarthritis (ESCEO); Fondazione Italiana per la Ricerca sulle Malattie Ossee (FIRMO); Società Italiana di Ortopedia e Medicina (ORTOMED); DIPINT-Tuscany Region; Amgen Dompé; Italy Stroder, EL.EN. Group
University of Padua	1. Improve patients' adherence	To study individual, social, and environmental barriers and determinants of exercise in older adults	Analysis and investigation of the personal, social and environmental variables involved in elderly physical activity participation with the use of questionnaires and focus group.	Perceived barriers to exercise, motivation to exercise, perceived environmental accesibility and safety, social support (by family and friends), Socio-Economical Status (SES).	Not given for all the action areas, we will include both elderly from the general population and from clinical population.	Elderly, age > 65 years	Sept. 2013	Dec. 2014	Personal, social and environmental variables that influence and determine exercise practice among older people.	Support tools will be: a) devices for monitoring PA quantity and quality and motor skills, that permit distance online communication with care givers; b) specific instruments for testing and support motivation to exercise (questionnaires, focus groups, motor skills assessment).	University of Padua; University of Leuven; University of Augsburg; University of Londrina; Parco dei Tigli psychiatric hospital; Technogym spa; ASL 6 vicenza.
University of Padua	1. Improve patients' adherence	To improve design and prescription of exercise programs for older people in the general population and for groups of independent patients	Analysis of the effectiveness of different exercise programs for older people, both healthy and outpatiens, from different countries and settings.	Investigated areas will be personal and social. Physical fitness will be measured with objective tests and devices.		Elderly, age > 65 years	Sept. 2013	Dec. 2014	Perceived quality of life, mood, enjoyment of physical activity, physical activity quantity and motor skills important for daily living activities such as balance, endurance and strenght.		as above
University of Padua	1. Improve patients' adherence	To promote strategies at individual and community levels to enhance the adherence to exercise	To deliver different strategies to motivate older adults to adopt an active lifestyle and maintain it, traying to endorse personal solution to cope with pain and fatigue and to overcome psychological barriers.	Evaluation of exercise adherence investigating by objective and subjective physical activity measures.		Elderly, age > 65 years	Sept. 2013	Dec. 2014	Physical activity quantity and exercise frequency.		as above
University of Padua	1. Improve patients' adherence	To better understand whether and how exercise can facilitate the adherence to care plans of independent patients.	To deliver different training programs for elderly, analysing exercise influence in care plans adherence and underlying different effectiveness of different programs.	Evaluation of the adherence to care plans of independent patients involving health care staff and families.		Elderly, age > 65 years, independent patients.	Sept. 2013	Dec. 2014	Adherence to personal health care plans.		as above
University of Padua	2. Empower the patients and care givers	Implementation of individual and group counseling and education initiatives at both levels of older people/patients and care givers	To deliver individual and group conseling programs to promote physical activity among older adults (healthy and clinical) and health care staff and care givers.	Counseling and educational initiatives for older people/patients and care givers		Elderly, clinical and general population, and care givers.	Sept. 2013	Dec. 2014	Counseling interventions for older people and care givers, standardization of the interventions across involved countries.		as above
University of Padua	2. Empower the patients and care givers	Creation of networks constituted by universities, public and private health care providers, industry and elderly's groups and associations	Exchange expertise, aims and procedure in the delivering of programs and care for elderly people.	Creation of networks constituted by universities, public and private health care providers, industry and elderly's groups and associations		Professionals from universities, healt care providers, hospitals, cultural and sport associations.	Sept. 2013	Dec. 2014	Networks of different professionals involved in the care and health promotion for an active healthy aging.		as above
University of Padua	3. Deliver improvements in the health care system	To suggest criteria for a better prescription of exercise for older people in general population and in older independent patients	Analysis of the organizational models of existing services (best practices) and the physical, pathophysiological and psychological outcomes of exercise involvement of older people/patients, by comparing different levels of engagement and various structures and geographical areas,	Analysis of the organizational models of existing services and the physical, pathophysiological and psychological outcomes of exercise involvement of older people/patients		Family physicians and clinicians	Sept. 2013	Dec. 2014	Description of organizational models across different countries for older adults		as above
University of Padua	3. Deliver improvements in the health care system	Development of specific tools to test the effectiveness of training programs in the middle and long term	To deliver different training programs for elderly, analysing personal and physical outcomes after different intensities and modalities of exercising, such as endurance compared to resistance training, and different modalities to carry out specific training for balance control.	Tools to test the effectiveness of training programs in the middle and long term		Older adults, both from healthy or clinical population, with more than 65 years.	Sept. 2013	Dec. 2014	Battery of test to evaluate the physical functioning in relation to the daily living activities and to test balance control.		as above
University of Padua	4. Research and methodology	Provide comparative data about exercise prescription and adherence of older people in general population and of elderly independent patients with specific problem	Description of different exercise programs across involved countries and older populations (clinical and general). Evaluation of exercise adherence through objective and subjective measure of exercise frequency.	Comparative data about exercise prescription and adherence of older people in general population and of elderly independent patients with specific problem		Older adults, both from healthy or clinical population, with more than 65 years.	Sept. 2013	Dec. 2014	Data about exercise prescription and adherence of older people in general population and of elderly independent patients from different countries.	Comparative data in terms of: subjective and objective evaluation of adherence to exercise prescription; the main physical, pathophysiological and psychological outcomes; adherence to care plans in older people who are physically active and in those who are sedentary.	as above

Commitment owner	Objective	Action	Activities	Deliverable	Target population: # people	Target population: category	Starting date	Deadline	Main Outcome	Remarks	Partners involved
University of Padua	4. Research and methodology	To Increase the knowledge and skills of different health care professionals regarding the benefits of physical activity in older people.	Delivering of educational programs for health care professionals, with contents on physical activity benefits, physical activity for older adults and physical activity for persons with special needs	Increasing of the knowledge and skills of health care professionals regarding the benefits of physical activity in older people.		Health care professionals.	Sept. 2013	Dec. 2014	Knowledge on physical activity benefits, improvement of physical activity attitudes among health care professionals.		as above
University of Padua	4. Research and methodology	Development of instrument for the cost-effectiveness analysis of different regional models.	Analysis and description of regional model for healthy aging promotion with physical activity programs. Collection of data on numerosity of involved population, proposed activities, system of evaluation and satisfaction of professionals and participants.	Instrument for the cost-effectiveness analysis of different regional models.		International partners and researchers	Sept. 2013	Dec. 2014	The development of an international instrument for the analysis of different regional models of care.		as above
University of Padua	5. Foster communication	To contribute to the development of a database/repository for clinical trials about exercise in the elderly, facilitating international, multidisciplinary co-operation.	Creation of a web-database accessible for the involved international group, with the possibility to see values of other countries about investigated variables and outcomes.	Web platform with international access and exchange of data and results about intervention on older people.		International partners and researchers	Sept. 2013	Dec. 2014	Web database and platform on investigated variables regarding physical activity among older adults.		as above
University of Padua	5. Foster communication	To contribute to the development of ICT, including data bases, platforms and other instrument to exchange best practices on adherence to exercise factors.	Creation of a computer tailored intervention for the promotion of physical activity and active living among elderly, exchanged with other countries, and implemented with sperimental data.	Effectiveness of the computer tailored intervention on physical activity practice among older adults.		Older adults computer users, capable to use Internet.	Sept. 2013	Dec. 2014	Physical activity quantity and perceived quality of life.		as above
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	1. Improve patients' adherence	To identify problems of adherence to polypharmacy in the elderly population in Piedmont.	1. selection of subjects by cluster randomization: clusters will be hospitals, nursing homes, and local pharmaceutical service units; 2. identification of 'no compliance' situations for each drug and its causes, and screening of potential cases of drug-induced intoxication	Survey to identify problems of adherence to polypharmacy in the elderly population in Piedmont.	1) 5.000 patients; 2) 500.000 citizens	1) patients (hospitalized, institutionalized); 2) 65+ years old citizens				Determinants of polypharmacy other than comorbidity will be examined, including specific symptoms, age, and functional/cognitive status	University of Turin; Piemonte Region; Order of Physicians and Dentists in the Province of Turin; Order of Pharmacists of the Piemonte Region; Federfarma Piemonte (Association of Owner Pharmacists of Piedmont Region)
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	3. Deliver improvements in the health care system	To assess the appropriateness of prescriptions, formulations, administration modalities, and drug-drug, drug-food, and supplement-drug interactions.		Geriatric therapy protocols							
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	3. Deliver improvements in the health care system	To implement training courses targeting physicians, pharmacists, clinical physicians, and nurses.		Training courses targeting physicians, pharmacists, clinical physicians, and nurses.	Professionals treating elderly patients: 1) 200 physicians; 2) 400 pharmacists; 3) 300 nurses	1) primary care physicians and clinical physicians; 2) local pharmacists; 3) nurses in hospital geriatric departments and in long-term institutions					
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	3. Deliver improvements in the health care system	Establishment of guidelines (and their communication to other Italian Regions) for correct drug use in the elderly and for promotion of adherence to treatments		Guidelines for managing specialized therapy in the elderly, targeting primary-care physicians and clinicians. Handbook to explain correct drug use, targeting the elderly, their families, and unskilled service personnel.	1) primary care physicians and clinicians; 2) 805.000 elderly people over 65 years old	1) primary care clinicians in Piemonte region; 2) elderly people over 65 years old in Piemonte region					
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	3. Deliver improvements in the health care system	Clinical audit of integrated care and implementation of best practices and guidelines		Clinical audit of integrated care							
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	4. Research and methodology	Publication of new guidelines (on international specialised journals) to perform clinical trials in older people before marketing new drugs		Guidelines to perform clinical trials in older people before marketing new drugs		Scientific Community involved in clinical trials on new drugs targeted to older people					
University of Turin, Dipartimento di Scienza e Tecnologia del Farmaco	5. Foster communication	ICT and portal communication to maximize clinical communication		ICT and portal for clinical communication among the different parners involved in geriatric theraphy		Medical and nursing staff in in hospital geriatric departments and in long-term institutions; pharmacists involved in counselling to 65+ years old citizens					