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Associated with document Ref. Ares(2020)3808350 - 20/07/2020

EUROPEAN COMMISSION
Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)

The Director

GRANT AGREEMENT

NUMBER 951442 — JADECARE

This **Agreement** ('the Agreement') is **between** the following parties:

on the one part,

the **Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)** ('the Agency'), under the powers delegated by the European Commission ('the Commission'), represented for the purposes of signature of this Agreement by Véronique WASBAUER, Director, or his/her duly authorised representative,

and

on the other part,

1. 'the coordinator':

ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE (KG), established in RONDA DE AZKUE 1 TORRE DEL BILBAO EXHIBITION CENTRE, BARAKALDO 48902, Spain, VAT number: ESG95646014, represented for the purposes of signing the Agreement by Director, Esteban DE MANUEL KEENOY

and the following other beneficiaries, if they sign their 'Accession Form' (see Annex 3 and Article 40):

2. **MINISTRY OF CIVIL AFFAIRS (MCA)**, established in Trg Bosne i Hercegovine 1, SARAJEVO 71000, Bosnia and Herzegovina,

3. **HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO (CIPH)**, established in ROCKEFELLEROVA 7, ZAGREB 10000, Croatia, VAT number: HR75297532041,

4. **MINISTERSTVO ZDRAVOTNICTVI CESKE REPUBLIKY (MZCR)**, established in PALACKEHO NAMESTI 375/4, PRAHA 12801, Czech Republic,

5. **REGION NORDJYLLAND (NORTH DENMARK REGION) (RND)**, established in Niels Bohrs Vej 30, AALBORG 9220, Denmark, VAT number: DK29190941,

6. **SOTSIAALMINISTEERIUM (MSAE)**, established in Suur-Ameerika 1, TALLINN 10122, Estonia,

7. **EUROMETROPOLE DE STRASBOURG (EUSTRAS)**, established in 1 PARC DE L'ETOILE, STRASBOURG CEDEX 67076, France,

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8. **BEHOERDE FUER ARBEIT, GESUNDHEIT, SOZIALES, FAMILIE UND INTEGRATION HAMBURG (BAGSFI)**, established in Billstrasse 80, Hamburg 20539, Germany, VAT number: DE118509725,

9. **4I DIOIKISI YGEIONOMIKIS PERIFEREIAS MAKEDONIAS KAI THRAKIS (4THYPE)**, established in 16 ARISTOTELOUS STR, THESSALONIKI 54623, Greece, VAT number: EL999122126,

10. **ALLAMI EGESZSEGUGYI ELLATO KOZPONT (AEEK)**, established in DIOS AROK 3, BUDAPEST 1125, Hungary, VAT number: HU15324683,

11. **AGENZIA NAZIONALE PER I SERVIZI SANITARI REGIONALI (AGENAS)**, established in VIA PUGLIE 23, ROMA 00187, Italy,

12. **NACIONALAIS VESELIBAS DIENESTS (NVD)**, established in 31 Cēsu str., k-3, 6.entrance, Riga LV-1012, Latvia, VAT number: 90009649337,

13. **LIETUVOS RESPUBLIKOS SVEIKATOS APSAUGOS MINISTERIJA (LR SAM)**, established in VILNIAUS G 33, VILNIUS LT 01506, Lithuania,

14. **ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP (ACSS)**, established in AVENIDA DO BRASIL 53, PARQUE DE SAUDE DE LISBOA EDIFICIO 16, Lisboa 1700-063, Portugal, VAT number: PT508188423,

15. **MINISTARSTVO ZDRAVLJE (MoHRS)**, established in NEMANJINA 22-26, BELGRADE 11000, Serbia,

16. **NACIONALNI INSTITUT ZA JAVNO ZDRAVJE (NIJZ)**, established in TRUBARJEVA CESTA 2, LJUBLJANA 1000, Slovenia, VAT number: SI44724535,

17. **REGIONAL HEALTH AND SOCIAL CARE BOARD (HSCB)**, established in LINENHALL STREET 12-22, BELFAST BT2 8BS, United Kingdom, VAT number: GB888808059,

Unless otherwise specified, references to ‘beneficiary’ or ‘beneficiaries’ include the coordinator.

The parties referred to above have agreed to enter into the Agreement under the terms and conditions below.

By signing the Agreement or the Accession Form, the beneficiaries accept the grant and agree to implement it under their own responsibility and in accordance with the Agreement, with all the obligations and conditions it sets out.

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The Agreement is composed of:

Terms and Conditions

Annex 1 Description of the action

Annex 2 Estimated budget for the action

Annex 2a Not applicable

Annex 3 Accession Forms

Annex 4 Model for the financial statements

Annex 5 Model for the certificate on the financial statements (CFS)

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CHAPTER 1 GENERAL

ARTICLE 1 — SUBJECT OF THE AGREEMENT

This Agreement sets out the rights and obligations and the terms and conditions applicable to the grant awarded to the beneficiaries for implementing the action set out in Chapter 2.

CHAPTER 2 ACTION

ARTICLE 2 — ACTION TO BE IMPLEMENTED

The grant is awarded for the action entitled '**Joint Action on implementation of digitally enabled integrated person-centred care — JADECARE**' **('action')**, as described in Annex 1.

ARTICLE 3 — DURATION AND STARTING DATE OF THE ACTION

The duration of the action will be **36 months** as of 01/10/2020 ('**starting date of the action**').

ARTICLE 4 — ESTIMATED BUDGET AND BUDGET TRANSFERS

4.1 Estimated budget

The '**estimated budget**' for the action is set out in Annex 2.

It contains the estimated eligible costs and the forms of costs, broken down by beneficiary (and affiliated entity) and budget category (see Articles 5, 6 and 11).

4.2 Budget transfers

The estimated budget breakdown indicated in Annex 2 may be adjusted — without an amendment (see Article 39) — by transfers of amounts between beneficiaries, budget categories and/or forms of costs set out in Annex 2, if the action is implemented as described in Annex 1.

However, the beneficiaries may not add costs relating to subcontracts not provided for in Annex 1, unless such additional subcontracts are approved by an amendment or in accordance with Article 10.

CHAPTER 3 GRANT

ARTICLE 5 — GRANT AMOUNT, FORM OF GRANT, REIMBURSEMENT RATE AND FORMS OF COSTS

5.1 Maximum grant amount

The '**maximum grant amount**' is **EUR 3 999 226.00** (three million nine hundred and ninety nine thousand two hundred and twenty six EURO).

5.2 Form of grant, reimbursement rate and forms of costs

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The grant reimburses **80% of the action's eligible costs** (see Article 6) (‘**reimbursement of eligible costs grant**’) (see Annex 2).

The estimated eligible costs of the action are EUR **4 999 032.51** (four million nine hundred and ninety nine thousand thirty two EURO and fifty one eurocents).

Eligible costs (see Article 6) must be declared under the following forms (**'forms of costs'** or **'costs forms'**):

(a) for **direct personnel costs**: as actually incurred costs (**actual costs**);

(b) for **direct costs of subcontracting**: as actually incurred costs (**actual costs**);

(c) for **other direct costs**: as actually incurred costs (**actual costs**);

(d) for **indirect costs**: on the basis of a flat-rate applied as set out in Article 6.2.D (‘**flat-rate costs**’);

5.3 Final grant amount — Calculation

The ‘**final grant amount**’ depends on the actual extent to which the action is implemented in accordance with the Agreement’s terms and conditions.

This amount is calculated by the Agency — when the payment of the balance is made — in the following steps:

Step 1 – Application of the reimbursement rate to the eligible costs

Step 2 – Limit to the maximum grant amount

Step 3 – Reduction due to the no-profit rule

Step 4 – Reduction due to substantial errors, irregularities or fraud or serious breach of obligations

5.3.1 Step 1 — Application of the reimbursement rate to the eligible costs

The reimbursement rate (see Article 5.2) is applied to the eligible costs (actual costs and flat-rate costs; see Article 6) declared by the beneficiaries and affiliated entities (see Article 15) and approved by the Agency (see Article 16).

5.3.2 Step 2 — Limit to the maximum grant amount

If the amount obtained following Step 1 is higher than the maximum grant amount set out in Article 5.1, it will be limited to the latter.

5.3.3 Step 3 — Reduction due to the no-profit rule

The grant must not produce a profit.

‘**Profit**’ means the surplus of the amount obtained following Steps 1 and 2 plus the action’s total receipts, over the action’s total eligible costs.

The ‘**action’s total eligible costs**’ are the consolidated total eligible costs approved by the Agency.

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The '**action's total receipts**' are the consolidated total receipts generated during its duration (see Article 3).

The following are considered **receipts**:

(a) income generated by the action;

(b) financial contributions given by third parties to the beneficiary or to an affiliated entity specifically to be used for costs that are eligible under the action.

The following are however **not** considered receipts:

(a) financial contributions by third parties, if they may be used to cover costs other than the eligible costs (see Article 6);

(b) financial contributions by third parties with no obligation to repay any amount unused at the end of the period set out in Article 3.

If there is a profit, it will be deducted in proportion to the final rate of reimbursement of the eligible actual costs approved by the Agency (as compared to the amount calculated following Steps 1 and 2).

5.3.4 Step 4 — Reduction due to substantial errors, irregularities or fraud or serious breach of obligations

If the grant is reduced (see Article 27), the Agency will calculate the reduced grant amount by deducting the amount of the reduction (calculated in proportion to the seriousness of the errors, irregularities or fraud or breach of obligations, in accordance with Article 27.2) from the maximum grant amount set out in Article 5.1.

The final grant amount will be the lower of the following two:

- the amount obtained following Steps 1 to 3 or
- the reduced grant amount following Step 4.

5.4 Revised final grant amount — Calculation

If — after the payment of the balance (in particular, after checks, reviews, audits or investigations; see Article 17) — the Agency rejects costs (see Article 26) or reduces the grant (see Article 27), it will calculate the '**revised final grant amount**' for the action or for the beneficiary concerned.

This amount is calculated by the Agency on the basis of the findings, as follows:

- in case of **rejection of costs**: by applying the reimbursement rate to the *revised* eligible costs approved by the Agency for the beneficiary concerned;
- in case of **reduction of the grant**: by deducting the amount of the reduction (calculated in proportion to the seriousness of the errors, irregularities or fraud or breach of obligations, in accordance with Article 27.2) from the maximum grant amount set out in Article 5.1 or from the maximum EU contribution indicated for the beneficiary in the estimated budget (see Annex 2).

In case of **rejection of costs and reduction of the grant**, the revised final grant amount will be the lower of the two amounts above.

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ARTICLE 6 — ELIGIBLE AND INELIGIBLE COSTS

6.1 General conditions for costs to be eligible

'**Eligible costs**' are costs that meet the following criteria:

(a) for **actual costs**:

(i) they must be actually incurred by the beneficiary;

(ii) they must be incurred in the period set out in Article 3, with the exception of costs relating to the submission of the periodic report for the last reporting period and the final report (see Article 15);

(iii) they must be indicated in the estimated budget set out in Annex 2;

(iv) they must be incurred in connection with the action as described in Annex 1 and necessary for its implementation;

(v) they must be identifiable and verifiable, in particular recorded in the beneficiary's accounts in accordance with the accounting standards applicable in the country where the beneficiary is established and with the beneficiary's usual cost accounting practices;

(vi) they must comply with the applicable national law on taxes, labour and social security, and

(vii) they must be reasonable, justified and must comply with the principle of sound financial management, in particular regarding economy and efficiency;

(b) for **unit costs**: not applicable;

(c) for **flat-rate costs**:

(i) they must be calculated by applying the flat-rate set out in Annex 2, and

(ii) the costs (actual costs) to which the flat-rate is applied must comply with the conditions for eligibility set out in this Article.

(d) for **lump sum costs**: not applicable;

6.2 Specific conditions for costs to be eligible

Costs are eligible if they comply with the general conditions (see above) and the specific conditions set out below, for each of the following budget categories:

A. direct personnel costs;
B. direct costs of subcontracting;
C. other direct costs;
D. indirect costs;

'Direct costs' are costs that are directly linked to the action implementation and can therefore be attributed to it directly. They must not include any indirect costs (see Point D below).

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'Indirect costs' are costs that are not directly linked to the action implementation and therefore cannot be attributed directly to it.

A. Direct personnel costs

Types of eligible personnel costs

A.1 Personnel costs are eligible if they are related to personnel working for the beneficiary under an employment contract (or equivalent appointing act) and assigned to the action ('**costs for employees (or equivalent)**'). They must be limited to salaries, social security contributions, taxes and other costs included in the **remuneration**, if they arise from national law or the employment contract (or equivalent appointing act).

They may also include **additional remuneration** for personnel assigned to the action (including payments on the basis of supplementary contracts regardless of their nature), if:

(a) it is part of the beneficiary's usual remuneration practices and is paid in a consistent manner whenever the same kind of work or expertise is required;

(b) the criteria used to calculate the supplementary payments are objective and generally applied by the beneficiary, regardless of the source of funding used.

A.2 The **costs for natural persons working under a direct contract** with the beneficiary other than an employment contract or **seconded by a third party against payment** are eligible personnel costs, if:

(a) the person works under the beneficiary's instructions and, unless otherwise agreed with the beneficiary, on the beneficiary's premises;

(b) the result of the work carried out belongs to the beneficiary, and

(c) the costs are not significantly different from those for personnel performing similar tasks under an employment contract with the beneficiary.

Calculation

Personnel costs must be calculated by the beneficiaries as follows:

- for persons **working exclusively on the action**:

  {monthly rate for the person

  multiplied by

  number of actual months worked on the action}.

  The months declared for these persons may not be declared for any other EU or Euratom grant.

  The **'monthly rate'** is calculated as follows:

  {annual personnel costs for the person

  divided by

  12}

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using the personnel costs for each full financial year covered by the reporting period concerned. If a financial year is not closed at the end of the reporting period, the beneficiaries must use the monthly rate of the last closed financial year available.

- for all **other** persons:

  {daily rate for the person

  multiplied by

  number of actual days worked on the action (rounded up or down to the nearest half-day)}.

  The number of actual days declared for a person must be identifiable and verifiable (see Article 13).

  The total number of days declared in EU or Euratom grants, for a person for a year, cannot be higher than the annual productive days used for the calculations of the daily rate. Therefore, the maximum number of days that can be declared for the grant are:

  {number of annual productive days for the year (see below)

  minus

  total number of days declared by the beneficiary, for that person for that year, for other EU or Euratom grants}.

  The '**daily rate**' is calculated as follows:

  {annual personnel costs for the person

  divided by

  number of individual annual productive days}

  using the personnel costs and the number of annual productive days for each full financial year covered by the reporting period concerned. If a financial year is not closed at the end of the reporting period, the beneficiaries must use the daily rate of the last closed financial year available.

  The 'number of individual annual productive days' is the total actual days worked by the person in the year. It may not include holidays and other absences (such as sick leave, maternity leave, special leave, etc). However, it may include overtime and time spent in meetings, trainings and other similar activities.

B. Direct costs of subcontracting (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are eligible if the conditions in Article 10.1.1 are met.

C. Other direct costs

C.1 **Travel costs and related subsistence allowances** (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are eligible if they are in line with the beneficiary's usual practices on travel.

C.2 The **depreciation costs of equipment, infrastructure or other assets** (new or second-hand) as recorded in the beneficiary's accounts are eligible, if they were purchased in accordance

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with Article 9.1.1 and written off in accordance with international accounting standards and the beneficiary's usual accounting practices.

The **costs of renting or leasing** equipment, infrastructure or other assets (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are also eligible, if they do not exceed the depreciation costs of similar equipment, infrastructure or assets and do not include any financing fees.

The only portion of the costs that will be taken into account is that which corresponds to the duration of the action and rate of actual use for the purposes of the action.

C.3 **Costs of other goods and services** (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are eligible, if they are purchased specifically for the action and in accordance with Article 9.1.1.

Such goods and services include, for instance, consumables and supplies, dissemination, protection of results, certificates on the financial statements (if they are required by the Agreement), translations and publications.

D. Indirect costs

Indirect costs are eligible if they are declared on the basis of the flat-rate of 7% of the eligible direct costs (see Article 5.2 and Points A to C above).

Beneficiaries receiving an operating grant[1] financed by the EU or Euratom budget cannot declare indirect costs for the period covered by the operating grant.

6.3 Conditions for costs of affiliated entities to be eligible

Costs incurred by affiliated entities are eligible if they fulfil — mutatis mutandis — the general and specific conditions for eligibility set out in this Article (Article 6.1 and 6.2) and Article 11.1.1.

6.4 Ineligible costs

'**Ineligible costs**' are:

(a) costs that do not comply with the conditions set out above (Article 6.1 to 6.3), in particular:

(i) costs related to return on capital;

(ii) debt and debt service charges;

(iii) provisions for future losses or debts;

(iv) interest owed;

[1] For the definition, see Article 121(1)(b) of Regulation (EU, Euratom) No 966/2012 of the European Parliament and of the Council of 25 October 2012 on the financial rules applicable to the general budget of the Union and repealing Council Regulation (EC, Euratom) No 1605/2002 (OJ L 218, 26.10.2012, p.1) ('**Financial Regulation No 966/2012**'): '**operating grant**' means direct financial contribution, by way of donation, from the budget in order to finance the functioning of a body which pursues an aim of general EU interest or has an objective forming part of and supporting an EU policy.

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(v) doubtful debts;

(vi) currency exchange losses;

(vii) bank costs charged by the beneficiary's bank for transfers from the Agency;

(viii) excessive or reckless expenditure;

(ix) deductible VAT;

(x) costs incurred during suspension of the implementation of the action (see Article 33);

(xi) in-kind contributions provided by third parties;

(b) costs declared under another EU or Euratom grant (including grants awarded by a Member State and financed by the EU or Euratom budget and grants awarded by bodies other than the Agency for the purpose of implementing the EU or Euratom budget); in particular, indirect costs if the beneficiary is already receiving an operating grant financed by the EU or Euratom budget in the same period;

(c) costs for staff of a national (or local) administration, for activities that are part of the administration's normal activities (i.e. not undertaken only because of the grant);

(d) costs (especially travel and subsistence costs) for staff or representatives of EU institutions, bodies or agencies.

6.5 Consequences of declaration of ineligible costs

Declared costs that are ineligible will be rejected (see Article 26).

This may also lead to any of the other measures described in Chapter 6.

CHAPTER 4 RIGHTS AND OBLIGATIONS OF THE PARTIES

SECTION 1 RIGHTS AND OBLIGATIONS RELATED TO IMPLEMENTING THE ACTION

ARTICLE 7 — GENERAL OBLIGATION TO PROPERLY IMPLEMENT THE ACTION

7.1 General obligation to properly implement the action

The beneficiaries must implement the action as described in Annex 1 and in compliance with the provisions of the Agreement and all legal obligations under applicable EU, international and national law.

7.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

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Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 8 — RESOURCES TO IMPLEMENT THE ACTION — THIRD PARTIES INVOLVED IN THE ACTION

The beneficiaries must have the appropriate resources to implement the action.

If it is necessary to implement the action, the beneficiaries may:

- purchase goods, works and services (see Article 9);
- call upon subcontractors to implement action tasks described in Annex 1 (see Article 10);
- call upon affiliated entities to implement action tasks described in Annex 1 (see Article 11).

In these cases, the beneficiaries retain sole responsibility towards the Agency and the other beneficiaries for implementing the action.

ARTICLE 8a — IMPLEMENTATION OF ACTION TASKS BY BENEFICIARIES NOT RECEIVING EU FUNDING

Not applicable

ARTICLE 9 — PURCHASE OF GOODS, WORKS OR SERVICES

9.1 Rules for purchasing goods, works or services

9.1.1 If necessary to implement the action, the beneficiaries may purchase goods, works or services.

The beneficiaries must make such purchases ensuring the best value for money or, if appropriate, the lowest price. In doing so, they must avoid any conflict of interests (see Article 20).

The beneficiaries must ensure that the Agency, the Commission, the European Court of Auditors (ECA) and the European Anti-fraud Office (OLAF) can exercise their rights under Articles 17 and 18 also towards their contractors.

9.1.2 Beneficiaries that are 'contracting authorities' within the meaning of Directive 2004/18/EC[2] (or 2014/24/EU[3]) or 'contracting entities' within the meaning of Directive 2004/17/EC[4] (or 2014/25/EU[5]) must comply with the applicable national law on public procurement.

9.2 Consequences of non-compliance

[2] Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public work contracts, public supply contracts and public service contracts (OJ L 134, 30.04.2004, p. 114).

[3] Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement and repealing Directive 2004/18/EC (OJ L 94, 28.3.2014, p. 65).

[4] Directive 2004/17/EC of the European Parliament and of the Council of 31 March 2004 coordinating the procurement procedures of entities operating in the water, energy, transport and postal services sectors (OJ L 134, 30.04.2004, p. 1).

[5] Directive 2014/25/EU of the European Parliament and of the Council of 26 February 2014 on procurement by entities operating in the water, energy, transport and postal services sectors and repealing Directive 2004/17/EC (OJ L 94, 28.3.2014, p. 243).

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If a beneficiary breaches any of its obligations under Article 9.1.1, the costs related to the contract concerned will be ineligible (see Article 6) and will be rejected (see Article 26).

If a beneficiary breaches any of its obligations under Article 9.1.2, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 10 — IMPLEMENTATION OF ACTION TASKS BY SUBCONTRACTORS

10.1 Rules for subcontracting action tasks

10.1.1 If necessary to implement the action, the beneficiaries may award subcontracts covering the implementation of certain action tasks described in Annex 1.

Subcontracting may cover only a limited part of the action.

The beneficiaries must award the subcontracts ensuring the best value for money or, if appropriate, the lowest price. In doing so, they must avoid any conflict of interests (see Article 20).

The tasks to be implemented and the estimated cost for each subcontract must be set out in Annex 1 and the total estimated costs of subcontracting per beneficiary must be set out in Annex 2. The Agency may however approve subcontracts not set out in Annex 1 and 2 without amendment (see Article 39), if:

- they are specifically justified in the periodic technical report and
- they do not entail changes to the Agreement which would call into question the decision awarding the grant or breach the principle of equal treatment of applicants.

The beneficiaries must ensure that the Agency, the Commission, the European Court of Auditors (ECA) and the European Anti-Fraud Office (OLAF) can exercise their rights under Articles 17 and 18 also towards their subcontractors.

10.1.2 The beneficiaries must ensure that their obligations under Articles 20, 21, 22 and 30 also apply to the subcontractors.

Beneficiaries that are ‘contracting authorities’ within the meaning of Directive 2004/18/EC (or 2014/24/EU) or ‘contracting entities’ within the meaning of Directive 2004/17/EC (or 2014/25/EU) must comply with the applicable national law on public procurement.

10.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under Article 10.1.1, the costs related to the subcontract concerned will be ineligible (see Article 6) and will be rejected (see Article 26).

If a beneficiary breaches any of its obligations under Article 10.1.2, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 11 — IMPLEMENTATION OF ACTION TASKS BY AFFILIATED ENTITIES

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11.1 Rules for calling upon affiliated entities to implement part of the action

11.1.1 The following '**affiliated entities**'[6] may implement the action tasks attributed to them in Annex 1:

- FUNDACION PARA LA FORMACION E INVESTIGACION SANITARIAS DE LA REGION DE MURCIA (FFIS), affiliated or linked to KG
- FUNDACION PUBLICA ANDALUZA PROGRESO Y SALUD (FPS), affiliated or linked to KG
- Servicio Cántabro de Salud (SCS), affiliated or linked to KG
- GERENCIA REGIONAL DE SALUD DE CASTILLA Y LEON (SACYL), affiliated or linked to KG
- CONSEJERIA DE SALUD y FAMILIAS DE LA JUNTA DE ANDALUCIA (CSFJA), affiliated or linked to KG
- FUNDACION INSTITUTO DE INVESTIGACION MARQUES DE VALDECILLA (IDIVAL), affiliated or linked to KG
- CONSORCI INSTITUT D'INVESTIGACIONS BIOMEDIQUES AUGUST PI I SUNYER (IDIBAPS), affiliated or linked to KG
- AGENCIA DE QUALITAT I AVALUACIO SANITARIES DE CATALUNYA (AQUAS), affiliated or linked to KG
- SERVICIO MURCIANO DE SALUD (SMS), affiliated or linked to KG
- ZAVOD ZA JAVNO ZDRAVSTVO FEDERACIJEBOSNE I HERCEGOVINE (ZZJZFBIH), affiliated or linked to MCA
- MINISTARSTVO ZDRAVLJA I SOCIJALNE ZASTITE REPUBLIKE SRPSKE (MHSw-RS), affiliated or linked to MCA
- HRVATSKI ZAVOD ZA ZDRAVSTVENO OSIGURANJE (CHIF), affiliated or linked to CIPH
- FAKULTNI NEMOCNICE OLOMOUC (UHO), affiliated or linked to MZCR
- REGION SYDDANMARK (RSD), affiliated or linked to RND
- SIHTASUTUS VILJANDI HAIGLA (VH), affiliated or linked to MSAE

[6] For the definition, see Article 122 of the Financial Regulation (EU, Euratom) No 966/2012: **entities** affiliated **to the beneficiary** are:
(a) entities that form a 'sole beneficiary' (i.e. where an entity is formed of several entities that satisfy the criteria for being awarded a grant, including where the entity is specifically established for the purpose of implementing an action to be financed by a grant);
(b) entities that satisfy the eligibility criteria and that do not fall within one of the situations referred to in Article 131(4) and that have a link with the beneficiary, in particular a legal or capital link, which is neither limited to the action nor established for the sole purpose of its implementation.

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- BAYERISCHES LANDESAMT FUR GESUNDHEIT UND LEBENSMITTELSICHERHEIT (LGL), affiliated or linked to BAGSFI
- ZTG ZENTRUM FUR TELEMATIK IM GESUNDHEITSWESEN GMBH (ZTG-GmBH), affiliated or linked to BAGSFI
- ARISTOTELIO PANEPISTIMIO THESSALONIKIS (AUTH), affiliated or linked to 4THYPE
- SEMMELWEIS EGYETEM (SU-HSMTC), affiliated or linked to AEEK
- JAHN FERENC DEL-PESTI KORHAZ ES RENDELOINTEZET (JFDPK), affiliated or linked to AEEK
- AZIENDA ULSS 4 VENETO ORIENTALE (PROMIS), affiliated or linked to AGENAS
- REGIONE LOMBARDIA (LOMBARDIA), affiliated or linked to AGENAS
- AZIENDA UNITA SANITARIA LOCALE UMBRIA 1 (UMBRIA), affiliated or linked to AGENAS
- MINISTERO DELLA SALUTE (MhH), affiliated or linked to AGENAS
- REGIONE MARCHE (MARCHE), affiliated or linked to AGENAS
- AGENZIA REGIONALE DI SANITA (TOSCANA), affiliated or linked to AGENAS
- AZIENDA SANITARIA LOCALE NA 2 NORD (ASL NA2), affiliated or linked to AGENAS
- BERNU KLINISKA UNIVERSITATES SLIMNICA VALSTS SIA (CCUH), affiliated or linked to NVD
- SPMS - SERVICOS PARTILHADOS DO MINISTERIO DA SAUDE EPE (SPMS), affiliated or linked to ACSS
- UNIVERSIDADE NOVA DE LISBOA (ENSP/NOVA), affiliated or linked to ACSS
- ZAVOD ZA ZDRAVSTVENO ZAVAROVANJE SLOVENIJE THE HEALTH INSURANCE INSTITUTE OF SLOVENIA (ZZZS), affiliated or linked to NIJZ

The affiliated entities may declare as eligible the costs they incur for implementing the action tasks in accordance with Article 6.3.

The beneficiaries must ensure that the Agency, the Commission, the European Court of Auditors (ECA) and the European Anti-Fraud Office (OLAF) can exercise their rights under Articles 17 and 18 also towards their affiliated entities.

11.1.2 The beneficiaries must ensure that their obligations under Articles 13, 15, 20, 21 and 22 also apply to their affiliated entities.

11.2 Consequences of non-compliance

If any obligation under Article 11.1.1 is breached, the costs of the affiliated entity will be ineligible (see Article 6) and will be rejected (see Article 26).

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If any obligation under Article 11.1.2 is breached, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 11a — FINANCIAL SUPPORT TO THIRD PARTIES

Not applicable

SECTION 2 RIGHTS AND OBLIGATIONS RELATED TO THE GRANT ADMINISTRATION

ARTICLE 12 — GENERAL OBLIGATION TO INFORM

12.1 General obligation to provide information upon request

The beneficiaries must provide — during implementation of the action or afterwards and in accordance with Article 25.2 — any information requested in order to verify eligibility of the costs, proper implementation of the action and compliance with any other obligation under the Agreement.

12.2 Obligation to keep information up to date and to inform about events and circumstances likely to affect the Agreement

Each beneficiary must keep information stored in the Participant Portal Beneficiary Register (via the electronic exchange system; see Article 36) up to date, in particular, its name, address, legal representatives, legal form and organisation type.

Each beneficiary must immediately inform the coordinator — which must immediately inform the Agency and the other beneficiaries — of any of the following:

(a) **events** which are likely to affect significantly or delay the implementation of the action or the EU's financial interests, in particular:

(i) changes in its legal, financial, technical, organisational or ownership situation or those of its affiliated entities and

(ii) changes in the name, address, legal form, organisation type of its affiliated entities;

(b) **circumstances** affecting:

(i) the decision to award the grant or

(ii) compliance with requirements under the Agreement.

12.3 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 13 — KEEPING RECORDS — SUPPORTING DOCUMENTATION

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13.1 Obligation to keep records and other supporting documentation

The beneficiaries must — for a period of five years after the payment of the balance — keep records and other supporting documentation, in order to prove the proper implementation of the action and the costs they declare as eligible.

They must make them available upon request (see Article 12) or in the context of checks, reviews, audits or investigations (see Article 17).

If there are on-going checks, reviews, audits, investigations, litigation or other pursuits of claims under the Agreement (including the extension of findings; see Article 17), the beneficiaries must keep the records and other supporting documentation until the end of these procedures.

The beneficiaries must keep the original documents. Digital and digitalised documents are considered originals if they are authorised by the applicable national law. The Agency may accept non-original documents if it considers that they offer a comparable level of assurance.

13.1.1 Records and other supporting documentation on the technical implementation

The beneficiaries must keep records and other supporting documentation on the technical implementation of the action, in line with the accepted standards in the respective field.

13.1.2 Records and other documentation to support the costs declared

The beneficiaries must keep the records and documentation supporting the costs declared, in particular the following:

(a) for **actual costs**: adequate records and other supporting documentation to prove the costs declared, such as contracts, subcontracts, invoices and accounting records. In addition, the beneficiaries' usual cost accounting practices and internal control procedures must enable direct reconciliation between the amounts declared, the amounts recorded in their accounts and the amounts stated in the supporting documentation;

(b) for **unit costs**: not applicable;

(c) for **flat-rate costs**: adequate records and other supporting documentation to prove the eligibility of the costs to which the flat-rate is applied. The beneficiaries do not need to identify the costs covered or provide supporting documentation (such as accounting statements) to prove the amount declared at a flat-rate;

(d) for **lump sum costs**: not applicable;

In addition, for **personnel costs** (declared as actual costs), the beneficiaries must keep **time records** for the number of days declared. The time records must be in writing and approved by the persons working on the action and their supervisors, at least monthly. In the absence of reliable time records of the days worked on the action, the Agency may accept alternative evidence supporting the number of days declared, if it considers that it offers an adequate level of assurance.

As an exception, for **persons working exclusively on the action**, there is no need to keep time records, if the beneficiary signs a **declaration** confirming that the persons concerned have worked exclusively on the action.

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For costs declared by affiliated entities (see Article 11), it is the beneficiary that must keep the originals of the financial statements and the certificates on the financial statements of its affiliated entities.

13.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, costs insufficiently substantiated will be ineligible (see Article 6) and will be rejected (see Article 26), and the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 14 — SUBMISSION OF DELIVERABLES

14.1 Obligation to submit deliverables

The coordinator must submit the '**deliverables**' identified in Annex 1, in accordance with the timing and conditions set out in it.

14.2 Consequences of non-compliance

If the coordinator breaches any of its obligations under this Article, the Agency may apply any of the measures described in Chapter 6.

ARTICLE 15 — REPORTING — PAYMENT REQUESTS

15.1 Obligation to submit reports

The coordinator must submit to the Agency (see Article 36) the technical and financial report(s) set out in this Article. These reports include request(s) for payment and must be drawn up using the forms and templates provided in the electronic exchange system (see Article 36).

15.2 Reporting periods

The action is divided into the following '**reporting periods**':

- RP1: from month 1 to month 18
- RP2: from month 19 to month 36

15.2a Request(s) for further pre-financing payment(s)

Not applicable

15.3 Periodic reports — Requests for interim payments

The coordinator must submit a periodic report within 60 days following the end of each reporting period.

The **periodic report** must include the following:

(a) a '**periodic technical report**' containing:

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(i) an **explanation of the work carried out** by the beneficiaries;

(ii) an **overview of the progress** towards the objectives of the action, including milestones and deliverables identified in Annex 1.

This report must include explanations justifying the differences between work expected to be carried out in accordance with Annex 1 and that actually carried out;

(iii) a **summary** for publication by the Agency;

(iv) the answers to the '**questionnaire**': covering issues related to the action implementation and its impact;

(b) a '**periodic financial report**' containing:

(i) an '**individual financial statement**' (see Annex 4) from each beneficiary and from each affiliated entity, for the reporting period concerned.

The individual financial statement must detail the eligible costs (actual costs and flat-rate costs; see Article 6) for each budget category (see Annex 2).

The beneficiaries and affiliated entities must declare all eligible costs, even if — for actual costs and flat-rate costs — they exceed the amounts indicated in the estimated budget (see Annex 2). Amounts which are not declared in the individual financial statement will not be taken into account by the Agency.

If an individual financial statement is not submitted for a reporting period, it may be included in the periodic financial report for the next reporting period.

The individual financial statements of the last reporting period must also detail the **receipts of the action** (see Article 5.3.3).

Each beneficiary and each affiliated entity must **certify** that:

- the information provided is full, reliable and true;
- the costs declared are eligible (see Article 6);
- the costs can be substantiated by adequate records and supporting documentation (see Article 13) that will be produced upon request (see Article 12) or in the context of checks, reviews, audits and investigations (see Article 17), and
- for the last reporting period: that all the receipts have been declared (see Article 5.3.3);

(ii) an **explanation of the use of resources** and the information on subcontracting (see Article 10) from each beneficiary and from each affiliated entity, for the reporting period concerned;

(iii) not applicable;

(iv) a '**periodic summary financial statement**', created automatically by the electronic

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exchange system, consolidating the individual financial statements for the reporting period concerned and including — except for the last reporting period — the **request for interim payment**;

(v) a '**certificate on the financial statements**' (drawn up in accordance with Annex 5) for each beneficiary and for each affiliated entity, if:

- the (cumulative) amount of EU contribution it requests as reimbursement of actual costs (and for which no certificate has yet been submitted) is EUR 150 000 or more and

- the maximum EU contribution indicated, for that beneficiary or affiliated entity, in the estimated budget (see Annex 2) as reimbursement of actual costs is EUR 200 000 or more.

15.4 Final report — Request for payment of the balance

In addition to the periodic report for the last reporting period, the coordinator must submit the final report within 60 days following the end of the last reporting period.

The **final report** must include the following:

(a) a '**final technical report**' with a **summary** for publication containing:

(i) an overview of the results and their dissemination;

(ii) the conclusions on the action and

(iii) the impact of the action;

(b) a '**final financial report**' containing a '**final summary financial statement**', created automatically by the electronic exchange system, consolidating the individual financial statements for all reporting periods and including the **request for payment of the balance**.

15.5 Information on cumulative expenditure incurred

Not applicable

15.6 Currency for financial statements and conversion into euro

Financial statements must be drafted in euro.

Beneficiaries and affiliated entities with accounting established in a currency other than the euro must convert the costs recorded in their accounts into euro at the average of the daily exchange rates published in the C series of the *Official Journal of the European Union*, calculated over the corresponding reporting period.

If no daily euro exchange rate is published in the *Official Journal of the European Union* for the currency in question, they must be converted at the average of the monthly accounting rates published on the Commission's website, calculated over the corresponding reporting period.

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Beneficiaries and affiliated entities with accounting established in euro must convert costs incurred in another currency into euro according to their usual accounting practices.

15.7 Language of reports

All report(s) (including financial statements) must be submitted in the language of the Agreement.

15.8 Consequences of non-compliance

If the report(s) submitted do not comply with this Article, the Agency may suspend the payment deadline (see Article 31) and apply any of the other measures described in Chapter 6.

If the coordinator breaches its obligation to submit the report(s) and if it fails to comply with this obligation within 30 days following a written reminder, the Agency may terminate the Agreement (see Article 34) or apply any of the other measures described in Chapter 6.

ARTICLE 16 — PAYMENTS AND PAYMENT ARRANGEMENTS

16.1 Payments to be made

The following payments will be made to the coordinator:

- a **pre-financing payment**;
- one or more **interim payments**, on the basis of the request(s) for interim payment (see Article 15), and
- one **payment of the balance**, on the basis of the request for payment of the balance (see Article 15).

16.2 Pre-financing payment — Amount

The aim of the pre-financing is to provide the beneficiaries with a float.

It remains the property of the EU until the payment of the balance.

The amount of the pre-financing payment will be EUR **1 999 613.00** (one million nine hundred and ninety nine thousand six hundred and thirteen EURO).

The Agency will — except if Article 32 applies — make the pre-financing payment to the coordinator within 30 days, either from the entry into force of the Agreement (see Article 42) or from 10 days before the starting date of the action (see Article 3) , whichever is the latest.

16.3 Interim payments — Amount — Calculation

Interim payments reimburse the eligible costs incurred for the implementation of the action during the corresponding reporting periods.

The Agency will pay to the coordinator the amount due as interim payment within 90 days from receiving the periodic report (see Article 15.3), except if Articles 31 or 32 apply.

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Payment is subject to the approval of the periodic report. Its approval does not imply recognition of compliance, authenticity, completeness or correctness of its content.

The **amount due as interim payment** is calculated by the Agency in the following steps:

Step 1 – Application of the reimbursement rate

Step 2 – Limit to 90% of the maximum grant amount

16.3.1 Step 1 — Application of the reimbursement rate

The reimbursement rate (see Article 5.2) is applied to the eligible costs (actual costs and flat-rate costs; see Article 6) declared by the beneficiaries and the affiliated entities (see Article 15) and approved by the Agency (see above) for the concerned reporting period.

16.3.2 Step 2 — Limit to 90% of the maximum grant amount

The total amount of pre-financing and interim payments must not exceed 90% of the maximum grant amount set out in Article 5.1. The maximum amount for the interim payment will be calculated as follows:

{90% of the maximum grant amount (see Article 5.1)

minus

{pre-financing and previous interim payments}}.

16.4 Payment of the balance — Amount — Calculation

The payment of the balance reimburses the remaining part of the eligible costs incurred by the beneficiaries for the implementation of the action.

If the total amount of earlier payments is greater than the final grant amount (see Article 5.3), the payment of the balance takes the form of a recovery (see Article 28).

If the total amount of earlier payments is lower than the final grant amount, the Agency will pay the balance within 90 days from receiving the final report (see Article 15.4), except if Articles 31 or 32 apply.

Payment is subject to the approval of the final report. Its approval does not imply recognition of compliance, authenticity, completeness or correctness of its content.

The **amount due as the balance** is calculated by the Agency by deducting the total amount of pre-financing and interim payments (if any) already made, from the final grant amount determined in accordance with Article 5.3:

{final grant amount (see Article 5.3)

minus

{pre-financing and interim payments (if any) made}}.

If the balance is positive, it will be paid to the coordinator.

The amount to be paid may however be offset — without the beneficiaries' consent — against any

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other amount owed by a beneficiary to the Agency, the Commission or another executive agency (under the EU or Euratom budget), up to the maximum EU contribution indicated, for that beneficiary, in the estimated budget (see Annex 2).

If the balance is negative, it will be recovered from the coordinator (see Article 28).

16.5 Notification of amounts due

When making payments, the Agency will formally notify to the coordinator the amount due, specifying that it concerns an interim payment or the payment of the balance.

For the payment of the balance, the notification will also specify the final grant amount.

In the case of reduction of the grant or recovery of undue amounts, the notification will be preceded by the contradictory procedure set out in Articles 27 and 28.

16.6 Currency for payments

The Agency will make all payments in euro.

16.7 Payments to the coordinator — Distribution to the beneficiaries

Payments will be made to the coordinator.

Payments to the coordinator will discharge the Agency from its payment obligation.

The coordinator must distribute the payments between the beneficiaries without unjustified delay.

Pre-financing may however be distributed only:

(a) if 90% of the beneficiaries have acceded to the Agreement (see Article 40) and

(b) to beneficiaries that have acceded to the Agreement (see Article 40).

16.8 Bank account for payments

All payments will be made to the following bank account:

Name of bank: KUTXABANK, S.A
Full name of the account holder: ASOCIACION CENTRO EXCEL INTERNACIONAL INVESTIG SOBRE CRONICIDAD
Full account number (including bank codes):
IBAN code: ES4920950611009111334073

16.9 Costs of payment transfers

The cost of the payment transfers is borne as follows:

- the Agency bears the cost of transfers charged by its bank;
- the beneficiary bears the cost of transfers charged by its bank;
- the party causing a repetition of a transfer bears all costs of the repeated transfer.

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16.10 Date of payment

Payments by the Agency are considered to have been carried out on the date when they are debited to its account.

16.11 Consequences of non-compliance

16.11.1 If the Agency does not pay within the payment deadlines (see above), the beneficiaries are entitled to **late-payment interest** at the rate applied by the European Central Bank (ECB) for its main refinancing operations in euros ('reference rate'), plus three and a half points. The reference rate is the rate in force on the first day of the month in which the payment deadline expires, as published in the C series of the *Official Journal of the European Union*.

If the late-payment interest is lower than or equal to EUR 200, it will be paid to the coordinator only upon request submitted within two months of receiving the late payment.

Late-payment interest is not due if all beneficiaries are EU Member States (including regional and local government authorities or other public bodies acting on behalf of a Member State for the purpose of this Agreement).

Suspension of the payment deadline or payments (see Articles 31 and 32) will not be considered as late payment.

Late-payment interest covers the period running from the day following the due date for payment (see above), up to and including the date of payment.

Late-payment interest is not considered for the purposes of calculating the final grant amount.

16.11.2 If the coordinator breaches any of its obligations under this Article, the grant may be reduced (see Article 27) and the Agreement or the participation of the coordinator may be terminated (see Article 34).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 17 — CHECKS, REVIEWS, AUDITS AND INVESTIGATIONS — EXTENSION OF FINDINGS

17.1 Checks, reviews and audits by the Agency and the Commission

17.1.1 Right to carry out checks

The Agency or the Commission will — during the implementation of the action or afterwards — check the proper implementation of the action and compliance with the obligations under the Agreement, including assessing deliverables and reports.

For this purpose, the Agency or the Commission may be assisted by external persons or bodies.

The Agency or the Commission may also request additional information in accordance with Article 12. The Agency or the Commission may request beneficiaries to provide such information to it directly.

Information provided must be accurate, precise and complete and in the format requested, including electronic format.

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17.1.2 Right to carry out reviews

The Agency or the Commission may — during the implementation of the action or afterwards — carry out reviews on the proper implementation of the action (including assessment of deliverables and reports) and compliance with the obligations under the Agreement.

Reviews may be started **up to five years after the payment of the balance**. They will be formally notified to the coordinator or beneficiary concerned and will be considered to have started on the date of the formal notification.

If the review is carried out on a third party (see Articles 9 to 11a), the beneficiary concerned must inform the third party.

The Agency or the Commission may carry out reviews directly (using its own staff) or indirectly (using external persons or bodies appointed to do so). It will inform the coordinator or beneficiary concerned of the identity of the external persons or bodies. They have the right to object to the appointment on grounds of commercial confidentiality.

The coordinator or beneficiary concerned must provide — within the deadline requested — any information and data in addition to deliverables and reports already submitted (including information on the use of resources). The Agency or the Commission may request beneficiaries to provide such information to it directly.

The coordinator or beneficiary concerned may be requested to participate in meetings, including with external experts.

For **on-the-spot** reviews, the beneficiaries must allow access to their sites and premises, including to external persons or bodies, and must ensure that information requested is readily available.

Information provided must be accurate, precise and complete and in the format requested, including electronic format.

On the basis of the review findings, a '**review report**' will be drawn up.

The Agency or the Commission will formally notify the review report to the coordinator or beneficiary concerned, which has 30 days to formally notify observations ('**contradictory review procedure**').

Reviews (including review reports) are in the language of the Agreement.

17.1.3 Right to carry out audits

The Agency or the Commission may — during the implementation of the action or afterwards — carry out audits on the proper implementation of the action and compliance with the obligations under the Agreement.

Audits may be started **up to five years after the payment of the balance**. They will be formally notified to the coordinator or beneficiary concerned and will be considered to have started on the date of the formal notification.

If the audit is carried out on a third party (see Articles 9 to 11a), the beneficiary concerned must inform the third party.

The Agency or the Commission may carry out audits directly (using its own staff) or indirectly (using

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external persons or bodies appointed to do so). It will inform the coordinator or beneficiary concerned of the identity of the external persons or bodies. They have the right to object to the appointment on grounds of commercial confidentiality.

The coordinator or beneficiary concerned must provide — within the deadline requested — any information (including complete accounts, individual salary statements or other personal data) to verify compliance with the Agreement. The Agency or the Commission may request beneficiaries to provide such information to it directly.

For **on-the-spot** audits, the beneficiaries must allow access to their sites and premises, including to external persons or bodies, and must ensure that information requested is readily available.

Information provided must be accurate, precise and complete and in the format requested, including electronic format.

On the basis of the audit findings, a '**draft audit report**' will be drawn up.

The Agency or the Commission will formally notify the draft audit report to the coordinator or beneficiary concerned, which has 30 days to formally notify observations ('**contradictory audit procedure**'). This period may be extended by the Agency or the Commission in justified cases.

The '**final audit report**' will take into account observations by the coordinator or beneficiary concerned. The report will be formally notified to it.

Audits (including audit reports) are in the language of the Agreement.

The Agency or the Commission may also access the beneficiaries' statutory records for the periodical assessment of flat-rate amounts.

17.2 Investigations by the European Anti-Fraud Office (OLAF)

Under Regulations No 883/2013[7] and No 2185/96[8] (and in accordance with their provisions and procedures), the European Anti-Fraud Office (OLAF) may — at any moment during implementation of the action or afterwards — carry out investigations, including on-the-spot checks and inspections, to establish whether there has been fraud, corruption or any other illegal activity affecting the financial interests of the EU.

17.3 Checks and audits by the European Court of Auditors (ECA)

Under Article 287 of the Treaty on the Functioning of the European Union (TFEU) and Article 161 of the Financial Regulation No 966/2012[9], the European Court of Auditors (ECA) may — at any moment during implementation of the action or afterwards — carry out audits.

[7] Regulation (EU, Euratom) No 883/2013 of the European Parliament and of the Council of 11 September 2013 concerning investigations conducted by the European Anti-Fraud Office (OLAF) and repealing Regulation (EC) No 1073/1999 of the European Parliament and of the Council and Council Regulation (Euratom) No 1074/1999 (OJ L 232, 18.09.2013, p. 1).

[8] Council Regulation (Euratom, EC) No 2185/1996 of 11 November 1996 concerning on-the-spot checks and inspections carried out by the Commission in order to protect the European Communities' financial interests against fraud and other irregularities (OJ L 292, 15.11.1996, p. 2).

[9] Regulation (EU, Euratom) No 966/2012 of the European Parliament and of the Council of 25 October 2012 on the financial rules applicable to the general budget of the Union and repealing Council Regulation (EC, Euratom) No 1605/2002 (OJ L 298, 26.10.2012, p. 1).

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The ECA has the right of access for the purpose of checks and audits.

17.4 Checks, reviews, audits and investigations for international organisations

Not applicable

17.5 Consequences of findings in checks, reviews, audits and investigations — Extension of findings

17.5.1 Findings in this grant

Findings in checks, reviews, audits or investigations carried out in the context of this grant may lead to the rejection of ineligible costs (see Article 26), reduction of the grant (see Article 27), recovery of undue amounts (see Article 28) or to any of the other measures described in Chapter 6.

Rejection of costs or reduction of the grant after the payment of the balance will lead to a revised final grant amount (see Article 5.4).

Findings in checks, reviews, audits or investigations may lead to a request for amendment for the modification of Annex 1 (see Article 39).

Checks, reviews, audits or investigations that find systemic or recurrent errors, irregularities, fraud or breach of obligations may also lead to consequences in other EU or Euratom grants awarded under similar conditions ('**extension of findings from this grant to other grants**').

Moreover, findings arising from an OLAF investigation may lead to criminal prosecution under national law.

17.5.2 Findings in other grants

The Agency or the Commission may extend findings from other grants to this grant ('**extension of findings from other grants to this grant**'), if:

(a) the beneficiary concerned is found, in other EU or Euratom grants awarded under similar conditions, to have committed systemic or recurrent errors, irregularities, fraud or breach of obligations that have a material impact on this grant and

(b) those findings are formally notified to the beneficiary concerned — together with the list of grants affected by the findings — **no later than five years after the payment of the balance** of this grant.

The extension of findings may lead to the rejection of costs (see Article 26), reduction of the grant (see Article 27), recovery of undue amounts (see Article 28), suspension of payments (see Article 32), suspension of the action implementation (see Article 33) or termination (see Article 34).

17.5.3 Procedure

The Agency or the Commission will formally notify the beneficiary concerned the systemic or recurrent errors and its intention to extend these audit findings, together with the list of grants affected.

17.5.3.1 If the findings concern **eligibility of costs**: the formal notification will include:

(a) an invitation to submit observations on the list of grants affected by the findings;

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(b) the request to submit **revised financial statements** for all grants affected;

(c) the **correction rate for extrapolation** established by the Agency or the Commission on the basis of the systemic or recurrent errors, to calculate the amounts to be rejected, if the beneficiary concerned:

(i) considers that the submission of revised financial statements is not possible or practicable or

(ii) does not submit revised financial statements.

The beneficiary concerned has 90 days from receiving notification to submit observations, revised financial statements or to propose a duly substantiated **alternative correction method**. This period may be extended by the Agency or the Commission in justified cases.

The Agency or the Commission may then start a **rejection procedure** in accordance with Article 26, either on the basis of the revised financial statements, the alternative method or the correction rate announced.

17.5.3.2 If the findings concern **substantial errors, irregularities or fraud** or **serious breach of obligations**: the formal notification will include:

(a) an invitation to submit observations on the list of grants affected by the findings and

(b) the flat-rate the Agency or the Commission intends to apply according to the principle of proportionality.

The beneficiary concerned has 90 days from receiving notification to submit observations or to propose a duly substantiated alternative flat-rate.

The Agency or the Commission may then start a **reduction procedure** in accordance with Article 27, either on the basis of the alternative flat-rate or the flat-rate announced.

17.6 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, any insufficiently substantiated costs will be ineligible (see Article 6) and will be rejected (see Article 26).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 18 — EVALUATION OF THE IMPACT OF THE ACTION

18.1 Right to evaluate the impact of the action

The Agency or the Commission may carry out interim and final evaluations of the impact of the action measured against the objective of the EU programme.

Evaluations may be started during implementation of the action and **up to five years after the payment of the balance**. The evaluation is considered to start on the date of the formal notification to the coordinator or beneficiaries.

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The Agency or the Commission may make these evaluations directly (using its own staff) or indirectly (using external bodies or persons it has authorised to do so).

The coordinator or beneficiaries must provide any information relevant to evaluate the impact of the action, including information in electronic format.

18.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the Agency may apply the measures described in Chapter 6.

SECTION 3 OTHER RIGHTS AND OBLIGATIONS

ARTICLE 19 — PRE-EXISTING RIGHTS AND OWNERSHIP OF THE RESULTS (INCLUDING INTELLECTUAL AND INDUSTRIAL PROPERTY RIGHTS)

19.1 Pre-existing rights and access rights to pre-existing rights

Where industrial and intellectual property rights (including rights of third parties) exist prior to the Agreement, the beneficiaries must establish a list of these pre-existing industrial and intellectual property rights, specifying the owner and any persons that have a right of use.

The coordinator must — before starting the action — submit this list to the Agency.

Each beneficiary must give the other beneficiaries and their affiliated entities access to any pre-existing industrial and intellectual property rights needed for the implementation of the action and compliance with the obligations under the Agreement.

19.2 Ownership of results and rights of use

The results of the action (including the reports and other documents relating to it) are owned by the beneficiaries.

The beneficiaries must give the Agency and the Commission the right to use the results for their communication activities under Article 22.

19.3 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such a breach may also lead to any of the other measures described in Chapter 6.

ARTICLE 20 — CONFLICT OF INTERESTS

20.1 Obligation to avoid a conflict of interests

The beneficiaries must take all measures to prevent any situation where the impartial and objective

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implementation of the action is compromised for reasons involving economic interest, political or national affinity, family or emotional ties or any other shared interest ('**conflict of interests**').

They must formally notify to the Agency without delay any situation constituting or likely to lead to a conflict of interests and immediately take all the necessary steps to rectify this situation.

The Agency may verify that the measures taken are appropriate and may require additional measures to be taken by a specified deadline.

20.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27) and the Agreement or participation of the beneficiary may be terminated (see Article 34).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 21 — CONFIDENTIALITY

21.1 General obligation to maintain confidentiality

During implementation of the action and for **five years after the payment of the balance**, the parties must keep confidential any data, documents or other material (in any form) that is identified as confidential at the time it is disclosed ('**confidential information**').

They may use confidential information to implement the Agreement.

The confidentiality obligations no longer apply if:

(a) the disclosing party agrees to release the other party;

(b) the information becomes generally and publicly available, without breaching any confidentiality obligation;

(c) the disclosure of the confidential information is required by EU or national law.

21.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 22 — PROMOTING THE ACTION — VISIBILITY OF EU FUNDING

22.1 Communication activities by the beneficiaries

22.1.1 General obligation to promote the action and its results

The beneficiaries must promote the action and its results.

22.1.2 Information on EU funding — Obligation and right to use the EU emblem

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Unless the Agency requests or agrees otherwise, any communication activity related to the action (including at conferences, seminars, in information material, such as brochures, leaflets, posters, presentations, etc., in electronic form, via social media, etc.) and any infrastructure, equipment or major results funded by the grant must:

- display the EU emblem and
- include the following text:

> "This [insert appropriate description, e.g. report, publication, conference, infrastructure, equipment, insert type of result, etc.] was funded by the European Union's Health Programme (2014-2020)."

When displayed in association with another logo, the EU emblem must have appropriate prominence.

For the purposes of their obligations under this Article, the beneficiaries may use the EU emblem without first obtaining approval from the Agency.

This does not, however, give them the right to exclusive use.

Moreover, they may not appropriate the EU emblem or any similar trademark or logo, either by registration or by any other means.

22.1.3 Disclaimer excluding Agency and Commission responsibility

Any communication activity related to the action must indicate the following disclaimer:

> "The content of this [insert appropriate description, e.g. report, publication, conference, etc.] represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains."

22.2 Communication activities by the Agency and the Commission

22.2.1 Right to use the beneficiaries' materials, documents or information

The Agency and the Commission may use information relating to the action, documents notably summaries for publication and public deliverables as well as any other material, such as pictures or audio-visual material received from any beneficiary (including in electronic form).

This does not change the confidentiality obligations in Article 21, which still apply.

The right to use the beneficiary's materials, documents and information includes:

(a) **use for its own purposes** (in particular, making them available to persons working for the Agency, the Commission or any other EU institution, body, office or agency or body or institutions in EU Member States; and copying or reproducing them in whole or in part, in unlimited numbers);

(b) **distribution to the public** (in particular, publication as hard copies and in electronic or digital format, publication on the internet, as a downloadable or non-downloadable file, broadcasting by any channel, public display or presentation, communicating through press information services, or inclusion in widely accessible databases or indexes);

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(c) **editing or redrafting** for communication and publicising activities (including shortening, summarising, inserting other elements (such as meta-data, legends, other graphic, visual, audio or text elements), extracting parts (e.g. audio or video files), dividing into parts, use in a compilation);

(d) **translation**;

(e) giving **access in response to individual requests** under Regulation No 1049/2001[10], without the right to reproduce or exploit;

(f) **storage** in paper, electronic or other form;

(g) **archiving**, in line with applicable document-management rules, and

(h) the right to authorise **third parties** to act on its behalf or sub-license the modes of use set out in Points (b), (c), (d) and (f) to third parties if needed for the communication and publicising activities of the Agency or the Commission.

If the right of use is subject to rights of a third party (including personnel of the beneficiary), the beneficiary must ensure that it complies with its obligations under this Agreement (in particular, by obtaining the necessary approval from the third parties concerned).

Where applicable (and if provided by the beneficiaries), the Agency or the Commission will insert the following information:

> "© – [year] – [name of the copyright owner]. All rights reserved. Licensed to the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) and the European Union (EU) under conditions."

22.3 Consequences of non-compliance

If the beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 23 — PROCESSING OF PERSONAL DATA

23.1 Processing of personal data by the Agency and the Commission

Any personal data under the Agreement will be processed by the Agency or the Commission under Regulation No 23/2001[11] and according to the 'notifications of the processing operations' to the Data Protection Officer (DPO) of the Agency or the Commission (publicly accessible in the DPO register).

Such data will be processed by the '**data controller**' of the Agency or the Commission, for the purposes of implementing, managing and monitoring the Agreement or protecting the financial interests of the EU or Euratom (including checks, reviews, audits and investigations; see Article 17).

[10] Regulation (EC) No 1049/2001 of the European Parliament and of the Council of 30 May 2001 regarding public access to European Parliament, Council and Commission documents, OJ L 145, 31.5.2001, p. 43.

[11] Regulation (EC) No 45/2001 of the European Parliament and of the Council of 18 December 2000 on the protection of individuals with regard to the processing of personal data by the Community institutions and bodies and on the free movement of such data (OJ L 8, 12.01.2001, p. 1).

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The persons whose personal data are processed have the right to access and correct their own personal data. For this purpose, they must send any queries about the processing of their personal data to the data controller, via the contact point indicated in the privacy statement(s) on the Agency and Commission websites.

They also have the right to have recourse at any time to the European Data Protection Supervisor (EDPS).

23.2 Processing of personal data by the beneficiaries

The beneficiaries must process personal data under the Agreement in compliance with applicable EU and national law on data protection (including authorisations or notification requirements).

The beneficiaries may grant their personnel access only to data that is strictly necessary for implementing, managing and monitoring the Agreement.

The beneficiaries must inform the personnel whose personal data are collected and processed by the Agency or the Commission. For this purpose, they must provide them with the privacy statement(s) (see above), before transmitting their data to the Agency or the Commission.

23.3 Consequences of non-compliance

If a beneficiary breaches any of its obligations under Article 23.2, the Agency may apply any of the measures described in Chapter 6.

ARTICLE 24 — ASSIGNMENTS OF CLAIMS FOR PAYMENT AGAINST THE AGENCY

The beneficiaries may not assign any of their claims for payment against the Agency to any third party, except if approved by the Agency on the basis of a reasoned, written request by the coordinator (on behalf of the beneficiary concerned).

If the Agency has not accepted the assignment or the terms of it are not observed, the assignment will have no effect on it.

In no circumstances will an assignment release the beneficiaries from their obligations towards the Agency.

CHAPTER 5 DIVISION OF BENEFICIARIES' ROLES AND RESPONSIBILITIES

ARTICLE 25 — DIVISION OF BENEFICIARIES' ROLES AND RESPONSIBILITIES

25.1 Roles and responsibilities towards the Agency

The beneficiaries have full responsibility for implementing the action and complying with the Agreement.

The beneficiaries are jointly and severally liable for the **technical implementation** of the action as described in Annex 1. If a beneficiary fails to implement its part of the action, the other beneficiaries become responsible for implementing this part (without being entitled to any additional EU funding for doing so), unless the Agency expressly relieves them of this obligation.

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The **financial responsibility** of each beneficiary is governed by Articles 28, 29 and 30.

25.2 Internal division of roles and responsibilities

The internal roles and responsibilities of the beneficiaries are divided as follows:

(a) Each **beneficiary** must:

(i) keep information stored in the Participant Portal Beneficiary Register (via the electronic exchange system) up to date (see Article 12);

(ii) inform the coordinator immediately of any events or circumstances likely to affect significantly or delay the implementation of the action (see Article 12);

(iii) submit to the coordinator in good time:

- individual financial statements for itself and its affiliated entities and, if required, certificates on the financial statements (see Article 15);
- the data needed to draw up the technical reports (see Article 15);
- any other documents or information required by the Agency or the Commission under the Agreement, unless the Agreement requires the beneficiary to submit this information directly.

(b) The **coordinator** must:

(i) monitor that the action is implemented properly (see Article 7);

(ii) act as the intermediary for all communications between the beneficiaries and the Agency (in particular, providing the Agency with the information described in Article 12), unless the Agreement specifies otherwise;

(iii) provide a pre-financing guarantee if requested by the Agency (see Article 16.2);

(iv) request and review any documents or information required by the Agency and verify their completeness and correctness before passing them on to the Agency;

(v) submit the deliverables and reports to the Agency (see Articles 14 and 15);

(vi) ensure that all payments are made to the other beneficiaries without unjustified delay (see Article 16).

The coordinator may not subcontract the above-mentioned tasks.

25.3 Internal arrangements between beneficiaries — Consortium agreement

The beneficiaries must have internal arrangements regarding their operation and co-ordination to ensure that the action is implemented properly. These internal arrangements must be set out in a written '**consortium agreement**' between the beneficiaries, which may cover:

- internal organisation of the consortium;

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- management of access to the electronic exchange system;
- distribution of EU funding;
- additional rules on rights and obligations related to pre-existing rights and results (see Article 19);
- settlement of internal disputes;
- liability, indemnification and confidentiality arrangements between the beneficiaries.

The consortium agreement must not contain any provision contrary to the Agreement.

CHAPTER 6 REJECTION OF COSTS — REDUCTION OF THE GRANT — RECOVERY — SANCTIONS — DAMAGES — SUSPENSION — TERMINATION — FORCE MAJEURE

SECTION 1 REJECTION OF COSTS — REDUCTION OF THE GRANT — RECOVERY — SANCTIONS

ARTICLE 26 — REJECTION OF INELIGIBLE COSTS

26.1 Conditions

The Agency will — at the time of an **interim payment**, **at the payment of the balance** or **afterwards** — reject any costs which are ineligible (see Article 6), in particular following checks, reviews, audits or investigations (see Article 17).

The rejection may also be based on the **extension of findings from other grants to this grant** (see Article 17.5.2).

26.2 Ineligible costs to be rejected — Calculation — Procedure

Ineligible costs will be rejected in full.

If the rejection of costs does not lead to a recovery (see Article 28), the Agency will formally notify the coordinator or beneficiary concerned of the rejection of costs, the amounts and the reasons why (if applicable, together with the notification of amounts due; see Article 16.5). The coordinator or beneficiary concerned may — within 30 days of receiving notification — formally notify the Agency of its disagreement and the reasons why.

If the rejection of costs leads to a recovery, the Agency will follow the contradictory procedure with pre-information letter set out in Article 28.

26.3 Effects

If the Agency rejects costs at the time of an **interim payment** or **the payment of the balance**, it will deduct them from the total eligible costs declared, for the action, in the periodic or final summary financial statement (see Article 15.3 and 15.4). It will then calculate the interim payment or payment of the balance as set out in Article 16.3 or 16.4.

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If the Agency — **after an interim payment but before the payment of the balance** — rejects costs declared in a periodic summary financial statement, it will deduct them from the costs declared in the next periodic summary financial statement or final summary financial statement. It will then calculate the interim payment or payment of the balance as set out in Article 16.3 or 16.4.

If the Agency rejects costs **after the payment of the balance**, it will deduct the amount rejected from the total eligible costs declared, by the beneficiary, in the final summary financial statement. It will then calculate the revised final grant amount as set out in Article 5.4. If the revised final grant amount is lower than the final grant amount, the Agency will recover the difference (see Article 28).

ARTICLE 27 — REDUCTION OF THE GRANT

27.1 Conditions

The Agency may — **at the payment of the balance or afterwards** — reduce the grant, if:

(a) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed:

(i) substantial errors, irregularities or fraud or

(ii) serious breach of obligations under the Agreement or during the award procedure (including improper implementation of the action, submission of false information, failure to provide required information, breach of ethical principles) or

(b) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have a material impact on this grant (**extension of findings from other grants to this grant**; see Article 17.5.2).

27.2 Amount to be reduced — Calculation — Procedure

The amount of the reduction will be proportionate to the seriousness of the errors, irregularities or fraud or breach of obligations.

Before reduction of the grant, the Agency will formally notify a '**pre-information letter**' to the coordinator or beneficiary concerned:

- informing it of its intention to reduce the grant, the amount it intends to reduce and the reasons why and

- inviting it to submit observations within 30 days of receiving notification.

If the Agency does not receive any observations or decides to pursue reduction despite the observations it has received, it will formally notify **confirmation** of the reduction (if applicable, together with the notification of amounts due; see Article 16).

27.3 Effects

If the Agency reduces the grant **at the time of the payment of the balance**, it will calculate the

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reduced grant amount for the action and then determine the amount due as payment of the balance (see Article 5.3.4 and 16.4).

If the Agency reduces the grant **after the payment of the balance**, it will calculate the revised final grant amount for the action or for the beneficiary concerned (see Article 5.4). If the revised final grant amount is lower than the final grant amount, the Agency will recover the difference (see Article 28).

ARTICLE 28 — RECOVERY OF UNDUE AMOUNTS

28.1 Amount to be recovered — Calculation — Procedure

The Agency will — **at the payment of the balance** or **afterwards** — claim back any amount that was paid but is not due under the Agreement.

The coordinator is fully liable for repaying debts of the consortium (under the Agreement) even if it has not been the final recipient of those amounts.

In addition, the beneficiaries (including the coordinator) are jointly and severally liable for repaying any unpaid debts under the Agreement (due by the consortium or any beneficiary, including late-payment interest) — up to the maximum EU contribution indicated, for each beneficiary, in the estimated budget (as last amended; see Annex 2).

Undue amounts paid by the Agency for costs declared by an affiliated entity will be considered as amounts unduly paid to the beneficiary.

28.1.1 Recovery at payment of the balance

If the payment of the balance takes the form of a recovery (see Article 16.4), the Agency will formally notify a '**pre-information letter**' to the coordinator:

- informing it of its intention to recover, the amount due as the balance and the reasons why and
- inviting the coordinator to submit observations within 30 days of receiving notification.

If no observations are submitted or the Agency decides to pursue recovery despite the observations it has received, it will **confirm** the amount to be recovered and formally notify to the coordinator a **debit note** with the terms and the date for payment (together with the notification of amounts due; see Article 16.5).

If payment is not made by the date specified in the debit note, the Agency or the Commission will **recover** the amount:

(a) by '**offsetting**' it — without the coordinator's consent — against any amounts owed to the coordinator by the Agency, Commission or another executive agency (from the EU or Euratom budget).

In exceptional circumstances, to safeguard the EU's financial interests, the Agency may offset before the payment date specified in the debit note;

(b) not applicable;

(c) by **holding** the other beneficiaries jointly and severally **liable** — up to the maximum EU

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contribution indicated, for each beneficiary, in the estimated budget (as last amended; see Annex 2)

(d) by **taking legal action** (see Article 41) or by **adopting an enforceable decision** under Article 299 of the Treaty on the Functioning of the EU (TFEU) and Article 79(2) of the Financial Regulation No 966/2012.

If payment is not made by the date in the debit note, the amount to be recovered (see above) will be increased by **late-payment interest** at the rate set out in Article 16.11, from the day following the payment date in the debit note, up to and including the date the Agency or the Commission receives full payment of the amount.

Partial payments will be first credited against expenses, charges and late-payment interest and then against the principal.

Bank charges incurred in the recovery process will be borne by the beneficiary, unless Directive 2007/64/EC applies.

28.1.2 Recovery of amounts after payment of the balance

If — after the payment of the balance — the Agency revised the final grant amount for the action or for the beneficiary concerned (see Article 5.4), due to a rejection of costs or reduction of the grant, and the revised final grant amount is lower than the final grant amount (see Article 5.3), the Agency will:

- if the rejection or reduction does *not* concern a specific beneficiary or its affiliated entities: claim back the difference from the coordinator (even if it has not been the final recipient of the amount in question)

or

- otherwise: claim back the difference from the beneficiary concerned.

The Agency will formally notify a **pre-information letter** to the coordinator or beneficiary concerned:

- informing it of its intention to recover, the amount to be repaid and the reasons why and

- inviting it to submit observations within 30 days of receiving notification.

If no observations are submitted or the Agency decides to pursue recovery despite the observations it has received, it will **confirm** the amount to be recovered and formally notify to the coordinator or beneficiary concerned a **debit note**. This note will also specify the terms and the date for payment.

If payment is not made by the date specified in the debit note, the Agency or the Commission will **recover** the amount:

(a) by '**offsetting**' it — without the coordinator's or beneficiary's consent — against any amounts owed to the coordinator or beneficiary by the Agency, Commission or another executive agency (from the EU or Euratom budget).

In exceptional circumstances, to safeguard the EU's financial interests, the Agency may offset before the payment date specified in the debit note;

(b) by **holding** the other beneficiaries jointly and severally **liable**, up to the maximum EU

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contribution indicated, for each beneficiary, in the estimated budget (as last amended; see Annex 2)

(c) by **taking legal action** (see Article 41) or by **adopting an enforceable decision** under Article 299 of the Treaty on the Functioning of the EU (TFEU) and Article 79(2) of the Financial Regulation No 966/2012.

If payment is not made by the date in the debit note, the amount to be recovered (see above) will be increased by **late-payment interest** at the rate set out in Article 16.11, from the day following the date for payment in the debit note, up to and including the date the Agency or the Commission receives full payment of the amount.

Partial payments will be first credited against expenses, charges and late-payment interest and then against the principal.

Bank charges incurred in the recovery process will be borne by the beneficiary, unless Directive 2007/64/EC applies.

ARTICLE 29 — ADMINISTRATIVE SANCTIONS

In addition to contractual measures, the Agency or the Commission may also adopt administrative sanctions under Articles 106 and 131(4) of the Financial Regulation No 966/2012 (i.e. exclusion from future procurement contracts, grants and expert contracts and/or financial penalties).

SECTION 2 LIABILITY FOR DAMAGES

ARTICLE 30 — LIABILITY FOR DAMAGES

30.1 Liability of the Agency

The Agency cannot be held liable for any damage caused to the beneficiaries or to third parties as a consequence of implementing the Agreement, including for gross negligence.

The Agency cannot be held liable for any damage caused by any of the beneficiaries or third parties involved in the action, as a consequence of implementing the Agreement.

30.2 Liability of the beneficiaries

Except in case of force majeure (see Article 35), the beneficiaries must compensate the Agency for any damage it sustains as a result of the implementation of the action or because the action was not implemented in full compliance with the Agreement.

SECTION 3 SUSPENSION AND TERMINATION

ARTICLE 31 — SUSPENSION OF PAYMENT DEADLINE

31.1 Conditions

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The Agency may — at any moment — suspend the payment deadline (see Article 16.2 to 16.4) if a request for payment (see Article 15) cannot be approved because:

(a) it does not comply with the provisions of the Agreement (see Article 15);

(b) the technical or financial report(s) have not been submitted or are not complete or additional information is needed, or

(c) there is doubt about the eligibility of the costs declared in the financial statements and additional checks, reviews, audits or investigations are necessary.

31.2 Procedure

The Agency will formally notify the coordinator of the suspension and the reasons why.

The suspension will **take effect** the day notification is sent by the Agency (see Article 36).

If the conditions for suspending the payment deadline are no longer met, the suspension will be **lifted** — and the remaining period will resume.

If the suspension exceeds two months, the coordinator may request the Agency if the suspension will continue.

If the payment deadline has been suspended due to the non-compliance of the technical or financial report(s) (see Article 15) and the revised report or statement is not submitted or was submitted but is also rejected, the Agency may also terminate the Agreement or the participation of the beneficiary (see Article 34.3.1(i)).

ARTICLE 32 — SUSPENSION OF PAYMENTS

32.1 Conditions

The Agency may — at any moment — suspend payments, in whole or in part for one or more beneficiaries, if:

(a) a beneficiary (or a natural person who has the power to represent or take decision on its behalf) has committed or is suspected of having committed:

  (i) substantial errors, irregularities or fraud or

  (ii) serious breach of obligations under this Agreement or during the award procedure (including improper implementation of the action, submission of false information, failure to provide required information, breach of ethical principles) or

(b) a beneficiary (or a natural person who has the power to represent or take decision on its behalf) has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have a material impact on this grant (**extension of findings from other grants to this grant**; see Article 17.5.2).

If payments are suspended for one or more beneficiaries, the Agency will make partial payment(s) for the part(s) not suspended. If suspension concerns the payment of the balance, the payment (or

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recovery) of the amount(s) concerned after suspension is lifted will be considered to be the payment that closes the action.

32.2 Procedure

Before suspending payments, the Agency will formally notify the coordinator or beneficiary concerned:

- informing it of its intention to suspend payments and the reasons why and
- inviting it to submit observations within 30 days of receiving notification.

If the Agency does not receive observations or decides to pursue the procedure despite the observations it has received, it will formally notify **confirmation** of the suspension. Otherwise, it will formally notify that the suspension procedure is not continued.

The suspension will **take effect** the day the confirmation notification is sent by the Agency.

If the conditions for resuming payments are met, the suspension will be **lifted**. The Agency will formally notify the coordinator or beneficiary concerned.

During the suspension, the periodic report(s) for all reporting periods except the last one (see Article 15.3) must not contain any individual financial statement(s) from the beneficiary concerned and its affiliated entities. The coordinator must include them in the next periodic report after the suspension is lifted or — if suspension is not lifted before the end of the action — in the last periodic report.

The beneficiaries may suspend implementation of the action (see Article 33.1) or terminate the Agreement or the participation of the beneficiary concerned (see Article 34.1 and 34.2).

ARTICLE 33 — SUSPENSION OF THE ACTION IMPLEMENTATION

33.1 Suspension of the action implementation, by the beneficiaries

33.1.1 Conditions

The beneficiaries may suspend implementation of the action or any part of it, if exceptional circumstances — in particular *force majeure* (see Article 35) — make implementation impossible or excessively difficult.

33.1.2 Procedure

The coordinator must immediately formally notify to the Agency the suspension (see Article 36), stating:

- the reasons why and
- the expected date of resumption.

The suspension will **take effect** the day this notification is received by the Agency.

Once circumstances allow for implementation to resume, the coordinator must immediately formally

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notify the Agency and request an **amendment** of the Agreement, to set the date on which the action will be resumed, extend the duration of the action and make other changes necessary to adapt the action to the new situation (see Article 39) — unless the Agreement or the participation of a beneficiary has been terminated (see Article 34).

The suspension will be **lifted** with effect from the resumption date set out in the amendment. This date may be before the date on which the amendment enters into force.

Costs incurred during suspension of the action implementation are not eligible (see Article 6).

33.2 Suspension of the action implementation, by the Agency

33.2.1 Conditions

The Agency may suspend implementation of the action or any part of it, if:

(a) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed or is suspected of having committed:

  (i) substantial errors, irregularities or fraud or

  (ii) serious breach of obligations under this Agreement or during the award procedure (including improper implementation of the action, submission of false declaration, failure to provide required information, breach of ethical principles) or

(b) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have a material impact on this grant (**extension of findings from other grants to this grant;** see Article 17.5.2).

33.2.2 Procedure

Before suspending implementation of the action, the Agency will formally notify the coordinator or beneficiary concerned:

- informing it of its intention to suspend the implementation and the reasons why and

- inviting it to submit observations within 30 days of receiving notification.

If the Agency does not receive observations or decides to pursue the procedure despite the observations it has received, it will formally notify **confirmation** of the suspension. Otherwise, it will formally notify that the procedure is not continued.

The suspension will **take effect** five days after confirmation notification is received (or on a later date specified in the notification).

It will be **lifted** if the conditions for resuming implementation of the action are met.

The coordinator or beneficiary concerned will be formally notified of the lifting and the Agreement will be **amended**, to set the date on which the action will be resumed, extend the duration of the action and make other changes necessary to adapt the action to the new situation (see Article 39) — unless the Agreement has already been terminated (see Article 34).

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The suspension will be lifted with effect from the resumption date set out in the amendment. This date may be before the date on which the amendment enters into force.

Costs incurred during suspension are not eligible (see Article 6).

The beneficiaries may not claim damages due to suspension by the Agency (see Article 30).

Suspension of the action implementation does not affect the Agency's right to terminate the Agreement or participation of a beneficiary (see Article 34), reduce the grant or recover amounts unduly paid (see Articles 27 and 28).

ARTICLE 34 — TERMINATION OF THE AGREEMENT OR OF THE PARTICIPATION OF ONE OR MORE BENEFICIARIES

34.1 Termination of the Agreement, by the beneficiaries

34.1.1 Conditions and procedure

The beneficiaries may terminate the Agreement.

The coordinator must formally notify termination to the Agency (see Article 36), stating:

- the reasons why and
- the date the termination will take effect. This date must be after the notification.

If no reasons are given or if the Agency considers the reasons do not justify termination, the Agreement will be considered to have been '**terminated improperly**'.

The termination will **take effect** on the day specified in the notification.

34.1.2 Effects

The coordinator must — within 60 days from when termination takes effect — submit a periodic report (for the open reporting period until termination; see Article 15.3) and the final report (see Article 15.4).

If the Agency does not receive the report(s) within the deadline (see above), only costs which are included in an approved periodic report will be taken into account.

The Agency will **calculate** the final grant amount (see Article 5.3) and the balance (see Article 16.4) on the basis of the report(s) submitted. Only costs incurred until termination are eligible (see Article 6). Costs relating to contracts due for execution only after termination are not eligible.

Improper termination may lead to a reduction of the grant (see Article 27).

After termination, the beneficiaries' obligations (in particular, Articles 15, 17, 18, 19, 20, 21, 22, 24, 26, 27 and 28) continue to apply.

34.2 Termination of the participation of one or more beneficiaries, by the beneficiaries

34.2.1 Conditions and procedure

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The participation of one or more beneficiaries may be terminated by the coordinator, on request of the beneficiary concerned or on behalf of the other beneficiaries.

The coordinator must formally notify termination to the Agency (see Article 36) and inform the beneficiary concerned.

If the coordinator's participation is terminated without its agreement, the formal notification must be done by another beneficiary (acting on behalf of the other beneficiaries).

The notification must include:

- the reasons why;
- the opinion of the beneficiary concerned (or proof that this opinion has been requested in writing);
- the date the termination takes effect. This date must be after the notification, and
- a request for amendment (see Article 39), with a proposal for reallocation of the tasks and the estimated budget of the beneficiary concerned (see Annexes 1 and 2) and, if necessary, the addition of one or more new beneficiaries (see Article 40). If termination takes effect after the period set out in Article 3, no request for amendment must be included, unless the beneficiary concerned is the coordinator. In this case, the request for amendment must propose a new coordinator.

If this information is not given or if the Agency considers that the reasons do not justify termination, the participation will be considered to have been **terminated improperly**.

The termination will **take effect** on the day specified in the notification.

34.2.2 Effects

The beneficiary concerned must submit to the coordinator:

(i) a technical report and

(ii) a financial statement covering the period from the end of the last reporting period to the date when termination takes effect.

This information must be included by the coordinator in the periodic report for the next reporting period (see Article 15.3).

If the request for amendment is rejected by the Agency (because it calls into question the decision awarding the grant or breaches the principle of equal treatment of applicants), the Agreement may be terminated according to Article 34.3.1(c).

If the request for amendment is accepted by the Agency, the Agreement is **amended** to introduce the necessary changes (see Article 39).

Improper termination may lead to a reduction of the grant (see Article 27) or termination of the Agreement (see Article 34).

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After termination, the concerned beneficiary's obligations (in particular Articles 15, 17, 18, 19, 21, 22, 24, 26, 27 and 28) continue to apply.

34.3 Termination of the Agreement or of the participation of one or more beneficiaries, by the Agency

34.3.1 Conditions

The Agency may terminate the Agreement or the participation of one or more beneficiaries, if:

(a) one or more beneficiaries do not accede to the Agreement (see Article 40);

(b) a change to their legal, financial, technical, organisational or ownership situation (or those of its affiliated entities) is likely to substantially affect or delay the implementation of the action or calls into question the decision to award the grant;

(c) following termination of participation for one or more beneficiaries (see above), the necessary changes to the Agreement would call into question the decision awarding the grant or breach the principle of equal treatment of applicants (see Article 39);

(d) implementation of the action is prevented by force majeure (see Article 35) or suspended by the coordinator (see Article 33.1) and either:

  (i) resumption is impossible, or

  (ii) the necessary changes to the Agreement would call into question the decision awarding the grant or breach the principle of equal treatment of applicants;

(e) a beneficiary is declared bankrupt, being wound up, having its affairs administered by the courts, has entered into an arrangement with creditors, has suspended business activities, or is subject to any other similar proceedings or procedures under national law;

(f) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has been found guilty of professional misconduct, proven by any means;

(g) a beneficiary does not comply with the applicable national law on taxes and social security;

(h) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed fraud, corruption, or is involved in a criminal organisation, money laundering or any other illegal activity;

(i) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed:

  (i) substantial errors, irregularities or fraud or

  (ii) serious breach of obligations under the Agreement or during the award procedure (including improper implementation of the action, submission of false information, failure to provide required information, breach of ethical principles);

(j) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have

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a material impact on this grant (**extension of findings from other grants to this grant**; see Article 17.5.2);

(k) despite a specific request by the Agency, a beneficiary does not request — through the coordinator — an amendment to the Agreement to end the participation of one of its affiliated entities that is in one of the situations under points (e), (f), (g), (h), (i) or (j) and to reallocate its tasks

34.3.2 Procedure

Before terminating the Agreement or participation of one or more beneficiaries, the Agency will formally notify the coordinator or beneficiary concerned:

- informing it of its intention to terminate and the reasons why and
- inviting it, within 30 days of receiving notification, to submit observations and — in case of Point (i.ii) above — to inform the Agency of the measures to ensure compliance with the obligations under the Agreement.

If the Agency does not receive observations or decides to pursue the procedure despite the observations it has received, it will formally notify to the coordinator or beneficiary concerned **confirmation** of the termination and the date it will take effect. Otherwise, it will formally notify that the procedure is not continued.

The termination will **take effect**:

- for terminations under Points (b), (c), (e), (g), (i.ii) and (k) above: on the day specified in the notification of the confirmation (see above);
- for terminations under Points (a), (d), (f), (h), (i.i) and (j) above: on the day after the notification of the confirmation is received.

34.3.3 Effects

(a) for **termination of the Agreement**:

The coordinator must — within 60 days from when termination takes effect — submit a periodic report (for the last open reporting period until termination; see Article 15.3) and a final report (see Article 15.4).

If the Agreement is terminated for breach of the obligation to submit reports (see Articles 15.8 and 34.3.1(i)), the coordinator may not submit any reports after termination.

If the Agency does not receive the report(s) within the deadline (see above), only costs which are included in an approved periodic report will be taken into account.

The Agency will **calculate** the final grant amount (see Article 5.3) and the balance (see Article 16.4) on the basis of the report(s) submitted. Only costs incurred until termination takes effect are eligible (see Article 6). Costs relating to contracts due for execution only after termination are not eligible.

This does not affect the Agency's right to reduce the grant (see Article 27) or to impose administrative sanctions (Article 29).

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The beneficiaries may not claim damages due to termination by the Agency (see Article 30).

After termination, the beneficiaries' obligations (in particular Articles 15, 17, 18, 19, 21, 22, 24, 26, 27 and 28) continue to apply.

(b) for **termination of the participation of one or more beneficiaries**:

The coordinator must — within 60 days from when termination takes effect — submit a request for amendment (see Article 39), with a proposal for reallocation of the tasks and estimated budget of the beneficiary concerned (see Annexes 1 and 2) and, if necessary, the addition of one or more new beneficiaries (see Article 40). If termination is notified after the period set out in Article 3, no request for amendment must be submitted unless the beneficiary concerned is the coordinator. In this case the request for amendment must propose a new coordinator.

The beneficiary concerned must submit to the coordinator:

(i) a technical report and

(ii) a financial statement covering the period from the end of the last reporting period to the date when termination takes effect.

This information must be included by the coordinator in periodic report for the next reporting period (see Article 15.3).

If the request for amendment is rejected by the Agency (because it calls into question the decision awarding the grant or breaches the principle of equal treatment of applicants), the Agreement may be terminated according to Article 34.3.1(c).

If the request for amendment is accepted by the Agency, the Agreement is **amended** to introduce the necessary changes (see Article 39).

After termination, the concerned beneficiary's obligations (in particular Articles 15, 17, 18, 19, 20, 21, 22, 24, 26, 27 and 28) continue to apply.

SECTION 4 FORCE MAJEURE

ARTICLE 35 — FORCE MAJEURE

'Force majeure' means any situation or event that:

- prevents either party from fulfilling their obligations under the Agreement,
- was unforeseeable, exceptional situation and beyond the parties' control,
- was not due to error or negligence on their part (or on the part of third parties involved in the action), and
- proves to be inevitable in spite of exercising all due diligence.

The following cannot be invoked as force majeure:

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- any default of a service, defect in equipment or material or delays in making them available, unless they stem directly from a relevant case of force majeure,

- labour disputes or strikes, or

- financial difficulties.

Any situation constituting force majeure must be formally notified to the other party without delay, stating the nature, likely duration and foreseeable effects.

The parties must immediately take all the necessary steps to limit any damage due to force majeure and do their best to resume implementation of the action as soon as possible.

The party prevented by force majeure from fulfilling its obligations under the Agreement cannot be considered in breach of them.

CHAPTER 7 FINAL PROVISIONS

ARTICLE 36 — COMMUNICATION BETWEEN THE PARTIES

36.1 Form and means of communication

Communication under the Agreement (information, requests, submissions, 'formal notifications', etc.) must:

- be made in writing and

- bear the number of the Agreement.

Until the payment of the balance: all communication must be made through the electronic exchange system and using the forms and templates provided there.

After the payment of the balance: formal notifications must be made by registered post with proof of delivery (‘formal notification on paper’).

Communications in the electronic exchange system must be made by persons authorised according to the Participant Portal Terms & Conditions. For naming the authorised persons, each beneficiary must have designated — before the signature of this Agreement — a ‘legal entity appointed representative (LEAR)’. The role and tasks of the LEAR are stipulated in his/her appointment letter (see Participant Portal Terms & Conditions).

If the electronic exchange system is temporarily unavailable, instructions will be given on the Agency and Commission websites.

36.2 Date of communication

Communications are considered to have been made when they are sent by the sending party (i.e. on the date and time they are sent through the electronic exchange system).

Formal notifications through the **electronic** exchange system are considered to have been made when they are received by the receiving party (i.e. on the date and time of acceptance by the receiving party,

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as indicated by the time stamp). A formal notification that has not been accepted within 10 days after sending is considered to have been accepted.

Formal notifications **on paper** sent by **registered post** with proof of delivery (only after the payment of the balance) are considered to have been made on either:

- the delivery date registered by the postal service or
- the deadline for collection at the post office.

If the electronic exchange system is temporarily unavailable, the sending party cannot be considered in breach of its obligation to send a communication within a specified deadline.

36.3 Addresses for communication

The **electronic** exchange system must be accessed via the following URL:

[redacted]

The Agency will formally notify the coordinator and beneficiaries in advance any changes to this URL.

Formal notifications on paper (only after the payment of the balance) addressed **to the Agency** must be sent to the following address:

Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)
Health and Food Safety Unit Health and Food Safety Unit
Drosbach Building
L-2920 Luxembourg

Formal notifications on paper (only after the payment of the balance) addressed **to the beneficiaries** must be sent to their legal address as specified in the Participant Portal Beneficiary Register.

ARTICLE 37 — INTERPRETATION OF THE AGREEMENT

37.1 Precedence of the Terms and Conditions over the Annexes

The provisions in the Terms and Conditions of the Agreement take precedence over its Annexes.

Annex 2 takes precedence over Annex 1.

37.2 Privileges and immunities

Not applicable

ARTICLE 38 — CALCULATION OF PERIODS, DATES AND DEADLINES

In accordance with Regulation No 1182/71[12], periods expressed in days, months or years are calculated from the moment the triggering event occurs.

[12] Regulation (EEC, Euratom) No 1182/71 of the Council of 3 June 1971 determining the rules applicable to periods, dates and time-limits (OJ L 124, 8/6/1971, p. 1).

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The day during which that event occurs is not considered as falling within the period.

ARTICLE 39 — AMENDMENTS TO THE AGREEMENT

39.1 Conditions

The Agreement may be amended, unless the amendment entails changes to the Agreement which would call into question the decision awarding the grant or breach the principle of equal treatment of applicants.

Amendments may be requested by any of the parties.

39.2 Procedure

The party requesting an amendment must submit a request for amendment signed in the electronic exchange system (see Article 36).

The coordinator submits and receives requests for amendment on behalf of the beneficiaries (see Annex 3).

If a change of coordinator is requested without its agreement, the submission must be done by another beneficiary (acting on behalf of the other beneficiaries).

The request for amendment must include:

- the reasons why;
- the appropriate supporting documents, and
- for a change of coordinator without its agreement: the opinion of the coordinator (or proof that this opinion has been requested in writing).

The Agency may request additional information.

If the party receiving the request agrees, it must sign the amendment in the electronic exchange system within 45 days of receiving notification (or any additional information the Agency has requested). If it does not agree, it must formally notify its disagreement within the same deadline. The deadline may be extended, if necessary for the assessment of the request. If no notification is received within the deadline, the request is considered to have been rejected.

An amendment **enters into force** on the day of the signature of the receiving party.

An amendment **takes effect** on the date agreed by the parties or, in the absence of such an agreement, on the date on which the amendment enters into force.

ARTICLE 40 — ACCESSION TO THE AGREEMENT

40.1 Accession of the beneficiaries mentioned in the preamble

The other beneficiaries must accede to the Agreement by signing the Accession Form (see Annex 3) in the electronic exchange system (see Article 36) within 30 days after its entry into force (see Article 42).

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They will assume the rights and obligations under the Agreement with effect from the date of its entry into force (see Article 42).

If a beneficiary does not accede to the Agreement within the above deadline, the coordinator must — within 30 days — request an amendment to make any changes necessary to ensure proper implementation of the action. This does not affect the Agency's right to terminate the Agreement (see Article 34).

40.2 Addition of new beneficiaries

In justified cases, the beneficiaries may request the addition of a new beneficiary.

For this purpose, the coordinator must submit a request for amendment in accordance with Article 39. It must include an Accession Form (see Annex 3) signed by the new beneficiary in the electronic exchange system (see Article 36).

New beneficiaries must assume the rights and obligations under the Agreement with effect from the date of their accession specified in the Accession Form (see Annex 3).

ARTICLE 41 — APPLICABLE LAW AND SETTLEMENT OF DISPUTES

41.1 Applicable law

The Agreement is governed by the applicable EU law, supplemented if necessary by the law of Belgium.

41.2 Dispute settlement

If a dispute concerning the interpretation, application or validity of the Agreement cannot be settled amicably, the General Court — or, on appeal, the Court of Justice of the European Union — has sole jurisdiction. Such actions must be brought under Article 272 of the Treaty on the Functioning of the EU (TFEU).

As an exception, if such a dispute is between the Agency and ‘MINISTRY OF CIVIL AFFAIRS’, ‘MINISTARSTVO ZDRAVLJE’, the competent Belgian courts have sole jurisdiction.

If a dispute concerns administrative sanctions, offsetting or an enforceable decision under Article 79(2) of the Financial Regulation No 966/2012 and Article 299 TFEU (see Articles 28, 29 and 30), the beneficiaries must bring action before the General Court — or, on appeal, the Court of Justice of the European Union — under Article 263 TFEU. Actions against enforceable decisions must be brought against the Commission (not against the Agency).

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ARTICLE 42 — ENTRY INTO FORCE OF THE AGREEMENT

The Agreement will enter into force on the day of signature by the Agency or the coordinator, depending on which is later.

SIGNATURES

For the coordinator

Esteban DE MANUEL KEENOY with ECAS id nmanuees signed in the Participant Portal on 20/07/2020 at 10:49:19 (transaction id SigId-125904-Dj0B2D0JivWZb3E2Mn1N68Yhs0aZXJ2Y6Sfbsk7ONpUnr4agNE4bIEUscFevbPbiliU1F73BzYp9yiJ3mzGYSa-jpJZscgsw0KmE9q55QdRE4-YbeV7rG9SG8Vxt2fdf7QSdPdJC3CphBXDzf3oQzLnrwfoB5Zk95wFAr9lZQkdJiUMQhACY0bFAS5Z34kIP3Aqk). Timestamp by third party at
Mon Jul 20 12:05:49 CEST 2020

For the Agency

Signed by Veronique WASBAUER with ECAS id wasbave as an authorised representative on 20-07-2020 12:47:00 (transaction id SigId-126829-Bhm5F8hFtv4otUbfw26rCBxCQ7UsSqABUDPVGzOm3AZRpRxlCsSMQeSlOfozYbnFndZkMrT0NzTzzonVeEf4ubW-jpJZscgsw0KmE9q55QdRE4-Fy00MCQtpacLMNHURMxRI0zuwddLHzOeWKZR587iS41PvlMWC4ktIC0EWg2VpJLxO9cyUehRg62bo4zTNaMFbbG)
Mon Jul 20 12:47:04 CEST 2020

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EUROPEAN COMMISSION
Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)

The Director

ANNEX 1 (part A)

Project

NUMBER — 951442 — JADECARE

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1.1. The project summary

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Project Number [1]	951442	Project Acronym [2]	JADECARE

One form per project

General information	
Project title [3]	Joint Action on implementation of digitally enabled integrated person-centred care
Starting date [4]	01/10/2020
Duration in months [5]	36
Call (part) identifier [6]	HP-JA-2019
Topic	JA-03-2019 Joint Action on implementation of digitally enabled integrated person-centred care
Fixed EC Keywords	
Free keywords	Integrated care, digitally, original good practices, next adopters, transfer, policy makers, implementation, pilots,

Abstract [7]

The journey of care delivery transformation in Europe is just at the beginning, and the underlying digital health technologies that will support the transformation of health and care need to be purposefully designed, developed, and must demonstrate cost-effectiveness potential.
The EU has launched a series of initiatives to support facing these challenges, as the EIP-AHA with actual twinning amongst partners, various Joint Actions and EU funded projects. Based on this previous work, four early adopters ´ original Good Practice (oGP) were selected to be transferred to other EU countries (next adopters). concerning integration, chronic conditions, multimorbidities, frail people and patients with complex needs, self-care, prevention and population health, disease management and case management.
JADECARE intends to reinforce the capacity of health authorities to successfully address important aspects of health system transformation, in particular the transition to digitally-enabled, integrated, person-centred care and support the best practice transfer from the systems of the “early adopters” to the ones of the “next adopters”.
JADECARE is focusing on the transfer and adoption of four Good Practices, so-called oGPs: Basque Health strategy in ageing and chronicity: integrated care, Catalan open innovation hub on ICT-supported integrated care services for chronic patients, The OptiMedis Model-Population-based integrated care (Germany) and Digital roadmap towards an integrated health care sector (Denmark).
JADECARE will involve partners from 17 countries all around Europe. providing a complete scenario of the idiosyncrasy and differences that can be found. The local context, maturity of integrated care models, legal frameworks, culture/values and relevant leaders are going to be considered for each of the 23 “next adopters”. The methodology will allow the transference in different contexts: socioeconomic, cultural, legal, models and maturity of health syst

1.2. List of Beneficiaries

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

Project Number [1]	951442	Project Acronym [2]	JADECARE

List of Beneficiaries

No	Name	Short name	Country	Project entry month[8]	Project exit month
1	ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE	KG	Spain	1	36
2	MINISTRY OF CIVIL AFFAIRS	MCA	Bosnia and Herzegovina	1	36
3	HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO	CIPH	Croatia	1	36
4	MINISTERSTVO ZDRAVOTNICTVI CESKE REPUBLIKY	MZCR	Czech Republic	1	36
5	REGION NORDJYLLAND (NORTH DENMARK REGION)	RND	Denmark	1	36
6	SOTSIAALMINISTEERIUM	MSAE	Estonia	1	36
7	EUROMETROPOLE DE STRASBOURG	EUSTRAS	France	1	36
8	BEHOERDE FUER ARBEIT, GESUNDHEIT, SOZIALES, FAMILIE UND INTEGRATION HAMBURG	BAGSFI	Germany	1	36
9	4I DIOIKISI YGEIONOMIKIS PERIFEREIAS MAKEDONIAS KAI THRAKIS	4THYPE	Greece	1	36
10	ALLAMI EGESZSEGUGYI ELLATO KOZPONT	AEEK	Hungary	1	36
11	AGENZIA NAZIONALE PER I SERVIZI SANITARI REGIONALI	AGENAS	Italy	1	36
12	NACIONALAIS VESELIBAS DIENESTS	NVD	Latvia	1	36
13	LIETUVOS RESPUBLIKOS SVEIKATOS APSAUGOS MINISTERIJA	LR SAM	Lithuania	1	36
14	ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP	ACSS	Portugal	1	36
15	MINISTARSTVO ZDRAVLJE	MoHRS	Serbia	1	36
16	NACIONALNI INSTITUT ZA JAVNO ZDRAVJE	NIJZ	Slovenia	1	36
17	REGIONAL HEALTH AND SOCIAL CARE BOARD	HSCB	United Kingdom	1	36

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

1.3. Workplan Tables - Detailed Implementation

1.3.1. WT1 List of work packages

WP Number[9]	WP Title	Lead beneficiary[10]	Person-months[11]	Start month[12]	End month[13]
WP1	Coordination and management	1 - KG	99.00	1	36
WP2	Dissemination	10 - AEEK	69.00	1	36
WP3	EVALUATION	9 - 4THYPE	93.75	1	36
WP4	INTEGRATION IN NATIONAL POLICIES AND SUSTAINABILITY	16 - NIJZ	162.65	1	36
WP5	BASQUE HEALTH STRATEGY IN AGEING AND CHRONICITY: INTEGRATED CARE GOOD PARCTICE: TRANSFER AND ADOPTION	1 - KG	137.74	1	36
WP6	CATALAN OPEN INNOVATION HUB ON ICT-SUPPORTED INTEGRATED CARE SERVICES FOR CHRONIC PATIENTS GOOD PRACTICE: TRANSFER AND ADOPTION	1 - KG	85.03	1	36
WP7	THE OPTIMEDIS MODEL-POPULATION BAED INTEGRATED CARE GOOD PRACTICE: TRANSFER AND ADOPTION	7 - EUSTRAS	52.20	1	36
WP8	DIGITAL ROADMAP TOWARDS AN INTEGRATED HEALTH CARE SECTOR GOOD PRACTICE TRANSFER AND ADOPTION	5 - RND	105.48	1	36
		Total	804.85		

1.3.2. WT2 list of deliverables

Deliverable Number[14]	Deliverable Title	WP number[9]	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D1.1	Project Handbook	WP1	1 - KG	Report	Public	6
D2.1	Leaflet	WP2	10 - AEEK	Report	Public	6
D2.2	Project website	WP2	8 - BAGSFI	Websites, patents filling, etc.	Public	6
D2.3	Dissemination and communication strategy and plan	WP2	10 - AEEK	Report	Public	6
D2.4	Final report on Dissemination	WP2	10 - AEEK	Report	Public	36
D2.5	Layman of the final report	WP2	10 - AEEK	Report	Public	36
D3.1	Impact Assessment Plan	WP3	9 - 4THYPE	Report	Public	9
D3.2	Interim Evaluation Report	WP3	9 - 4THYPE	Report	Public	18
D3.3	Final Evaluation Report	WP3	9 - 4THYPE	Report	Public	36
D4.1	Local Good Practices and Action Plans	WP4	11 - AGENAS	Report	Public	15
D4.2	Blueprint on learning from Good Practices	WP4	11 - AGENAS	Report	Public	35
D4.3	Characteristics of JADECARE practices, leading to sustainability and integration in national policies	WP4	16 - NIJZ	Report	Public	36
D5.1	The Basque integrated care approach original Good Practice and transfer process	WP5	1 - KG	Report	Public	30
D6.1	The Catalan Innovation Hub original Good Practice and transfer process	WP6	1 - KG	Report	Public	30
D7.1	The Optimedis Model original Good Practice and transfer process	WP7	7 - EUSTRAS	Report	Public	30
D8.1	The Danish roadmap towards Integrated Care original Good Practice and transfer process	WP8	5 - RND	Report	Public	30

1.3.3. WT3 Work package descriptions

Work package number [9]	WP1	**Lead beneficiary** [10]	1 - KG
Work package title	Coordination and management		
Start month	1	**End month**	36

Objectives

KG will be the Leading Executive Organisation (LEO) of WP1.

This WP aims at adequately manage and coordinate the project. It will imply the following specific objectives:
-To provide technical, scientific, financial and administrative management and support
-To steer efforts of the partners for the achievement of milestones
-To elaborate a project management handbook defining general procedures for the project management and quality assurance
-To monitor progress to avoid deviations
-To ensure ethical compliance
-To communicate with CHAFEA and SANTE
-To comply with the CHAFEA rules (financial, legal & administrative issues)
-To organize coordination meetings on a regular basis

Description of work and role of partners

WP1 - Coordination and management [Months: 1-36]
KG, MCA, CIPH, MZCR, RND, MSAE, EUSTRAS, BAGSFI, 4THYPE, AEEK, AGENAS, NVD, LR SAM, ACSS, MoHRS, NIJZ, HSCB
T1.1: CONSORTIUM OPERATING PROCEDURES DEFINITION & QUALITY ASSURANCE (LEADER: KG, PARTICIPANTS: ALL) (M1-M36)
KRONIKGUE will elaborate a Handbook for project management and quality assurance. It will include guidelines for financial reporting, presentation standards for deliverables and reports to CHAFEA, measures to ensure timely reporting, payment procedures plan and calendar, etc.
The Project Handbook is a quick reference manual for partners to consult management procedures. It will summarize the Consortium organizational structure, decision-making procedures, the deliverables acceptance procedure, roles and responsibilities, internal communication policy and quality and risk management procedures. It will provide the project plans and the project change management plan. It becomes the basis for managing the project throughout its lifecycle and is an important point of reference for all project members and stakeholders. The Project Handbook will be kept up to date throughout the life of the project. For deliverables and other documents, it is expected that documents could be associated to one or more tasks of the project and therefore has one or more contributors. Each deliverable has usually a main contributor, which is also the partner responsible for the deliverable. This responsibility is always shared with the WP Leads. All the deliverables must be submitted within the deadlines defined in the project. To guarantee the quality of the document a reviewer/s will be assigned per each deliverable according to the expertise in the area. The Reviewer assigned will review the reports and deliverables from each work package and will give feedback and comments in advance of the submission date of the deliverable. The Lead beneficiary of a deliverable will take into consideration the feedback from the reviewer and implement changes (if necessary).
Internal communication procedures will be defined in order to achieve the best results on the project execution. KRONIKGUNE will support the communication between Competent Authorities and WP Leads and co-leaders and will facilitate the relevant information/results exchange.
Different tools will be developed and updated during the project lifetime: project plans, action lists, risk register, project stakeholder matrix, internal personnel lists and payment/budget evolution according to the internal and CHAFEA financial rules.

T1.2: COORDINATION OF THE JA AND DAY-TO-DAY MANAGEMENT (KG, PARTICIPANTS: ALL) (M1-M36)
This task will involve coordination and management of administrative and financial matters, administrative support to Competent Authorities, submission of high-quality deliverables, project progress monitoring, preparation of periodic reports and communication with CHAFEA services and Project Officers for purposes of coordination. Kronikgune, as Joint Action coordinator, will be in charge of this task supported by the rest of the involved parties in the project. The

official Periodic Reporting Document will be submitted to CHAFEA in M18 and M36. The management structure and progress monitoring of the Joint Action is described in depth in Section 9.

T1.3: CONSORTIUM MEETINGS (LEADER: KG, PARTICIPANTS: ALL) (M1-M36)
Consortium meetings will be held in a location with good access, contributing to keep transportation costs as low as possible. The following set of meetings is foreseen:
-KICK-OFF MEETING: this first meeting will take place at the start of the project (M1).
-CONSORTIUM MEETINGS: consortium meetings will take place to ensure that the project is being properly carried out, and to provide relevant guidelines (first meeting at M12-M13, second meeting at M24-M26 and third meeting at M34-M36).
-FINAL CONFERENCE: at the end of the project, the final conference will take place in order to present the project results and outcomes. All partners and EC representatives will be invited to these meetings.
-POLICY LEVEL MEETINGS: will be convened annually.
-MANAGERIAL VIRTUAL MEETINGS: Kronikgune will led dedicated teleconferences at convenience with Competent Authorities, every 2 months approximately.
-TECHNICAL VIRTUAL MEETINGS: teleconferences between Kronikgune and WP Leads, co-leaders and task leaders will be held every two weeks in order to monitor the technical aspects of WPs. Face-to-face meetings will be held during consortium meetings.

T 1.4 ETHICAL MANAGEMENT (LEADER: KG, PARTICIPANTS: ALL) (M1-M36)
This activity will provide ethical oversight, analysis, and guidance on all aspects of the JA.
Task 1.4 will deal with ethical values, moral principles and social rules form the basis of social life as well as national laws, regarding the whole provision of integrated care (change of model and service) and use of ICT tools, from a holistic point of view: patients, healthcare professionals, carers or others.

T1.5. LEGAL MANAGEMENT (LEADER: KG, PARTICIPANTS: ALL) (M1-M36)
This task will deal with all contractual and other legal issues related to the Joint Action, which will primarily focus on partnership management and formalization of updates of the work plan, roles and resources assignments as needed. In particular, it will comprise Grant Agreement and Consortium Agreement implementation and amendments, support to partners in legal issues, production of non-disclosure agreements.

MILESTONES
M1: Kick-off meeting (LB & LEO: KG) (M1)
M2: Periodic technical and financial report (LB & LEO: KG) (M18)
M3: Final technical and financial report (LB & LEO: KG) (M36)

Participation per Partner

Partner number and short name	WP1 effort
1 - KG	67.00
2 - MCA	2.00
3 - CIPH	2.00
4 - MZCR	2.00
5 - RND	2.00
6 - MSAE	2.00
7 - EUSTRAS	2.00
8 - BAGSFI	2.00
9 - 4THYPE	2.00
10 - AEEK	2.00
11 - AGENAS	2.00
12 - NVD	0.00

Partner number and short name	WP1 effort
CCUH	2.00
13 - LR SAM	2.00
14 - ACSS	2.00
15 - MoHRS	2.00
16 - NIJZ	2.00
17 - HSCB	2.00
Total	99.00

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D1.1	Project Handbook	1 - KG	Report	Public	6

Description of deliverables

D1.1 : Project Handbook [6]

LB & LEO KG Will describe the consortium structure, roles and responsibilities, internal communication procedures, quality assurance (for example, deliverable review process), activities monitoring, risk and issues management and decision-making procedures, becoming the basis for managing and monitoring the project throughout its lifecycle.

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS1	Kick-off meeting	1 - KG	1	Kick off meeting (LB & LEO: KG)
MS2	Periodic technical and financial report	1 - KG	18	Periodic technical and financial report sent to CHAFEA (LB & LEO: KG)
MS3	Final technical and financial report	1 - KG	36	Final technical and financial report sent to CHAFEA (LB & LEO: KG)

Work package number [9]	WP2	Lead beneficiary [10]	10 - AEEK
Work package title	Dissemination		
Start month	1	End month	36

Objectives

SU-HSMTC will be the Leading Executive Organization (LEO) of WP2 and BAGSFI the Co-Leading Executive Organization.

The overall objective of Work Package 2 is to disseminate high quality information on Joint Action Digital Care deliverables and progress to contribute to the development of a sustainable mechanism of advancing/providing high quality services of integrated care in Europe. The work starts with initial communication activities to position the JA on the EU landscape, generate recognition and understanding of the project goals and ambitions. This general communication serves attracting key stakeholder groups listed in chapter 3, especially patients and their families and employers, as well as health workforce and care provider organizations, insurance funds and policy makers. These stakeholders are the end-users of the digitally enabled care solutions. The goal is to prepare and assist engagement of stakeholders in the implementation of work packages (mainly WP5-8), not only to share the aims and objectives of the Joint Action, but to learn the needs of the end-users as well. Among them, patients will be put into the focus in order to strengthen the patient centered scope of the action. JADECARE will make use of available policy recommendations and guidance to increase patient empowerment (delivered by other joint actions, e.g. eHAction, or good practices). Involvement of key stakeholders is essential for the successful identification of real needs and analysation of next adopters' ecosystem. Research shall be reached out to be able to showcase existing digital offerings that can be introduced to the end-users or further developed to meet unmet needs of patients and their care providers and payers.
Outreach to patients will have a special role in preparing and executing pilot actions to assist care provider organizations and their staff to offer digital integrated health services. Results of patient involvement in the preparation phases (task 5.1, 6.1, 7.1 and 8.1, as well as 5.2, 6.2, 7.2 and 8.2) will be communicated and disseminated too.

Specific dissemination activities will follow to enhance and magnify the results, effect and impact of the common work, and support the sustainability of best practice transfer and replication. In addition, end-users - especially patients - would be informed about the results of the pilots in order to help to embed sustainable solutions into next adopters' health system and replicate the outcomes.
The specific objectives of the Work Package 2 are:
-To ensure that the results and deliverables of the Joint Action of digitally enabled integrated person-centered care are known both to general public and the stakeholders.
-To actively identify and engage stakeholders throughout the course of the project in order to ensure that the results of the project are applicable and appropriate to stakeholders.
-To improve knowledge, capacity and use of the JA methodologies, tools and practices by supporting the work of Work Package 4 and 5 to 8 with relevant communication and engagement tools

Description of work and role of partners

WP2 - Dissemination [Months: 1-36]
AEEK, KG, MCA, CIPH, MZCR, RND, MSAE, EUSTRAS, BAGSFI, 4THYPE, AGENAS, NVD, LR SAM, ACSS, MoHRS, NIJZ, HSCB
T2.1 EXTERNAL AND INTERNAL COMMUNICATION PLANS AND EXECUTION (LEADER: SU-HSMTC, PARTICIPANTS: ALL) (M1-M36)
The task is providing the initial strategy for internal and external communication and dissemination. This document will give an overview of the aims of the JA dissemination activities as well as setting up guidelines for the principles and process flow of dissemination for internal project partners: when, who, to whom, how and what partners should disseminate led, coordinated and regulated by WP2.

The over-arching ambition of the dissemination strategy is to ensure that, by the end of the 3-year timeline of the project, the relevant European and member state level stakeholder groups will be aware of the results, they will align with and support the project objectives, and engage in its activities on a sustainable basis. Thus, dissemination should be a vivid activity and should support multi-stakeholder dialogue on integrated care in order to put the JA in a central position in the domain of integrated care.

The strategy is then transferred to action items (actual campaigns, events, workshops, webinars etc. and their timings) in order to achieve the best impact of the project results.
This activity will organize, implement and coordinate the communication and dissemination actions addressed to make JA information available to the target audiences. The Communication Plan developed in Task 2.1 will define the type of activities that should be undertaken to reach the audiences more efficiently and provide the tools for doing so.

The initial dissemination channels have been identified to maximize impact and widespread reach to all target audiences, at local, national and international levels:
-Website – delivered in T2.3
-Social media accounts (Twitter, Linkedin, YouTube)
-eNewsletter
-Events and webinars – delivered in T2.4

Task 2.1 will generate news items for the website, as well as rich content for the social media accounts, based on the input and results of the implementation WPs and WP4.
The team will also support the event participation and presentations of the other WPs, as well as report about them in social media feeds and the website. The content of the newsletter should be a joint effort of the consortium, reflecting on the actual actions and results of the project.
In order to achieve the best coverage all other WPs should dedicate PM effort towards WP2, and maintain a lively internal communication and information flow, so that fresh and interesting project results can be relayed towards stakeholders and wider lay public.
The task will also monitor the quality and impact of the project dissemination by setting targeted KPIs, and following their development (social media engagement, website visitors, event participation, etc.)

T2.2 VISUAL IDENTITY AND PROMOTIONAL MATERIALS (LEADER: SU-HSMTC, PARTICIPANTS: ALL) (M1-M36)
As part of the dissemination strategy set out in T2.1 the WP2 team will create the visual identity of the project. After choosing the final acronym of the project the logo, colors, design elements, font type, brand tool with all the rules (including the EU rules) will be set and collected into the official House Style.
Once the branding is set promotional materials will be produced: leaflets, handouts, roll up, folders, posters, banners, infographics. Content of these promotional materials should be aligned with the website narrative, the production of which should be also a full consortium effort, in order to best articulate the goals and ambitions of the project.
Those project collaterals will be continuously monitored and updated mirroring the evolution and release of the project results and achievements

T2.3 WEBSITE - (LEADER: ZTG GMBH, PARTICIPANTS: ALL) (M1-M36)
The website is essential to fulfil the overall objectives of Work Package 2. i.e. to disseminate high quality information on all deliverables of JADECARE and hence to contribute to the development of a sustainable mechanism of advancing/ providing high quality services of integrated care in Europe. Overall:
-It helps to materialize the Communication Strategy for both external and internal communication
-It contributes to the impact of the project branding, press activities and social media
-It mirrors and extends the visual identity: logo, claim, key visual, etc.
-It serves as a central reference point for promotional materials: leaflets, roll up, folders, posters, press releases and newsletters
-It serves likewise as central reference point for announcing events, stakeholders' forums etc.
The project website is a focal point of all dissemination activities. It corresponds with all work packages and will provide information on public events, press/publications etc.

Moreover, project deliverables, methods and tools are provided.
-The website is instrumental to implement the dissemination strategy, which may define specific tasks.
-It has to comply with all project branding (initially a "pre-branded" website may function as placeholder)
-It shares text and visual information with flyers, roll-ups etc. and serves as second level reference of all promotion.
-It serves as gateway for tools and methods that the project makes available, publicly and/or in reserved areas.
-It leverages synergies with social media campaigns, e.g. through a Twitter feed and providing reference information.
-Via partner information slots, Joint Action partners and affiliates can redirect visitors to their own websites.

The website aims to address a broad audience consisting of the general public (people, patients, media etc.) and professional audiences in health and care as well as in the health and care administrations. Audience specific features will be established as much as feasible and possible. Minimally, the search facility will allow specifying needs, interests and stakeholder groups.

Like other dissemination materials, the website will also be adapted and tailored to local (local languages will however only be supported for parts of the content to keep resources under control), national and European target groups, including:
-Relevant scientific community
-Policy makers on issues related to healthcare
-Health Policy makers and experts
-Health professionals and other operators
-Municipalities and local health authorities
-Patients
-Carers or other social entities working in the field
-General population

The project website will be an easy to navigate entry point to a project-related repository of information. To fulfil this task smoothly, these features and requirements – reflecting lessons learned in other projects - will be implemented for accommodating the publishing and communication needs of JADECARE:
-Balanced, invitational homepage, attracting visitors' interest for concepts and deliverables
-Careful branding and visualizations to demonstrate the added value of the project)
-Responsive web design, making the website accessible also for mobile devices
-Standard provision of elementary website objects (pages, resources (PDF), news, events, links etc.)
-Repository for resources and deliverables; preparation for fast accessibility
-Social media buttons and an option to display of recent project related tweets
-Efficient search facility, combining full text information and metadata per document
-Structured and simple navigation (no bells and whistles) as established by many large organizations today
To best support the task, technical implementation will build on top of well-established technologies like WordPress to minimize development efforts. The website will be "responsive" (suitable for mobile as well as desktop devices) and comply with Web Accessibility guidelines.

For internal communication, mailing lists, internal newsletters, joint calendaring and file sharing will be established. The definition of the collaboration tools will be fine-tuned ahead of the project and fine-tuned within the first 3 months of the project activities. Some criteria to be used are:
-Pre-existing knowledge and daily usage
-Extensible (or free) licensing
-Workflow integration

T2.4 EVENT ORGANIZATION, INCLUDING STAKEHOLDER FORUM - (LEADER: LGL, PARTICIPANTS: ALL) (M1-M36)
Task 2.4 consists of the organization of events, especially the Stakeholders Forum each year and will be conducted by the affiliated entity "Bavarian Health and Food Safety Authority" (LGL). The forum is intended to facilitate the exchange of experience between the organizations participating in the Joint Action and relevant stakeholders. Thus, the current status of the local implementation of best practices, emerging problems, but also further ideas and solutions can be discussed. For this purpose, time slots for workshops are offered to the entities of WP4 to 8, specifically the next adopters. Furthermore, there will be the opportunity to bring all participants up to date and to create a common understanding of the Joint Action. The project management is given the opportunity to review the current implementation of the Joint Action and to adjust it if necessary. In terms of content, there are links to WP4, task 4.2, so that knowledge transfer is supported by the workshops mentioned above. As a positive side effect, the exchange is supported by networking at the Stakeholders Forum.

The main tasks concerning the Stakeholder Forum are, Planning and Organizing the annual Stakeholder Forum, especially:
-Providing a suitable location and catering
-Inviting participants of the Joint Action in consultation with leader WP1
-Defining the schedule in consultation with leader WP1
-Serving as a contact partner before, during and after the event
-Supporting the knowledge transfer and exchange during the event (time slots for workshops, networking activities)
-Organization of external speakers (as covered by the budget)
-A questionnaire regarding potential optimization potential (e.g. open questions in consultation with leader task 4.2, event improvement)
Additionally, WP2, task 2.4, will prepare a regular calendar with the most relevant (scientific) events and share them with partners in advance (publication via the homepage) to facilitate their participation - reminders via email will

be distributed. Furthermore task 2.4 serves as a contact partner for other WPs in case of questions concerning event organization.

Depending on the available budget, further events supporting the overall target of WP4, task 4.2 (“knowledge transfer”) are planned:
-Organization of one workshop implied in WP4.1 at the beginning of the Joint Action (topic: identifying common principles),
-Organization of one workshop for WP3 in 2021 (topic: preparation of the evaluation design)
-Organization of one workshop for WP4 in 2022 (topic: sustainability and final reporting)
-Organization of the study visits as planned in WP4, task 4.2
-Organization of webinars as required by the leaders of WP (e.g. internal coordination of next adopters).

MILESTONES
M4 - Project slide deck and branded templates (LB: AEEK, LEO:SU-HSMTC) (M3)
M5- Dissemination and communication plan (LB: AEEK, LEO:SU-HSMTC) (M6)
M6- Website launching (LB: BAGSFI, LEO: ZTG GMBH) (M6)
M7- Mid-term report on Dissemination (LB: AEEK, LEO:SU-HSMTC) (M18)
M8 - Final Conference (LB: BAGSFI, LEO: LGL) (M36)

Participation per Partner

Partner number and short name	WP2 effort
1 - KG	1.00
FFIS	0.25
FPS	0.75
SCS	0.25
SACYL	1.00
CSFJA	0.25
IDIVAL	0.75
IDIBAPS	1.00
AQUAS	1.00
SMS	0.75
2 - MCA	1.00
ZZJZFBIH	1.00
MHSw-RS	1.00
3 - CIPH	1.00
4 - MZCR	1.00
UHO	1.00
5 - RND	1.00
RSD	1.00
6 - MSAE	1.00
VH	1.00
7 - EUSTRAS	1.00
8 - BAGSFI	1.00
LGL	5.00

Partner number and short name	WP2 effort
ZTG-GmBH	5.00
9 - 4THYPE	1.00
AUTH	1.00
10 - AEEK	1.00
SU-HSMTC	19.00
JFDPK	1.00
11 - AGENAS	1.00
PROMIS	1.00
LOMBARDIA	1.00
UMBRIA	1.00
MhH	1.00
MARCHE	1.00
TOSCANA	1.00
ASL NA2	1.00
12 - NVD	1.00
CCUH	1.00
13 - LR SAM	1.00
14 - ACSS	1.00
ENSP/NOVA	1.00
15 - MoHRS	1.00
16 - NIJZ	1.00
ZZZS	1.00
17 - HSCB	1.00
Total	69.00

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D2.1	Leaflet	10 - AEEK	Report	Public	6
D2.2	Project website	8 - BAGSFI	Websites, patents filling, etc.	Public	6
D2.3	Dissemination and communication strategy and plan	10 - AEEK	Report	Public	6
D2.4	Final report on Dissemination	10 - AEEK	Report	Public	36

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D2.5	Layman of the final report	10 - AEEK	Report	Public	36

Description of deliverables

D2.1 : Leaflet [6]

LB: AEEK, LEO:SU-HSMTC Summary presentation of JADECARE project, available in the 17 official languages of the JADECARE countries.

D2.2 : Project website [6]

LB: BAGSFI, LEO: ZTG GMBH JADECARE dedicated website will have a public part and one accessible only to the JADECARE participants.

D2.3 : Dissemination and communication strategy and plan [6]

LB: AEEK, LEO:SU-HSMTC Will include the specific communication and dissemination activities planned for JADECARE. The dissemination and communication strategy will be detailed, including who the target audiences and key stakeholders are based in the initial ones included in the proposal (Table 1), main topics (oGPs description, how to transfer to next adopters, changes required in the system for the adoption, expected benefits for patients and general population, impact envisioned), type of messages adapted to each stakeholder group, means to be used (website, e-newsletter, social media, stakeholder forum, participation in international and national events and organization of webinars), timeline (as described in the WP) and the translations into the 17 JADECARE required for the dissemination materials.

D2.4 : Final report on Dissemination [36]

LB: AEEK, LEO:SU-HSMTC Report with all the dissemination activities developed during the whole project and the analysis of the impact produced in the target groups.

D2.5 : Layman of the final report [36]

LB: AEEK, LEO:SU-HSMTC The Layman report will describe the background, challenges and overview of the project, including project's specific objectives, the benefits of the innovative solution implemented, the partners involved and the impact or results (core part of the report). Te European added value will be presented as well. The report will be available in the 17 official languages represented in JADECARE countries and will be written for the general public (to be accessible for all the stakeholders identified in the project).

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS4	Project slide deck and branded templates	10 - AEEK	3	Project slide deck and branded templates (LB: AEEK, LEO:SU-HSMTC)
MS5	Dissemination and communication plan	10 - AEEK	6	Dissemination and communication plan (LB: AEEK, LEO:SU-HSMTC)
MS6	Website launching	8 - BAGSFI	6	Website launching (LB: BAGSFI, LEO: ZTG GMBH)
MS7	Mid-term report on Dissemination	10 - AEEK	18	Final Conference (LB: AEEK, LEO:SU-HSMTC)

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS8	Final Conference	8 - BAGSFI	36	Final conference of the project (LB: BAGSFI, LEO: LGL)

Work package number [9]	WP3	Lead beneficiary [10]	9 - 4THYPE
Work package title	EVALUATION		
Start month	1	End month	36

Objectives

AUTH will be the Leading Executive Organization (LEO) of WP3 and AQUAS the Co-Leading Executive Organization.

WP3 will:
-Provide a methodological framework for assessing the different features of the oGPs adopted to cover the requirements and expectations.
-Assess the quality and compliance of the project process and stakeholders' views inclusion and satisfaction
-Perform a systematic appraisal of the quality of the transfer and implementation process, understanding, evaluating and reporting the experience of adopting oGPs in in heterogeneous next adopter sites.
-Evaluate the reinforcement of the capacity of health authorities to organise and deliver digitally-enabled, integrated, person-centered care
-Evaluate the transfer the good practices (or their significant elements) from the oGPs to the "next adopters" in terms of performance, acceptance, satisfaction and sustainability.

Description of work and role of partners

WP3 - EVALUATION [Months: 1-36]
4THYPE, KG, MCA, CIPH, MZCR, RND, MSAE, EUSTRAS, BAGSFI, AEEK, AGENAS, NVD, LR SAM, ACSS, MoHRS, NIJZ
T3.1 PROJECT PROGRESS MONITORING (LEADER: AQUAS, PARTICIPANTS: ALL) (M1-M36)
This task will provide a systematic assessment of the quality and compliance of the project process and stakeholders' views on inclusion and satisfaction. This task will oversee the establishment of the monitoring and internal evaluation plan, which will be responsible for assessing the progress of the project. The main objectives of this task are: a) to verify the planned implementation of the project and the achievement of the objectives using a comprehensive approach with quantitative and qualitative methods and b) to provide key information to beneficiaries to correct the limitations detected and boost the strengths in the development of activities, helping to produce the most valuable outputs and outcomes.
a) Design of the Monitoring and Internal Evaluation Plan, which will include a set of qualitative and quantitative assessment indicators. These indicators will be output, outcome and process indicators, and will follow the RACER strategy for SMART objectives. The Monitoring and Internal Evaluation Plan will define general indicators to all WPs and a set of specific indicators for each WP. The definition of completion, acceptance or no completion criteria for each indicator will be agreed with WP Leads, as well as the definition of thresholds for measuring the compliance with process progress for each WP and for the overall project.
b) Ongoing evaluation and reporting activities.This stage includes the development of assessment tools, in order to analyze project beneficiaries' satisfaction and their perception in terms of project progress. To achieve this, surveys (satisfaction of meetings' participants) and others (interviews, protocols, focus groups, etc.) will be used. There will be an ongoing share of brief summaries of main results of surveys from meetings and workshops, interviews and key information to WP Leads and partners with the aim to keep improving stakeholder's inclusion and satisfaction, as well as overcoming experienced barriers in a timely manner. .
c) Measurement of project progress. This stage will include the monitoring of the project, with regular collection of indicators from each WP, observational evaluations and completion of quality forms (collection of data quality process). The assessment of the data will inform WP Leads and implementers on the development of the tasks in order to boost strengths and overcome barriers timely, supporting the efficient use of resources, ensuring the needed support is provided at any time during the project and at all levels.
d) Interim and Final reporting. This stage will produce the Interim Evaluation Report (M20), summarizing activities and main results from the monitoring and evaluation, stakeholder's satisfaction and quality forms from M1 to M18 of the JA, and the Final Evaluation report (M36), with the final results of the monitoring and internal evaluation assessment, which will include lessons learnt and recommendations.

T3.2 QUALITY ASSURANCE OF IMPLEMENTATION (LEADER: KG, PARTICIPANTS: NEXT ADOPTERS, AUTH, AQUAS) (M1-M36)
This task is responsible for performing a systematic appraisal of the quality of the transfer and implementation process, throughout the course of JADECARE, adaptable to the different needs and maturity of the early adopters. The

main objectives of this task are a) to define an implementation methodology, b) to provide methodological support to implementation sites during the operational phase, c) to monitor blended local Good Practice and Action Plans implementation d) to monitor the next adopters' pilot implementation and e) to analyse the factors that might have influenced (positively or negatively) the implementation process.

The methodology will follow the next steps:
1) Scope Definition. Selection of elements of the oGPs that will be finally implemented and integrated in each local Good Practice. Specifically, the core features will be identified (such as target population, risk stratification, care pathways, patient empowerment and telemonitoring) and prioritized in terms of relevance, local needs, aspirations, leading to next adopters´ final selection. This selection will consider implementation site´s capabilities and feasibility (needs, maturity level, project time, resources and funding constraints).
2) Situation analysis. Performance of SWOT analysis to identify the action areas on which the implementation sites have to focus based on the analysis of internal and external factors. These factors will be program-related (population, risk stratification, care pathways, patient empowerment, telemonitoring etc.) and implementation-related (leadership, engagement, institutional involvement, available resources). The SCIROCCO model will be used to recognize the maturity requirements of oGPs contexts to facilitate the transfer and scaling-up to next adopters.
3) Local Good Practice and Action Plan. The Local Good Practices will be built upon local existing interventions, will integrate specific features from selected original GP(s) and will describe how the implementation site provides integrated care to citizens, including the new elements adopted. The Action Plan will produce the blueprint that outlines the implementation of local Good Practices, will address relevant related issues identified in the SWOT analysis and will define specific implementation objectives, activities, resources and indicators.
4) Operation phase. Using the Plan-Do-Study-Act (PDSA) method, that aims to facilitate the implementation and testing interventions. Also, it will ensure the documentation of each step, in order to ensure technical robustness, quality, team reflection and learning and capture knowledge and learning. Next adopters' implementation will be monitored on this operation phase and specific templates and procedures will be developed for this purpose.
5) Implementation process analysis. Process progress questionnaires will be sent to implementers. At the same time, observational evaluation of implementations will be performed. Blended Framework for Implementation Research (CFIR) will be used to analyze the factors that might have influenced (positively or negatively) the implementation process.
6) Reporting of the implementation. SQUIRE 2.0 will be used to report the implementation study to enhance the evidence base and transferability potential.

Kronikgune will be in charge of the methodological support at centralized level. Different actions will be taken to enable next adopters to perform the activities:
-Workshop at Kick off meeting: the methodology for the scope definition will be explained by Kronikgune
-Workshop at study visits: dedicated sessions led by Kronikgune to present the methodology to perform the SWOT analysis and to define local interventions and Action Plans.
-Teleconference: to monitor the SWOT analysis planning in each site
-Teleconference: to review the output of the SWOT analysis of each site
-Webinar: to refresh the methodology to define the local interventions and Action Plans
-Teleconference: review the Action Plans of each site
-Workshop at 1st Consortium Meeting: next adopters present their local GP and Action Plan and the methodology of PDSA cycles is explained by Kronikgune
-Teleconference: to review the planning of the activities (Planning phase of PDSA)
-Sessions during the thematic workshops: next adopters present their learnings and experience during the first months of the implementation and Kronikgune provides support and coaching if needed
-Webinar: the methodology for implementation experience reporting is explained by Kronikgune

The results of this task will be analyzed and summarized in the interim and final evaluation reports accordingly.

T3.3. IMPACT EVALUATION (LEADER: AUTH, PARTICIPANTS: NEXT ADOPTERS, AQUAS, KG) (M1-M36)
The impact of the Project will be measured at two levels: a) the Joint Action in overall (including impact on external stakeholders) and b) the next adopters. The former, will be based on the specific objectives:
-To support and reinforce digitally enabled integrated person-centered care (DEIPCC) in 23 European settings with different degrees of maturity
-To improve next adopters´ digital transformation
-To support the next adopters in facilitating the sustainability of the practice with plans for actions at local/regional/national level
-To create a community of stakeholders that includes caregivers, healthcare experts, academia, industry, policy makers and /or general public.

-To perform a systematic appraisal of the quality of the transfer and implementation process, understanding, evaluating and reporting the experience of adopting oGPs in heterogeneous next adopter sites.
-Quality, compliance and usefulness
-To improve knowledge and skills of transfer methodologies and tools

It is directly related to WP4, which deeply analyses the impact of the Joint Action at policy level and focuses on GP sustainability.
Implementation of Good Practices at next adopters' sites evaluation will based on the SMART objectives and KPIs identified in the transfer work Packages for each site Action Plan. At next adopters level evaluation will be customized in each site according to the SMART objectives and key performance indicators of the local Good Practice and Action Plans defined in the transfer Work Packages (WP 5-8). They will includer general dimensions and digital transformation.
Regarding general dimensions, the KPIs will include:
-scope and degree of adoption of original Good Practices (oGPs),
-specific process, pathway reorganization and change management,
-the involvement and commitment of key stakeholders,
-the implementation experience,
-continuity and sustainability of the practice,
-readiness of the organization to uptake digitalization.

Regarding digital transformation, the KPIs will include:
-digital health system infrastructure;
-risk stratification and data analytics,
-use of technologies including Electronic Health Record, personal health folder and electronic prescription,
-citizen empowerment and use of patient reported data,
-innovation initiatives on integrated care reorganization of care pathways, workforce roles and skills,
-training and research programs,
-access to health services,
-management of change towards digitalization,
-ethical aspects of digitalization.

For the quantification of the aforementioned, a network of stakeholders will be built in each participating country and their degree of usefulness and acceptance regarding the GP will be measured through questionnaires and interviews and other evaluation techniques. LIWGs and Work Package leaders will provide this information on the implementation process via periodic data collection. Surveys of usefulness among patients treated in sites which implemented the GP in each participating country will be distributed. The customization of the indicators will be framed into transfer WPs (WP 5-8) during the definition of specific interventions and action to implement.

3.3.1. Definition of the Impact Assessment Plan. During this stage the impact indicators will be identified. Establishing the general and digital transformation indicators involves their definition (numerator and denominator and time frame) that provides the evidence that will allow us to determine whether the Local GP objectives have been achieved. The target levels, according to the SMART objectives will be established. This evaluation will involve a mix of qualitative and quantitative methods. oGP owners will assist in defining the KPIs. The information that need to be collected and the collection methods will be identified. Different sources will be used such as:
-Routine project statistics (client records, training registers)
-Management information (project documents and reports)
-National or local health statistics
-Baseline-end line surveys (target group, key informants)
-Semi-structured Interviews (general or key informants)
-Focus groups (discussions with patients, caregivers and healthcare providers)
-Observation (client-provider interactions)
The evaluation in order to assess whether the observed effects can be attributed to the adoption of GP will be designed.

3.3.2 The impact assessment evaluation. I) The data collection. All the questionnaires/surveys will be administered and the interviews/focus groups will be conducted. All the information gained will be checked in order to assure their accuracy and will be translated into useable forms for analysis. Ii) The data analysis and reporting. Content (for qualitative data) or statistical (for quantitative data) analysis will be performed and results will be reported. The oGP owners will assist in interpretation, understanding, and deployment of experience and extraction of key-learnings
The results of this task will be analyzed and summarized in the interim and final evaluation reports (deliverables D3.2 and D3.3 respectively)

MILESTONES

M9 Monitoring and Evaluation Plan (LB: 4RTHYPE, LEO: AUTH) (M8)
M10 Implementation strategy in place (LB & LEO: KG) (M9)
M11 Impact Assessment Plan (LB: 4RTHYPE, LEO: AUTH) (M9)
M12 Interim Evaluation (LB: 4RTHYPE, LEO: AUTH) (M18)
M13 Final Evaluation (LB: 4RTHYPE, LEO: AUTH) (M36)

Participation per Partner

Partner number and short name	WP3 effort
1 - KG	10.00
FFIS	1.00
FPS	2.00
SCS	1.00
SACYL	2.00
CSFJA	0.75
IDIVAL	2.00
AQUAS	13.00
SMS	1.00
2 - MCA	0.00
ZZJZFBIH	2.00
MHSw-RS	2.00
3 - CIPH	2.00
4 - MZCR	0.00
UHO	2.00
5 - RND	2.00
6 - MSAE	0.00
VH	2.00
7 - EUSTRAS	2.00
8 - BAGSFI	2.00
9 - 4THYPE	0.00
AUTH	20.00
10 - AEEK	0.00
JFDPK	2.00
11 - AGENAS	0.00
LOMBARDIA	2.00
UMBRIA	2.00
MARCHE	2.00
TOSCANA	2.00
ASL NA2	2.00
12 - NVD	0.00

Partner number and short name	WP3 effort
CCUH	2.00
13 - LR SAM	2.00
14 - ACSS	2.00
SPMS	1.00
ENSP/NOVA	2.00
15 - MoHRS	2.00
16 - NIJZ	0.00
ZZZS	2.00
Total	93.75

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D3.1	Impact Assessment Plan	9 - 4THYPE	Report	Public	9
D3.2	Interim Evaluation Report	9 - 4THYPE	Report	Public	18
D3.3	Final Evaluation Report	9 - 4THYPE	Report	Public	36

Description of deliverables

D3.1 : Impact Assessment Plan [9]

LB: 4RTHYPE, LEO: AUTH Will include the evaluation framework (objectives, process, output and outcomes indicators), analysis plan (quantitative and qualitative), data management procedures and templates, responsibilities and timeline. The evaluation framework will be the same for all the 23 JADECARE next adopters. Project progress monitoring plan and the methodology for the implementation quality assurance will be included as well. .

D3.2 : Interim Evaluation Report [18]

LB: 4RTHYPE, LEO: AUTH Demonstration of how JADECARE activities are monitored within the project, including the preliminary evaluation of the KPIs (mainly process indicators) defined in JADECARE and the local Action Plans. If deviations in indicators achievement are detected, improvement or corrective actions will be identified.

D3.3 : Final Evaluation Report [36]

LB: 4RTHYPE, LEO: AUTH The final evaluation will include the impact at next adopters' level. The key performance indicators of the local Good Practice and Action Plans defined in the transfer Work Packages (WP 5-8) will be analyzed. They will include general dimensions (scope and degree of adoption of oGPs, specific process, pathway reorganization and change management, the involvement and commitment of key stakeholders, the implementation experience and continuity and sustainability of the practices, and readiness of the organization to uptake digitalization) and digital transformation (digital health system infrastructure, risk stratification and data analytics, use of technologies, citizen empowerment and use of patient reported data, innovation initiatives on integrated care, reorganization of care pathways, workforce roles and skills and training and research programs, access to health services, management of change towards digitalization, ethical aspects of digitalization). The final report will include the assessment of the quality and compliance of the project process and stakeholders' views on inclusion and satisfaction, providing lessons learnt and recommendations.

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS9	Monitoring and Evaluation Plan	9 - 4THYPE	8	Monitoring and evaluation plan (LB: 4RTHYPE, LEO: AUTH)
MS10	Implementation strategy in place	1 - KG	9	Implementation strategy in place (LB & LEO: KG)
MS11	Impact Assessment Plan	9 - 4THYPE	9	Impact Assessment Plan (LB: 4RTHYPE, LEO: AUTH)
MS12	Interim Evaluation	9 - 4THYPE	18	Interim Evaluation (LB: 4RTHYPE, LEO: AUTH)
MS13	Final Evaluation	9 - 4THYPE	9	Final Evaluation (LB: 4RTHYPE, LEO: AUTH)

Work package number [9]	WP4	Lead beneficiary [10]	16 - NIJZ
Work package title	INTEGRATION IN NATIONAL POLICIES AND SUSTAINABILITY		
Start month	1	End month	36

Objectives

NIJZ will be the Leading Executive Organization (LEO) of WP4 and AGENAS the Co-Leading Executive Organization.

Objectives:
-Identify general principles and individual characteristics of successful implementation of good practices, based on oGPs
-Support exchange of knowledge and experiences of implementation by next adopters including study visits and thematic workshops
-Support next adopters in a mix-match approach to blend objectives and activities related to core features from different oGP in one local Good Practice and Action Pla
-Generate recommendations and guidance for uptake of good practices with new knowledge and understanding, based on the results of implementation by next adopters
-Support next adopters to facilitate the sustainability of the practice by strategy and plans for actions at local/regional/national level
-Present a potential use of results and deliverables of JADECARE for further building up the capacity of national and regional authorities to organize and deliver integrated person-centered care including integration in policies
-Deliver guiding material to support the countries scale up of JADECARE results and to support sustainability after the end of the JADECARE project

Description of work and role of partners

WP4 - INTEGRATION IN NATIONAL POLICIES AND SUSTAINABILITY [Months: 1-36]
NIJZ, KG, MCA, CIPH, MZCR, RND, MSAE, EUSTRAS, BAGSFI, 4THYPE, AEEK, AGENAS, NVD, LR SAM, ACSS, MoHRS, HSCB
TASK 4.1. IDENTIFY CORE CHARACTERISTICS OF OGPS AND GENERAL PRINCIPLES (LEADER: BAGSFI, PARTICIPANTS: NEXT ADOPTERS, EARLY ADOPTERS, NIJZ, AGENAS) (M1-M9)
The activities are:
-To facilitate first in depth oGPs presentation, based on the common template prepared by 4.1 (M1, at kick-off meeting), and assessment of expectations from JA partners (M1, at kick-off meeting, using DELPHI questionnaire)
-To develop the methodology for identification of core features (population approach/data analytics, coordination/pathways, patient empowerment, IT support, etc.), context characteristics (SCIROCCO Maturity Model) and core characteristics of implementation process of oGPs (based on CFIR), in alignment with WP3 (M2)
-To identify and analyze core features, context characteristics and core characteristics of implementation process of the oGPs; the analyses of the oGPs (how they were implemented step-by-step, how problems were resolved etc.) will provide input to the Deliverables 5.1, 6.1, 7.1 and 8.1.
-To report on general principles of successful implementation, based on oGPs (M9), input to Deliverables 4.1, 4.2 and 4.3

TASK 4.2. KNOWLEDGE EXCHANGE AND GENERATION (BAGSFI, ALL PARTICIPANTS) (M1-M36)
Organize activities to support knowledge exchange and generation including:
-Set up and support learning community, to promote knowledge generation/exchange, to facilitate implementation (such as organization of webinars, workshops, face-to-face meetings, mentoring from experts, availability of tools and knowledge resources etc.)
-Prepare structure and templates, organize and report on study visits of next adopters at oGPs sites; the visits will be organized before local Good Practices and Action Plans are prepared, to share in detail core features, core context characteristics and core characteristics of implementation and sustainability process of oGPs, as identified in 4.1. The summary report of the visits (M12) will provide input to Deliverables 4.1.
-Prepare structure and templates of thematic workshops, organized during the implementation phase by next adopters with the support of WP5-8 leaders and co-leaders, that will also be responsible for reporting. These workshops/have three key roles: 1) bring visibility to next adopters at local/regional/national level and boost communication with stakeholders, that are important for the sustainability; 2) intermediate self-evaluation of the progress of the implementation with a potential to start next PDSA cycle and 3) give structured feedback to the JA leadership regarding the chosen methods to plan and support implementation. The best timing would be agreed with individual next adopters. The summary report will be prepared by Task 4.2 (M27) and will provide input to Deliverables 4.2 and 4.3. The

realization will be carried out collectively by BAGSFI Hamburg and the two affiliated entities Bavarian Health and Food Safety Authority (LGL) and North Rheine-Westphalia.

TASK 4.3. MERGING ACTION PLANS OF NEXT ADOPTERS' LOCAL GP (LEADER: AGENAS, PARTICIPANTS: NEXT ADOPTERS, EARLY ADOPTERS, NIJZ) (M6-M15)
This task will support WP5-8 leaders and next adopters to develop their local Good Practice and Action Plans. The local Good Practices will describe how the practice to transfer looks like, how they are set up, the locations, the target groups, the number of citizens/patients covered by each pilot etc.; whereas the local Action Plan will define the concrete actions (what) needed for the implementation, the responsible actor (who), timeline (when) and the settings (where). For those next adopters with a mix-match approach adopting core features from more than one oGP, it will coordinate the effort of putting together (consolidating/blending) the inputs from scope, situation analysis, objectives and implementation activities of each of the oGP features developed in the respective transfer work package (WP5-8). It will be based on identified common principles of oGPs (T4.1) and study visits outputs (T4.2), and taking into account transfer Work Packages tasks 1, 2 and 3 results (WP5-8). The support will include: addressing scope, relevant related issues identified in the SWOT analysis and identification of specific implementation objectives, activities, resources and indicators.

The special support given to next adopters willing to mix and match different oGP features, identifying problems (gaps, overlaps and contradictions) and thus aiming for a sound and effective implementation. Special assistance will be provided already in the scope definition phase and SWOT analysis phase to avoid fragmented processes as conflicting or duplicate interventions and insuring to provide a unique and effective action plan of the mix-and-match next adopters.

To identify common issues in WP5, 6, 7 and 8 activities by:
-Collecting x.1, x.2, x.3 results (input to Deliverable 4.1)
-Identifying common issues
-Agreeing (with task x.1, x.2, x.3 leaders) on the common issues list (input to Deliverable 4.2) to ensure soundness and effectiveness of next adopters local implementation action plans and blueprints by:
-Defining the methodology to blend Individual implementation action plans on next adopters' (input to Deliverable 4.2)
-Exchange the methodology with next adopters and provide on-line support
-Reviewing the proposed action plans by the next adopters and suggesting actions to boost synergies and resolve problems. Results will be discussed locally, but also in transferability sessions, such as workshops among partners (input to Deliverable 4.1).

TASK 4.4. RECOMMENDATIONS AND GUIDANCE FOR UPTAKE OF GOOD PRACTICES (LEADER: AGENAS, PARTICIPANTS: ALL PARTICIPANTS) (M27-M35)
Based on WP5-8 local implementation reports and WP3 outputs, propose recommendations including lessons learnt to:
-Illustrate potential implications and how to support the implementation or the adoption of an identified good practice, based on CFIR and SQURE 2.0 reports and by collecting and reviewing lessons learnt from WP5-8 and to define common implementation principles (input to Deliverable 4.2).
-Co-creation (i.e. together with next adopters and with task 4.5) of guidelines and standard operation procedures for good practice uptake, including core elements to assure scale up and sustainability after the end of the project to guarantee further implementation at a European level (including sustainability at national or on the local or regional level, together with task 4.5) - input to Deliverable 4.2.

TASK 4.5. SUSTAINABILITY STRATEGY AND ACTION PLAN OF NEXT ADOPTERS' PRACTICES (LEADER: NIJZ, PARTICIPANTS: ALL PARTICIPANTS) (M1 - M35)
The activities are:
-To discuss and define core elements for sustainability with JADECARE partners. These include identification of the holder of sustainability planning process, what should be sustainable including expected results, assessment of the context/situation, planning for support of key stakeholders and community. It also addresses the assessment of long-term stability and flexibility of the holder and the strategic partnerships, the strategic financial planning and the development of action plan (detailed description for next 1-2 years). The core elements for sustainability will be input to Deliverable 4.3.
-To assure that elements of sustainability are addressed in analyses of individual original GPs.
-To assure that elements of sustainability are addressed in individual implementation action plans, during the implementation and in individual implementation reports.
-To facilitate establishment and collaboration among next adopters and key stakeholders identified to be important to assure sustainability as local/regional/national networks, aligned with activities of 4.2, 4.4 and 4.6. Patients' representative organizations and representatives of healthcare professionals will be obligatory members of local implementation working groups and/or of the local/regional/national networks, depending on the focus of the next adopter's practice.

-To support development of sustainability strategy and action plan via templates, provided by NIJZ. Next adopters will be the driving forces of the process and the final elaboration of sustainability strategy and action plan, that will be finalized during workshop/focus group/policy dialogue in the reporting period. The results will give input into Deliverable 4.3.
-To prepare a summary report with core findings, that is an input to Deliverable 4.3.

TASK 4.6 POLICY BOARD (LEADER: NIJZ, PARTICIPANTS: ALL PARTICIPANTS) (M1-M36)
The aims of the policy board are to support successful design and implementation of local Good Practices in next adopters from the focus of sustainability, to further reinforce capacities of national and/or regional care authorities to organize and deliver integrated person centered care based on lessons learnt, including integration in policies, and to co-create EU added value of the JADE CARE.

Policy board has therefore two main advisory roles: 1. alignment of local Good Practices to national, regional and/or local policies, strategies, plans and/or program, such as the broader context of legal framework, potential political/policy support, funding stability, strategic partnerships and strategic planning and to national, regional and/or local leadership; 2. Identifying and building up potential EU added value of JADECARE such as implementing EU legislation, achieving economies of scale, promoting best practice, benchmarking for decision making, considering cross-border threats, fostering movement of people and/or networking. Policy Board discussions in the format of Policy dialogues will address ways to reinforce the capacity of health authorities to successfully address the health system transformation, in particular the transition to digitally-enabled, integrated, person-centred care.

Members of the policy board: all competent authorities of JADECARE that are MoHs, national focal points for Health Programme at EC (or other representatives of MSs identified by them) from those MSs from EU and EEA that do not participate in JADECARE, representative of DG Sante and CHAFEA, and all other policy-oriented stakeholder that implementers will find at their sustainability-related analyses as important, such as Statutory Health Insurance in Bismarckian health systems. First membership list will be available by M3, and will be kept open, since competent authorities and next adopters may identify important policy-level stakeholders to be invited during development and implementation of the activities. However, maximum number of members should not exceed 32. Members of Policy Board from countries of next adopters will include local/regional/national networks (see Task 4.5), and will participate during the process and the final elaboration of local Good Practice sustainability strategy and action plans by participating in the respective workshop/focus group/policy dialogue, that will be held during reporting period. An obligatory element of sustainability strategy and action plan will be the potential integration of JADECARE results into country's policy. Action plans will specifically detail how the involved MS could contribute/support sustainability and could potentially integrate the results of the projects in their national/regional policies, as appropriate, including visibility of European Union co-funding and potential institutions outside JADECARE (EIT HEALTH, other Member states, International Organizations…)". Core messages to support evidence-based policy making with respect to sustainability of JADECARE result will be an input to Deliverable 4.3.

Policy Board will be led by NIJZ with support of AGENAS/MoH Italy; secretariat will be provided by NIJZ. Operating procedures will be prepared by NIJZ and /MoH Italy by the first meeting in M9-M12, when needs assessment from the perspective of members of policy board will be performed by NIJZ. Policy board will meet three times as face to face meetings.

MILESTONES
M14 General principles of successful implementation described (LB & LEO: BAGSFI) (M9)
M15 Summary reports from study visits at oGPs sites finalized (LB & LEO: BAGSFI) (M10)
M16 Common issues from needs and scope (x.1), situation analysis (x.2), interventions and actions (x.3) identified (LB & LEO: AGENAS) (M15)
M17 Summary report from meetings of policy board (LB & LEO: NIJZ) (M36)

Participation per Partner

Partner number and short name	WP4 effort
1 - KG	3.00
FFIS	1.00
FPS	2.00
SCS	1.00

Partner number and short name	WP4 effort
SACYL	2.00
CSFJA	1.00
IDIVAL	2.25
IDIBAPS	2.00
SMS	1.00
2 - MCA	3.00
ZZJZFBIH	2.00
MHSw-RS	2.00
3 - CIPH	1.40
4 - MZCR	4.00
UHO	2.00
5 - RND	4.00
RSD	3.00
6 - MSAE	3.00
VH	2.00
7 - EUSTRAS	3.00
8 - BAGSFI	5.25
LGL	2.25
ZTG-GmBH	2.75
9 - 4THYPE	4.00
10 - AEEK	5.00
JFDPK	2.00
11 - AGENAS	18.25
LOMBARDIA	2.00
UMBRIA	2.00
MhH	3.00
MARCHE	2.00
TOSCANA	2.00
ASL NA2	2.00
12 - NVD	0.00
CCUH	4.00
13 - LR SAM	4.00
14 - ACSS	2.75
SPMS	1.00
ENSP/NOVA	1.75
15 - MoHRS	4.00

Partner number and short name	WP4 effort
16 - NIJZ	43.00
ZZZS	2.00
17 - HSCB	3.00
Total	162.65

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D4.1	Local Good Practices and Action Plans	11 - AGENAS	Report	Public	15
D4.2	Blueprint on learning from Good Practices	11 - AGENAS	Report	Public	35
D4.3	Characteristics of JADECARE practices, leading to sustainability and integration in national policies	16 - NIJZ	Report	Public	36

Description of deliverables

D4.1 : Local Good Practices and Action Plans [15]

LB & LEO:AGENAS Comprehensive description of the local Good Practices of each pilot (how the practice to transfer looks like, how they are set up, the locations, the target groups, the number of citizens/patients covered by each pilot etc.) and the local Action Plans will be documented. The outputs from the scope definition and the situation analysis (WP5-WP8) will be key for Good Practice and Action Plans definition. The next adopters following the mix-match approach will describe their local Good Practice and Action Plan with input coming from more than one transfer WP.

D4.2 : Blueprint on learning from Good Practices [35]

LB & LEO: AGENAS Guidelines and operation procedures for JADECARE good practice transfer, including core elements to assure scale up and sustainability after the end of the project. This document will support good practice transfer beyond JADECARE.

D4.3 : Characteristics of JADECARE practices, leading to sustainability and integration in national policies [36]

LB & LEO: AGENAS Description of characteristics of JADECARE, that facilitate sustainability and integration into (national) policies. How JADECARE has helped Member States to support and reinforce their capacity for digitally enabled patient centered integrated care will be included.

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS14	General principles of successful implementation described	8 - BAGSFI	9	General principles of successful implementation described (LB & LEO: BAGSFI)

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS15	Summary reports from study visits at oGPs sites finalized	8 - BAGSFI	10	Summary reports from study visits at oGPs sites finalized (LB & LEO: BAGSFI)
MS16	Common issues from needs and scope (x.1), situation analysis (x.2), interventions and actions (x.3) identified	11 - AGENAS	15	Common issues from needs and scope (x.1), situation analysis (x.2), interventions and actions (x.3) identified (LB & LEO: AGENAS)
MS17	Summary report from meetings of policy board	16 - NIJZ	36	Summary report from meetings of policy board (LB & LEO: NIJZ)

Work package number [9]	WP5	**Lead beneficiary** [10]	1 - KG
Work package title	BASQUE HEALTH STRATEGY IN AGEING AND CHRONICITY: INTEGRATED CARE GOOD PARCTICE: TRANSFER AND ADOPTION		
Start month	1	**End month**	36

Objectives

KG will be the Leading Executive Organization (LEO) of WP5 and AUTH the Co-Leading Executive Organization.
The main objectives of WP5 are:
-To select the core features of the oGP that next adopter´s will work on.
-To perform the situation analysis and define the strategic actions of next adopters
- To define the specific interventions and actions that will be transferred to next adopters.
-To facilitate and support the transfer of oGP features to next adopters´ context.

Description of work and role of partners

WP5 - BASQUE HEALTH STRATEGY IN AGEING AND CHRONICITY: INTEGRATED CARE GOOD PARCTICE: TRANSFER AND ADOPTION [Months: 1-36]
KG, MCA, CIPH, MZCR, RND, MSAE, 4THYPE, AGENAS, LR SAM, ACSS, MoHRS
TASK 5.1. NEEDS AND SCOPE DEFINITION (LEADER: KG, PARTICIPANTS: NEXT ADOPTERS, AUTH) (M1-M3)
Next adopters will have the opportunity to know better the original GP (oGP) in a dedicated workshop during the Kick off meeting by month 1 (T4.1). First, Kronikgune will explain the methodology for the scope definition which is mainly delimited by selecting the features of the intervention that will be finally implemented. Then, following this methodology, Kronikgune will describe in depth the core features of the oGP implemented in the Basque Country that are structural and functional integration of health organizations, integrated care pathways in routine practice, eHealth strategy and patient empowerment approach (classification according to health literacy, provision of appropriate empowerment services and empowerment assessment). Elements of sustainability will be stressed out at all aspects. Next adopters will pre-select the core features in which they are initially interested in. Moreover, Kronikgune will provide a detailed description of the oGP and how it was implemented step-by-step in the Basque Country (resources and capabilities needed, barriers and facilitators, how problems were resolved etc.) in D5.1.

Then, at next adopter´s site, local teams (including patients 'perspective), depending on their needs, expectations, strategic objectives, real possibilities and existing local interventions, will choose the final core features by month 3. Kronikgune will support next adopters during this process if required.

TASK 5.2. SITUATION ANALYSIS (LEADER: AUTH, PARTICIPANTS: NEXT ADOPTERS, KG) (M4-M7)
Study visits will be organized in order to provide next adopters with the possibility to acquire deep knowledge on specific aspects of the oGP and establish close contact with the stakeholders involved in the oGP implementation (T4.2). Core features, context characteristics using the Scirocco Maturity Model and the implementation process based on CFIR will be analyzed and shared by stakeholders of the Basque Country during the study visit. Elements of sustainability will be highlighted as crucial aspects to be considered for the transfer and adoption. This analysis will help next adopters in understanding the requirements for adoption.
During the study visit Kronikgune will have a dedicated session to explain the SWOT analysis (what it is, how to perform, stakeholders needed, templates provided). Next adopters will have the opportunity to test the methodology so the procedures are clear to replicate at home with their local teams. In addition, Kronikgune will introduce the methodology for interventions and actions definition.

Next adopters will perform a SWOT analysis at their site. Before the SWOT meeting with their teams, next adopters will participate in a webinar organized by AUTH, together with Kronikgune. The aim of this virtual meeting is to support next adopters in SWOT analysis planning.

Then, next adopters will perform the SWOT analysis related to the selected core feature(s) of the oGP. The dimensions of the Scirocco Maturity Model that were considered relevant for the implementation by the stakeholders of the Basque Country during the study visit will be considered as well. Two perspectives will be studied in the SWOT: original GP-related and local implementation-related. The former can include examples of existing assets related to the oGP features to be adopted such as existing data bases and ICT infrastructure, trained staff or positive results in health outcomes of

integrated care pilots. The latter can include examples such as existence of resources, information systems or leadership (clinical professionals and managers promote the integrated care approach).

The SWOT analysis output will provide next adopters with a clear view of their improvement areas, priorities and the strategic action required for planning the implementation and its sustainability. The SWOT analysis shall deliver information on needs and the readiness of the next adopters' key stakeholders for transferring knowledge, solutions, experiences and learnings into their ecosystem regarding the core features of the oGP; potential barriers preventing the next adopters to prepare, implement, maintain and replicate the transfer, including ranking the barriers by their impacts, strength and resources required to eliminate them; gaps that might not be covered by the transfer from the specific oGP to the next adopters' ecosystem or potential areas of transfer from other oGPs to cover the identified gaps. Next adopter and AUTH will jointly review the SWOT output in a webinar. It might happen that the SWOT affects to the scope definition, so an iterative process can be envisioned.

TASK 5.3. SPECIFIC INTERVENTIONS AND ACTIONS (LEADER: AGENAS, PARTICIPANTS: NEXT ADOPTERS, KG, AUTH, AQUAS, NIJZ) (M8-M10)
A virtual meeting will be organized by Kronikgune in order to refresh the methodology for interventions and actions definition introduced in the study visits. Kronikgune will be responsible for leading the webinar and providing guidelines and templates.

Local teams, based on the scope, improvement areas and strategic actions, will (i) set up concrete objectives, (ii) define activities to reach the previous objectives (called "Change Package") (iii) specify Key Performance indicators (process or health-related) based on WP3 and WP4 guidelines and (iv) plan activities to support sustainability. If a given next adopter is interested in implementing the Basque patient empowerment programme for multimorbid patients, the adaptation of the programme to the new context is needed. The example of objective, activity and indicators is provided below:
-Objective: to design an effective and sustainable empowerment programme
-Activity: create a multidisciplinary working group including all stakeholders ensuring that all perspectives are covered (nurses of primary care and hospital, researchers, patients and patient´s relatives, health managers)

Indicators:
-No of primary care nurses involved
-No of hospital nurses involved
-No of researchers involved
-No patients involved
-No of patient´s relatives involved
-No of health managers involved

Next adopters will be supported by AGENAS, AUTH, AQuAS, NIJZ and Kronikgune.

Then, next adopters will virtually share and review their local interventions and actions with AGENAS and Kronikgune by month 10 to make any refinement if needed.
The next adopters who have selected core features from more than one oGP (mix and match strategy will blend the interventions and action from different transfer WPs. This task will be led by AGENAS as T4.3 leader. At the end, all next adopters, irrespective of the transfer strategy chosen, will define their local GP (lGP)and Action Plan.
During the annual Consortium Meeting by month 12, next adopters will present their local GP and Action Plans in a dedicated session. Discussion will be encouraged specially to analyse GP and Action Plans from ambition, feasibility and sustainability perspectives. This session will be supported by AGENAS and NIJZ as T4.3 and T4.5 leaders, respectively.
During the annual Consortium Meeting Kronikgune will explain the PDSA methodology. Next adopters will actively participate to ensure that the methods and procedures are clear and allow them to start with the implementation.

TASK 5.4. IMPLEMENTATION (LEADER: KG, PARTICIPANTS: NEXT ADOPTERS, AGENAS, AUTH) (M13-M36)
Next adopters will extend and develop the previously defined Action Plan with a more detailed planning of the activities and defining concrete actors (who), functions and roles (what), timeframe (when) and setting (where). They will share the planning with Kronikgune in a dedicated teleconference to guarantee that everything is in place. Then, implementation will start, and specific interventions will roll out based on PDSA. Next adopters will complete at least one PDSA cycle and will commit to promote the implementation beyond the Joint Action via refined sustainability plan.

During the first months of the implementation (month 15-18), a maximum of three thematic workshops/study visits (T4.2) will be organized at three next adopter sites. Each workshop will focus on a limited number of specific core features. For example, (i) Risk stratification approach, (ii) Integrated care and Health strategy and (iii) Patient empowerment. The role of the thematic workshop/study visit is also a) to bring visibility to next adopters at

local/regional/national level & boost communication with stakeholders, that are important for the sustainability, b) intermediate (self-) evaluation of the progress of the implementation with a potential to start next PDSA cycle, c) give structured feedback to the JA leadership regarding the chosen methods to plan and support implementation. The summary report of all thematic workshops/study visits at next adopters' site will be prepared by Task 4.2, based on the reports of next adopters.

Next adopters will attend the thematic workshops in which the core features they selected are discussed. These workshops will be a great scenario to share learning and experiences between stakeholders involved in the implementation of a given core feature in Basque Country and the local teams of next adopters.

During the implementation, Kronikgune will schedule monthly teleconferences to closely monitor the progress of next adopters. Kronikgune will support and coach implementers.
After the 12-month implementation, next adopters will report the whole implementation experience using the SQUIRE 2.0 tool. Kronikgune will support next adopters in the report development. This report will contain specific elements regarding local GP sustainability beyond the Joint Action. In the last annual Consortium Meeting (month 30 approximately), next adopters will present their implementation report to (i) share their experience and learning and (ii) collect feedback from partners that will help refining the final report.

MILESTONES
M18 Complete scope definition of the WP5 implementation sites (LB & LEO: KG) (M3)
M19 Complete situation analysis (SWOT) of the WP5 implementation sites (LB: 4RTHYPE, LEO: AUTH) (M7)
M20 Define specific interventions and action, for all WP5 implementation sites (LB & LEO: AGENAS) (M10)
M21 Implementation started (LB & LEO: KG) (M15)

Participation per Partner

Partner number and short name	WP5 effort
1 - KG	13.00
FPS	5.00
CSFJA	1.00
2 - MCA	0.00
ZZJZFBIH	7.00
3 - CIPH	2.80
CHIF	2.00
4 - MZCR	0.00
UHO	5.34
5 - RND	7.50
6 - MSAE	0.00
VH	4.60
9 - 4THYPE	15.00
AUTH	3.00
11 - AGENAS	3.00
UMBRIA	14.00
TOSCANA	14.00
13 - LR SAM	7.50
14 - ACSS	8.00
SPMS	4.00

Partner number and short name	WP5 effort
ENSP/NOVA	6.00
15 - MoHRS	15.00
Total	137.74

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D5.1	The Basque integrated care approach original Good Practice and transfer process	1 - KG	Report	Public	30

Description of deliverables

D5.1 : The Basque integrated care approach original Good Practice and transfer process [30]

LB & LEO: KG This deliverable will document: -The description of the “Basque integrated care approach” oGP, including: main blocks and core features identified in Task 4.1, the implementation requirements and process, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. -The implementation process of the “Basque integrated care approach” in each next adopter´s site will be described: how it started, who was involved, who was “coached”, how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS18	Complete scope definition of the WP5 implementation sites	1 - KG	3	Complete scope definition of the WP5 implementation sites (LB & LEO: KG)
MS19	Complete situation analysis (SWOT) of the WP5 implementation sites	9 - 4THYPE	7	Complete situation analysis (SWOT) of the WP5 implementation sites (LB: 4RTHYPE, LEO: AUTH)
MS20	Define specific interventions and action, for all WP5 implementation sites	11 - AGENAS	10	Define specific interventions and action, for all WP5 implementation sites (LB & LEO: AGENAS)
MS21	Implementation started -WP5	1 - KG	15	Implementation started -WP5 (LB & LEO: KG)

Work package number [9]	WP6	Lead beneficiary [10]	1 - KG
Work package title	CATALAN OPEN INNOVATION HUB ON ICT-SUPPORTED INTEGRATED CARE SERVICES FOR CHRONIC PATIENTS GOOD PRACTICE: TRANSFER AND ADOPTION		
Start month	1	End month	36

Objectives

IDIBAPS will be the Leading Executive Organization (LEO) of WP6 and AEEK the Co-Leading Executive Organization.

The Catalan Open Innovation Hub is conceived to serve the entire population of Catalonia (ES), 7.6M citizens. The target group is chronic patients with focus on multimorbidity management and on patients with complex health and social care needs. Accordingly, it encompasses both vertical (specialized vs. community-based care) and horizontal (healthcare vs. social support) integrations, combining a population-health orientation with a collaborative adaptive case management approach. The Catalan oGP has a two fold objectives:

(i) To foster cross-country transferability of fully adopted achievements at Catalan level, contributing to a collaborative European network aiming to promote generation, deployment and evaluation of digitally-supported innovative health services
(ii) To further consolidate regional implementation of ongoing specific key and singular levers of change in Catalonia

In order to efficiently organize transferability to next adopters, we have identified five well-defined blocks with high potential for implementation by next adopters, as well as specific actions within each of them, as indicated below, in T6.1:
1. Health risk assessment: population-based and enhanced clinical decision making (Block 1)
2. Promotion of healthy life styles (Block 2)
3. Vertical and Horizontal integration experiences adopted in Catalonia (Block 3)
4. Innovative assessment and regulatory aspects of digitally-supported integrated care services (Block 4)
5. Digital support of integrated care services (Block 5)

Description of work and role of partners

WP6 - CATALAN OPEN INNOVATION HUB ON ICT-SUPPORTED INTEGRATED CARE SERVICES FOR CHRONIC PATIENTS GOOD PRACTICE: TRANSFER AND ADOPTION [Months: 1-36]
KG, MZCR, MSAE, AEEK, AGENAS
TASK 6.1. NEEDS AND SCOPE DEFINITION (LEAD: IDIBAPS, PARTICIPANTS: NEXT ADOPTERS, AEEK) (M1-M3)
The Catalan oGP evolves fully aligned with the Chronic Care Program formulated and executed within the Catalan Health Plan 2016-2020 from the Dept of Health, Generalitat de Catalunya, the regional government. The Catalan oGP articulates an extensive network of organizations (governmental, private non-profit and private for-profit) holding contracts with the single public payer (CatSalut). They show different profiles and degrees of participation in the initiative. IDIBAPS plays an umbrella role coordinating their participation into the JADEIPCC, with full alignment with the Catalan Dept of Health. It is of note that the RIS3CAT project Nextcare 2016-2019 (http://www.nextcarecat.cat/) has played a seminal role in the Catalan oGP by generating synergies between several innovation initiatives and fully adopted practices.

Specific features, by Blocks, offered by the oGP to be considered by next adopters in the implementation sites are:
-Block 1: (i) Population-based risk stratification tool (GMA, adjusted-morbidity groups, incorporating progressively additional clinical variables and data on social determinants); (ii) Health data management strategy (Catalan Health Surveillance System, CHSS); and, (iii) Enhanced multilevel clinical risk assessment strategy.
-Block 2: (i) Pre-habilitation program with a trimodal approach (Physical Activity/Exercise; Nutritional balance; and, Mindfulness); and, (ii) Comprehensive rehabilitation for chronic patients.
-Block 3: Successful deployments encompassing vertical and horizontal integration experiences adopted by different providers. Selected cases are: (i) Programme for complex chronic and frail patients; (ii) Complex patient management linking tertiary care and community; (iii) Healthcare support programmes for nursing homes; and, (iv) Integrated care for admission avoidance of subacute and frail patients.

-Block 4: (i) Practicalities of the evaluation framework reported by Baltaxe ; (ii) Regulatory aspects associated with patient' self-tracking biological data, PROMS/PREMS through the Catalan Personal Health Folder (La Meva Salut, opened to caregivers in patients with severe disability/cognitive impairment); and, (iii) Differential regulatory aspects of health data management for quality assurance and for research purposes (PADRIS program), respectively.
-Block 5: Includes fully adopted digital tools supporting services at regional level, such as: (i) Shared regional health record (HC3); (ii) Personal Health Folder (La Meva Salut); and, (iv) Electronic prescription, as well as current deployment of enhanced digital transformation initiatives under the SISCAT program (2019 -2024), including cloud-based strategies, collaborative adaptive case management tools, unified care plan across healthcare tiers/provider for complex chronic patients, etc. The rationale formulated by Baltaxe will be proposed as a methodological approach.

Next adopters will have the opportunity to know better the Catalan GP in a dedicated workshop, organised by Task 4.1 and oGPs, during the Kick off meeting by month 1. First, Kronikgune will explain the methodology for the scope definition which is mainly delimited by selecting the features of the intervention that will be finally implemented. Then, following this methodology, the Catalan GP will describe in depth the core features of the oGP implemented in Catalonia (ES) (7,6 M inhabitants) that are encompasses. Next adopters will pre-select the core features in which they are initially interested in. Moreover, IDIBAPS will provide a detailed description of the oGP and how it was implemented step-by-step in Catalonia (resources and capabilities needed, barriers and facilitators, how problems were resolved etc.) in D6.1. Then, at next adopter´s site, local teams (including patients´ perspective), depending on their needs, expectations, strategic objectives, real possibilities and existing local interventions, will choose the final core features by month 3. The Catalan GP will support next adopters during this process if required.

TASK 6.2. SITUATION ANALYSIS (LEADER: AEEK, PARTICIPANTS: NEXT ADOPTERS, IDIBAPS) (M4-M7)
Study visits at Catalan GP site will be organized by IDIBAPS order to provide next adopters with the possibility to acquire deep knowledge on specific aspects of the Catalan GP and establish close contact with the stakeholders involved in the Catalan GP implementation. General outline of the study visits will be developed by Task 4.2. Core features, context characteristics using the Scirocco Maturity Model and the implementation process based on CFIR will be analysed and shared by Catalan GP during the study visit. Elements of sustainability will be highlighted by input of Task 4.5 as crucial aspects to be considered for the transfer and adoption. This analysis will help next adopters in understanding the requirements for adoption.

During the study visit IDIBAPS will have a dedicated session to explain the methodology of SWOT analysis (what it is, how to perform, stakeholders needed, templates provided). Next adopters will have the opportunity to test the methodology, so the procedures are clear to replicate at home with their local teams. In addition, Kronikgune will introduce the methodology for interventions and actions definition, and Task 4.5 on general approach to develop sustainability plans.

Next adopters will perform a SWOT analysis at their site. Before the meeting of local teams to prepare the SWOT, next adopters will participate in a webinar organized by AEEK, together with IDIBAPS. The aim of this virtual meeting is to support next adopters in SWOT analysis planning.

Then, next adopters will perform the SWOT analysis related to the selected core feature(s) of the oGP. The dimensions of the Scirocco Maturity Model that were considered relevant for the implementation by IDIBAPS during the study visit will be considered as well. Two perspectives will be studied in the SWOT: original GP-related and implementation-related. The former can include examples such as implementation of the GMA as the risk stratification approach in Catalonia was seen as an opportunity by health policy makers and primary care professionals. The latter can include examples such as cost-effectiveness of home hospitalization in Barcelona-Esquerra (AISBE) was considered strengths by professionals, patients and policy makers.

The SWOT analysis output will provide next adopters with a clear view of their improvement areas, priorities and the strategic action required for planning the implementation. The SWOT analysis shall deliver information on needs and the readiness of the next adopters' key stakeholders for transferring knowledge, solutions, experiences and learnings into their ecosystem regarding the 5 blocks of the oGP; potential barriers preventing the next adopters to prepare, implement, maintain and replicate the transfer, including ranking the barriers by their impacts, strength and resources required to eliminate them; gaps that might not be covered by the transfer from the specific oGP to the next adopters' ecosystem or potential areas of transfer from other oGPs to cover the identified gaps. Next adopter and IDIBAPS will jointly review the SWOT output in a webinar. It might happen that the SWOT affects to the scope definition, so an iterative process can be envisioned.

TASK 6.3. SPECIFIC INTERVENTIONS AND ACTIONS (LEADER: AGENAS, PARTICIPANTS: NEXT ADOPTERS, AUTH, AQUAS, NIJZ, IDIBAPS, AEEK) (M8-M10)
A virtual meeting will be organized by Kronikgune in order to refresh the methodology for interventions and actions definition introduced in the study visits at oGPs sites. Kronikgune will be responsible for leading the webinar and

providing guidelines and templates. Core elements of sustainability will also be presented by Task 4.5, that will also support defining the actions to be taken by next adopters.

Local teams, based on the scope, improvement areas and strategic actions, will (i) set up concrete objectives, (ii) define activities to reach the previous objectives (called "Change Package") and (iii) specify Key Performance indicators (process or health-related), (iv) plan activities to support sustainability. For example, if a given next adopter is interested in implementing the rehabilitation program for perioperative care from the Catalan GP, the adaptation of the program to the new context is needed. The transferability process includes: (i) Definition of objectives, which involves to design efficient service workflows and to build-up a sustainable empowerment program; (ii) Capacity building, create a multidisciplinary working group including all stakeholders ensuring that all perspectives are covered and infrastructure, as well as logistics, are in place; and, (iii) Define KPIs considering health outcomes/costs indicators, process indicators and structure indicators. Next adopters will be supported by AGENAS, AUTH, AQuAS, NIJZ and IDIBAPS.
Then, next adopters will virtually share and review their local interventions and actions with AGENAS and the Catalan GP by month 10 to make any refinement if needed.

The next adopters who have selected core features from more than one oGP (mix and match strategy will blend the interventions and action from different transfer WPs. This task will be led by AGENAS as T4.3 leader. At the end, all next adopters, irrespective of the transfer strategy chosen, will define their local GP (lGP) and Action Plan.
During the annual Consortium Meeting by month 12, next adopters will present their local GP and Action Plans in a dedicated session. Discussion will be encouraged specially to analyse GP and Action Plans from ambition, feasibility and sustainability perspectives. This session will be supported by AGENAS and NIJZ as T4.3 and T4.5 leaders, respectively.
During the annual Consortium Meeting, Kronikgune will explain the PDSA methodology. Next adopters will actively participate to ensure that the methods and procedures are clear and allow them to start with the implementation.

TASK 6.4. IMPLEMENTATION (LEADER: IDIBAPS, PARTICIPANTS: NEXT ADOPTERS, AGENAS, AEEK) (M13-M36)
Next adopters will extend and develop the previously defined Action Plan with a more detailed planning of the activities and definition of the concrete actors (who), functions and roles (what), timeframe (when) and setting (where). They will share the planning with IDIBAPS and Kronikgune in a dedicated teleconference to guarantee that everything is in place.

Then, implementation will start, and specific interventions will roll out based on PDSA. Next adopters will complete at least one PDSA cycle and will commit to promote the implementation beyond the Joint Action in line with the sustainability plan that will evolve during implementation based on barriers and opportunities encountered. Local/regional/national networks among next adopters and stakeholders identified to be important to assure sustainability should be established and facilitated by Task 4.5 if needed.

During the first month of the implementation (month 15-18), a maximum of three thematic workshops will be organized by Task 4.2 at three next adopter´s sites to support the learning community. Each workshop will focus on a limited number of specific core features. For example: (i) Risk assessment strategies; (ii) Implementation of integrated care services; and, (iii) Digital transformation. The role of the thematic workshop/study visit is also a) to bring visibility to next adopters at local/regional/national level & boost communication with stakeholders, that are important for the sustainability, b) intermediate (self-) evaluation of the progress of the implementation with a potential to start next PDSA cycle, c) give structured feedback to the JA leadership regarding the chosen methods to plan and support implementation.
The summary report of all thematic workshops/study visits at next adopters' site will be prepared by Task 4.2, based on the reports of next adopters. Next adopters will attend the thematic workshops in which the core features they selected are discussed. These workshops will be a great scenario to share learning and experiences between stakeholders involved in the implementation of a given core feature in Catalonia and the local teams of next adopters.

During the implementation, IDIBAPS will schedule monthly teleconferences to closely monitor the progress of next adopters. IDIBAPS will support and coach implementers.
After the 12-month implementation, next adopters will report the whole implementation experience using the SQUIRE 2.0 Guidelines. IDIBAPS and Kronikgune will support next adopters in the report development. This report will contain specific elements regarding local GP sustainability beyond the Joint Action. In the last annual Consortium Meeting (month 30 approximately), next adopters will present their implementation report to (i) share their experience and learning and (ii) collect feedback from partners that will help refining the final report.

MILESTONES
M22 Complete scope definition of the WP6 implementation sites (LB: KG, LEO: IDIBAPS) (M3)
M23 Complete situation analysis (SWOT) of the WP6 implementation sites (LB & LEO: AEEK) (M7)
M24 Define specific interventions and action, for all WP6 implementation sites (LB & LEO: AGENAS) (M10)
M25 Implementation started (LB: KG, LEO: IDIBAPS) (M15)

Participation per Partner

Partner number and short name	WP6 effort
1 - KG	0.00
FPS	5.00
CSFJA	1.00
IDIBAPS	13.00
4 - MZCR	0.00
UHO	5.33
6 - MSAE	0.00
VH	4.70
10 - AEEK	9.00
JFDPK	16.00
11 - AGENAS	3.00
MARCHE	14.00
ASL NA2	14.00
Total	85.03

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D6.1	The Catalan Innovation Hub original Good Practice and transfer process	1 - KG	Report	Public	30

Description of deliverables

D6.1 : The Catalan Innovation Hub original Good Practice and transfer process [30]

LB: KG, LEO: IDIBAPS This deliverable will document: -The description of the “Catalan Innovation Hub” oGP, including: main blocks and core features identified in Task 4.1, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. -The implementation process of the “Catalan Innovation Hub” in each next adopter´s site will be described: how it started, who was involved, who was “coached”, how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS22	Complete scope definition of the WP6 implementation sites	1 - KG	3	Complete scope definition of the WP6 implementation sites (LB: KG, LEO: IDIBAPS)
MS23	Complete situation analysis (SWOT) of the WP6 implementation sites	10 - AEEK	7	Complete situation analysis (SWOT) of the WP6 implementation sites (LB & LEO: AEEK)
MS24	Define specific interventions and action, for all WP6 implementation sites	11 - AGENAS	10	Define specific interventions and action, for all WP6 implementation sites (LB & LEO: AGENAS)
MS25	Implementation started -WP6	1 - KG	15	Implementation started (LB: KG, LEO: IDIBAPS)

Work package number [9]	WP7	**Lead beneficiary** [10]	7 - EUSTRAS
Work package title	THE OPTIMEDIS MODEL-POPULATION BAED INTEGRATED CARE GOOD PRACTICE: TRANSFER AND ADOPTION		
Start month	1	**End month**	36

Objectives

OPTIMEDIS will be the Leading Executive Organization (LEO) of WP7 and NIJZ the Co-Leading Executive Organization.

Optimedis is a private company will participate as a subcontractor of EUSTRAS (see section 9.4)

The main objective of WP7 will be:
-To select the core features of the original oGP that next adopter´s will work on.
-To perform the situation analysis and define the strategic actions of next adopters
-To define the specific interventions and actions that will be transferred to next adopters.
-To facilitate and support the transfer of oGP features to next adopters´ context.

Description of work and role of partners

WP7 - THE OPTIMEDIS MODEL-POPULATION BAED INTEGRATED CARE GOOD PRACTICE: TRANSFER AND ADOPTION [Months: 1-36]
EUSTRAS, MCA, RND, MSAE, AGENAS, NIJZ
TASK 7.1. NEEDS AND SCOPE DEFINITION (LEADER: EUSTRAS(OPTIMEDIS), PARTICIPANTS: NEXT ADOPTERS, NIJZ) (M1-M3)
Next adopters will have the opportunity to know better the original GP (oGP) and the learnings of OptiMedis (OM) in between in other locations/regions in a dedicated workshop, organised by Task 4.1 and oGPs, during the Kick off meeting by month 1. First, Kronikgune will explain the methodology for the scope definition which is mainly delimited by selecting the features of the intervention that will be finally implemented. Then, following this methodology, OM will describe in depth the core features of the oGP implemented in Kinzigtal, Billstedt-Horn and Werra-Meißner that are health data warehouse, IT supported information continuity between providers, patient activation and a shared savings approach. Next adopters will pre-select the core features in which they are initially interested in. Moreover, Optimedis will provide a detailed description of the oGP and how it was implemented step-by-step in Germany (resources and capabilities needed, barriers and facilitators, how problems were resolved etc.) in D7.1.
At Kick-off meeting, WP7 leader and coleader will present the general outline of WP7 leadership and management plan at all phases of the implementation, including final reporting.
At next adopter´s site, local teams (including patient ‘perspectives), depending on their needs, expectations, strategic objectives, real possibilities and existing local interventions, will choose the final core features by month 3. OM will support next adopters during this process if required.

TASK 7.2. SITUATION ANALYSIS (LEADER: NIJZ, PARTICIPANTS: NEXT ADOPTERS, EUSTRAS(OPTIMEDIS)) (M4-M7)
Study visits at oGP site will be organized by OM in order to provide next adopters the possibility to acquire deep knowledge on specific aspects of the oGP and establish close contact with the stakeholders involved in the oGP implementation. General outline of the study visits will be developed by Task 4.2 and collect the reports. Core features, context characteristics using the Scirocco Maturity Model and the implementation process based on CFIR will be analysed and shared by OM during the study visit. Elements of sustainability will be highlighted by input of Task 4.5 as crucial aspects to be considered for the transfer and adoption. This analysis will help next adopters in understanding the requirements for adoption.

During the study visit Kronikgune will have a dedicated session to explain the methodology of SWOT analysis (what it is, how to perform, stakeholders needed, templates provided). Next adopters will have the opportunity to test the methodology, so the procedures are clear to replicate at home with their local teams. In addition, Kronikgune will introduce the methodology for interventions and actions definition, and Task 4.5 on general approach to develop sustainability plans.
Next adopters will perform a SWOT analysis at their site. Before the meeting of local teams to prepare the SWOT, next adopters will participate in a webinar organized by NIJZ, together with Kronikgune (Task 3.2). The aim of this virtual meeting is to support next adopters in SWOT analysis planning.

Then, next adopters will perform the SWOT analysis related to the selected core feature(s) of the oGP. The dimensions of the Scirocco Maturity Model that were considered relevant for the implementation by OM during the study visit will be considered as well. Two perspectives will be studied in the SWOT: original GP-related and implementation-related. The former can include examples such as the use of routine health information databases to construct performance feedback reports to health care providers that encourage evidence-based prescription and therapy. The latter can include examples such as the availability of a functioning governance structure for existing health care providers in order to support seamless implementation of the characteristics of the good practice.

The SWOT analysis output will provide next adopters with a clear view of their improvement areas, priorities and the strategic action required for planning the implementation. The SWOT analysis shall deliver information on needs and the readiness of the next adopters' key stakeholders for transferring knowledge, solutions, experiences and learnings into their ecosystem regarding the 5 blocks of the oGP; potential barriers preventing the next adopters to prepare, implement, maintain and replicate the transfer, including ranking the barriers by their impacts, strength and resources required to eliminate them; gaps that might not be covered by the transfer from the specific oGP to the next adopters' ecosystem or potential areas of transfer from other oGPs to cover the identified gaps. Next adopter and NIJZ will jointly review the SWOT output in a webinar. It might happen that the SWOT affects to the scope definition, so an iterative process can be envisioned.

TASK 7.3. SPECIFIC INTERVENTIONS AND ACTIONS (LEADER: AGENAS, PARTICIPANTS: NEXT ADOPTERS, AUTH, AQUAS, NIJZ, EUSTRAS(OPTIMEDIS)) (M8-M10)
A virtual meeting will be organized by Kronikgune in order to refresh the methodology for interventions and actions definition introduced in the study visits at oGPs sites. Kronikgune will be responsible for leading the webinar and providing guidelines and templates. Core elements of sustainability will also be presented by Task 4.5, which will also support defining the actions to be taken by next adopters.

Local teams, based on the scope, improvement areas and strategic actions, will (i) set up concrete objectives, (ii) define activities to reach the previous objectives (called "Change Package") and (iii) specify Key Performance indicators (process or health-related), (iv) plan activities to support sustainability. For example, if a next adopter is interested in adapting a community outreach centre/activity to improve patient empowerment and health literacy then various context factors such as morbidity, social demographics, migrant population, economic development and service delivery structures need to be considered. Indicators would be % of people with insufficient language skills, % of people with limited health literacy, % of people experiencing difficulties in accessing primary/secondary care, % of hospital admissions sensitive to primary care improvements. Next adopters will be supported by AGENAS, AUTH, AQuAS, NIJZ and OM.

Then, next adopters will virtually share and review their local interventions and actions with AGENAS and Eurométropole/OptiMedis by month 10 to make any refinement if needed.

The next adopters who have selected core features from more than one oGP (mix and match strategy) will blend the interventions and action from different transfer WPs. This task will be led by AGENAS as T4.3 leader. At the end, all next adopters, irrespective of the transfer strategy chosen, will define their local GP (lGP) and Action Plan.
During the annual Consortium Meeting by month 12, next adopters will present their local GP and Action Plans in a dedicated session. Discussion will be encouraged especially to analyse GP and Action Plans from ambition, feasibility and sustainability perspectives. This session will be supported by AGENAS and NIJZ as T4.3 and T4.5 leaders, respectively.
During the annual Consortium Meeting Kronikgune will explain the PDSA methodology. Next adopters will actively participate to ensure that the methods and procedures are clear and allow them to start with the implementation.

TASK 7.4. IMPLEMENTATION (LEADER : EUSTRAS(OPTIMEDIS), PARTICIPANTS: NEXT ADOPTERS, AGENAS, NIJZ) (M13-M36)
Next adopters will extend and develop the previously defined Action Plan with a more detailed planning of the activities and definition of the concrete actors (who), functions and roles (what), timeframe (when) and setting (where). They will share the planning with (Eurométropole/OptiMedis) and Kronikgune in a dedicated teleconference to guarantee that everything is in place.

Then, implementation will start and specific interventions will roll out based on PDSA. PDSA processes will not be directed at patients to avoid potential ethical and time-management issues regarding patient recruitment, consent, and follow-up, but rather programme management improvement processes. Next adopters, at least, will complete one PDSA cycle and will commit to promote the implementation beyond the Joint Action in line with the sustainability plan that will evolve during implementation based on barriers and opportunities encountered. Local/regional/national networks among next adopters and stakeholders identified to be important to assure sustainability should be established and facilitated by Task 4.5 if needed.

During the first month of the implementation (month 15-18), a maximum of three thematic workshops will be organized by Task 4.2 at three next adopters´ sites to support the learning community. Each workshop will focus on a limited number of specific core features. For example, issues to be discussed could be best practices to increase patient activation in different contexts, strategies to increase physician collaboration for multi-morbid chronic patients; IT tools to provide seamless care etc. Next adopters will attend the thematic workshops in which the core features they selected are discussed. These workshops will be a great scenario to share learning and experiences between stakeholders involved in the implementation of a given core feature in Kinzigal, Billstedt-Horn and Werra-Meißner and the local teams of next adopters.
During the implementation, Eurométropole/OptiMedis will schedule monthly teleconferences to closely monitor the progress of next adopters. Eurométropole/OptiMedis will support and coach implementers.

Organization of study visits at next adopters' site will be strongly encouraged and supported by Task 4.2 in order to: a) bring visibility to next adopters at local/regional/national level and boost communication with stakeholders, that are important for the sustainability, b) intermediate (self-)evaluation of the progress of the implementation with a potential to start next PDSA cycle, c) give structured feedback to the JA leadership regarding the chosen methods to plan and support implementation. They may be joined to thematic workshops, if not too early with respect to the level of implementation. The summary report of all study visits at next adopters' site will be prepared by Task 4.2, based on the reports of next adopters.

After the 12-month implementation, next adopters will report the whole implementation experience using the SQUIRE 2.0 guidelines. Eurométropole/OptiMedis and Kronikgune will support next adopters in the report development. This report will contain specific elements regarding local GP sustainability beyond the Joint Action. In the last annual Consortium Meeting (month 30 approximately), next adopters will present their implementation report to (i) share their experience and learning and (ii) collect feedback from partners that will help refining the final report.

MILESTONES
M26 Complete scope definition of the WP7 implementation sites (LB: EUSTRAS, LEO: Optimedis) (M3)
M27 Complete situation analysis (SWOT) of the WP7 implementation sites (LB & LEO: NIJZ) (M7)
M28 Define specific interventions and action, for all WP7 implementation sites (LB & LEO: AGENAS) (M10)
M29 Implementation started (LB: EUSTRAS, LEO: Optimedis) (M15)

Participation per Partner

Partner number and short name	WP7 effort
2 - MCA	0.00
ZZJZFBIH	7.00
MHSw-RS	14.00
5 - RND	7.50
6 - MSAE	0.00
VH	4.70
7 - EUSTRAS	6.00
11 - AGENAS	3.00
16 - NIJZ	0.00
ZZZS	10.00
Total	52.20

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D7.1	The Optimedis Model original Good Practice and transfer process	7 - EUSTRAS	Report	Public	30

Description of deliverables

D7.1 : The Optimedis Model original Good Practice and transfer process [30]

LB: EUSTRAS, LEO: Optimedis The deliverable will document: -The description of the “Optimedis Model” oGP, including: main blocks and core features identified in Task 4.1, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. The implementation process of the “Optimedis Model” in each next adopter´s site will be described: how it started, who was involved, who was “coached”, how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS26	Complete scope definition of the WP7 implementation sites	7 - EUSTRAS	3	Complete scope definition of the WP7 implementation sites (LB: EUSTRAS, LEO: Optimedis)
MS27	Complete situation analysis (SWOT) of the WP7 implementation sites	16 - NIJZ	7	Complete situation analysis (SWOT) of the WP7 implementation sites (LB & LEO: NIJZ)
MS28	Define specific interventions and action, for all WP7 implementation sites	11 - AGENAS	10	Define specific interventions and action, for all WP7 implementation sites (LB & LEO: AGENAS)
MS29	Implementation started-WP7	7 - EUSTRAS	15	Implementation started - WP7 (LB: EUSTRAS, LEO: Optimedis)

Work package number [9]	WP8	**Lead beneficiary** [10]	5 - RND
Work package title	DIGITAL ROADMAP TOWARDS AN INTEGRATED HEALTH CARE SECTOR GOOD PRACTICE TRANSFER AND ADOPTION		
Start month	1	**End month**	36

Objectives

RSD will be the Leading Executive Organization (LEO) of WP8 and UHO the Co-Leading Executive Organization.

The main objectives will be:
-To select the core features of the original oGP that next adopter´s will work on.
-To perform the situation analysis and define the strategic actions of next adopters
-To define the specific interventions and actions that will be transferred to next adopters.
-To facilitate and support the transfer of oGP features to next adopters´ context.

Description of work and role of partners

WP8 - DIGITAL ROADMAP TOWARDS AN INTEGRATED HEALTH CARE SECTOR GOOD PRACTICE TRANSFER AND ADOPTION [Months: 1-36]
RND, KG, CIPH, MZCR, AGENAS, NVD, LR SAM
TASK 8.1. NEEDS AND SCOPE DEFINITION (LEADER: RSD, PARTICIPANTS: NEXT ADOPTERS, UHO) (M1-M3)
Next adopters will have the opportunity to know better the oGP in a dedicated workshop during the Kick off meeting by month 1 (T4.1). First, Kronikgune will explain the methodology for the scope definition which is mainly delimited by selecting the features of the intervention that will be finally implemented. Then, following this methodology, the Region of Southern Denmark will describe in depth the core features of the oGP, Roadmap towards Integrated Care, implemented in the Region of Southern Denmark. The Roadmap towards Integrated Care consists of different elements that together make up the foundation for the digital and cross sectorial communication. They are: (i) Cross sectorial digital communication: standards and agreements, including health agreements, messaging standards, SAM:BO Agreement, (ii) Cross sectorial digital communication: Additional solutions to support complex disease areas, including Tele-COPD, Tele-psychiatry, My Patient Journey, Online physical rehabilitation, Digital Health Centre and Geri Toolbox. Across all elements the key success factors are a strong collaboration between the different organizations in the regional eco-system consisting of academia, knowledge institutions and private companies; a focus on user involvement of both professionals and end-users in co-designing solutions and implementation processes; a good public-private partnership and preferably and agile one as well as a strong IT infrastructure to make digital communication possible.

Next adopters will pre-select the core features in which they are initially interested in. Moreover, RSD will provide a detailed description of the oGP and how it was implemented step-by-step in Denmark (resources and capabilities needed, barriers and facilitators, how problems were resolved etc.) in D8.1.
Then, at next adopter´s site, local teams (including patients 'perspective), depending on their needs, expectations, strategic objectives, real possibilities and existing local interventions, will choose the final core features by month 3. The Health Innovation Centre, representing the Region of Southern Denmark in the Joint Action, will support next adopters during this process if required.

TASK 8.2. SITUATION ANALYSIS (LEADER: UHO, PARTICIPANTS: NEXT ADOPTERS, RSD) (M4-M7)
Study visits will be organized in order to provide next adopters the possibility to acquire deep knowledge on specific aspects of the oGP and establish close contact with the stakeholders involved in the oGP implementation (T4.2). Core features, context characteristics using the Scirocco Maturity Model and the implementation process based on CFIR will be analysed and shared by the Health Innovation Centre of Southern Denmark during the study visit. Elements of sustainability will be highlighted as crucial aspects to be considered for the transfer and adoption. This analysis will help next adopters in understanding the requirements for adoption.
During the study visit Kronikgune will have a dedicated session to explain the SWOT analysis (what it is, how to perform, stakeholders needed, templates provided). Next adopters will have the opportunity to test the methodology so the procedures are clear to replicate at home with their local teams. In addition, Kronikgune will introduce the methodology for interventions and actions definition.

Next adopters will perform a SWOT analysis at their site. Before the SWOT meeting with their teams, next adopters will participate in a webinar organized by the Health Innovation Centre of Southern Denmark, together with Kronikgune. The aim of this virtual meeting is to support next adopters in SWOT analysis planning.
Then, next adopters will perform the SWOT analysis related to the selected core feature(s) of the oGP. The dimensions of the Scirocco Maturity Model that were considered relevant for the implementation by the Health Innovation Centre of Southern Denmark during the study visit will be considered as well. Two perspectives will be studied in the SWOT: original GP-related and implementation-related. The former can include examples such as resistance to change, technical barriers or the lack of available local resources. The latter can include examples such as increasing the communication and understanding across different sectors, a higher degree of patient involvement and a focus on patient pathways and safety.

The SWOT analysis output will provide next adopters with a clear view of their improvement areas, priorities and the strategic action required for planning the implementation and its sustainability. The SWOT analysis shall deliver information on needs and the readiness of the next adopters' key stakeholders for transferring knowledge, solutions, experiences and learnings into their ecosystem regarding the 5 blocks of the oGP; potential barriers preventing the next adopters to prepare, implement, maintain and replicate the transfer, including ranking the barriers by their impacts, strength and resources required to eliminate them; gaps that might not be covered by the transfer from the specific oGP to the next adopters' ecosystem or potential areas of transfer from other oGPs to cover the identified gaps. Next adopter and the Health Innovation Centre of Southern Denmark will jointly review the SWOT output in a webinar. It might happen that the SWOT affects to the scope definition, so an iterative process can be envisioned.

TASK 8.3. SPECIFIC INTERVENTIONS AND ACTIONS (LEADER: AGENAS, PARTICIPANTS: NEXT ADOPTERS, AUTH, AQUAS, NIJZ, RSD, UHO) (M8-M10)
A virtual meeting will be organized by Kronikgune in order to refresh the methodology for interventions and actions definition introduced in the study visits. Kronikgune will be responsible for leading the webinar and providing guidelines and templates.

Local teams, based on the scope, improvement areas and strategic actions, will (i) set up concrete objectives, (ii) define activities to reach the previous objectives (called "Change Package") (iii) specify Key Performance indicators (process or health-related), and (iv) plan activities to support sustainability. For example, if a given next adopter is interested in implementing the Online Rehabilitation Platform an adaptation of the solution is needed. This would include subtexting the training videos, translating the information material and training key personnel in using the platform. Key Performance indicators could be the number of available videos to be used in the individually designed training programmes, number of therapists using the platform as a supplement in the rehabilitation plan and the number of patients using the platform at home as well as their indications of pain and difficulty level. Next adopters will be supported by AGENAS, AUTH, AQuAS, NIJZ and the Health Innovation Centre of Southern Denmark.
Then, next adopters will virtually share and review their local interventions and actions with AGENAS and the Health Innovation Centre by month 10 to make any refinement if needed.

The next adopters who have selected core features from more than one oGP (mix and match strategy will blend the interventions and action from different transfer WPs. This task will be led by AGENAS as T4.3 leader. AT the end, all next adopters, irrespective of the transfer strategy chosen, will define their local GP (lGP)and Action Plan.
During the annual Consortium Meeting by month 12, next adopters will present their local GP and Action Plans in a dedicated session. Discussion will be encouraged especially to analyse GP and Action Plans from ambition, feasibility and sustainability perspectives. This session will be supported by AGENAS and NIJZ as T4.3 and T4.5 leaders, respectively.
During the annual Consortium Meeting Kronikgune will explain the PDSA methodology. Next adopters will actively participate to ensure that the methods and procedures are clear and allow them to start with the implementation.

TASK 8.4. IMPLEMENTATION (LEADER: RSD, PARTICIPANTS: NEXT ADOPTERS, AGENAS, UHO) (M13-M36)
Next adopters will extend and develop the previously defined Action Plan with a more detailed planning of the activities and defining concrete actors (who), functions and roles (what), timeframe (when) and setting (where). They will share the planning with the Health Innovation centre of Southern Denmark and Kronikgune in a dedicated teleconference to guarantee that everything is in place.
Then, implementation will start, and specific interventions will roll out based on PDSA. Next adopters will complete at least one PDSA cycle and will commit to promote the implementation beyond the Joint Action.

During the first months of the implementation (month 15-18), a maximum of three thematic workshops will be organized at three next adopters' sites (T4.2w). Each workshop will focus on a limited number of specific core features. For example, electronic standards, organization of cross-sectoral communication and patient involvement. Next adopters

will attend the thematic workshops in which the core features they selected are discussed. These workshops will be a great scenario to share learning and experiences between stakeholders involved in the implementation of a given core feature in the Region of Southern Denmark and the local teams of next adopters. The role of the thematic workshop/ study visit is also a) to bring visibility to next adopters at local/regional/national level and boost communication with stakeholders, that are important for the sustainability, b) intermediate (self-)evaluation of the progress of the implementation with a potential to start next PDSA cycle, c) give structured feedback to the JA leadership regarding the chosen methods to plan and support implementation. The summary report of all thematic workshops/study visits at next adopters' site will be prepared by Task 4.2, based on the reports of next adopters.

During the implementation, the Health Innovation Centre of Southern Denmark will schedule monthly teleconferences to closely monitor the progress of next adopters. The Health Innovation Centre of Southern Denmark will support and coach implementers.
After the 12-month implementation, next adopters will report the whole implementation experience using the SQUIRE 2.0 tool. The Health Innovation Centre of Southern Denmark and Kronikgune will support next adopters in the report development. This report will contain specific elements regarding local GP sustainability beyond the Joint Action. In the last annual Consortium Meeting (month 30 approximately), next adopters will present their implementation report to (i) share their experience and learning and (ii) collect feedback from partners that will help refining the final report.

MILESTONES
M30 Complete scope definition of the WP8 implementation sites (LB: RND: LEO: RSD) (M3)
M31 Complete situation analysis (SWOT) of the WP8 implementation sites (LB: MCZR, LEO: UHO) (M7)
M32 Define specific interventions and action, for all WP8 implementation sites (LB & LEO: AGENAS) (M10)
M33 Implementation started (LB: RND: LEO: RSD) (M15)

Participation per Partner

Partner number and short name	WP8 effort
1 - KG	0.00
FFIS	3.25
SCS	4.00
SACYL	14.00
IDIVAL	7.00
SMS	7.00
3 - CIPH	3.00
CHIF	3.40
4 - MZCR	0.00
UHO	5.33
5 - RND	0.00
RSD	13.00
11 - AGENAS	3.00
LOMBARDIA	14.00
12 - NVD	6.00
CCUH	15.00
13 - LR SAM	7.50
Total	105.48

List of deliverables

Deliverable Number[14]	Deliverable Title	Lead beneficiary	Type[15]	Dissemination level[16]	Due Date (in months)[17]
D8.1	The Danish roadmap towards Integrated Care original Good Practice and transfer process	5 - RND	Report	Public	30

Description of deliverables

D8.1 : The Danish roadmap towards Integrated Care original Good Practice and transfer process [30]

LB: RND, LEO: RSD -The description of the “Danish Roadmap towards Integrated Care” oGP, including: main blocks and core features identified in Task 4.1, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. -The implementation process of the “Danish Roadmap towards Integrated Care” in each next adopter´s site will be described: how it started, who was involved, who was “coached”, how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.

Schedule of relevant Milestones

Milestone number[18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS30	Complete scope definition of the WP8 implementation sites	5 - RND	3	Complete scope definition of the WP8 implementation sites (LB: RND: LEO: RSD)
MS31	Complete situation analysis (SWOT) of the WP8 implementation sites	4 - MZCR	7	Complete situation analysis (SWOT) of the WP8 implementation sites (LB: MCZR, LEO: UHO)
MS32	Define specific interventions and action, for all WP8 implementation sites	11 - AGENAS	10	Define specific interventions and action, for all WP8 implementation sites (LB & LEO: AGENAS)
MS33	Implementation started - WP8	5 - RND	15	Implementation started - WP8 (LB: RND: LEO: RSD)

1.3.4. WT4 List of milestones

Milestone number[18]	Milestone title	WP number[9]	Lead beneficiary	Due Date (in months)[17]	Means of verification
MS1	Kick-off meeting	WP1	1 - KG	1	Kick off meeting (LB & LEO: KG)
MS2	Periodic technical and financial report	WP1	1 - KG	18	Periodic technical and financial report sent to CHAFEA (LB & LEO: KG)
MS3	Final technical and financial report	WP1	1 - KG	36	Final technical and financial report sent to CHAFEA (LB & LEO: KG)
MS4	Project slide deck and branded templates	WP2	10 - AEEK	3	Project slide deck and branded templates (LB: AEEK, LEO:SU-HSMTC)
MS5	Dissemination and communication plan	WP2	10 - AEEK	6	Dissemination and communication plan (LB: AEEK, LEO:SU-HSMTC)
MS6	Website launching	WP2	8 - BAGSFI	6	Website launching (LB: BAGSFI, LEO: ZTG GMBH)
MS7	Mid-term report on Dissemination	WP2	10 - AEEK	18	Final Conference (LB: AEEK, LEO:SU-HSMTC)
MS8	Final Conference	WP2	8 - BAGSFI	36	Final conference of the project (LB: BAGSFI, LEO: LGL)
MS9	Monitoring and Evaluation Plan	WP3	9 - 4THYPE	8	Monitoring and evaluation plan (LB: 4RTHYPE, LEO: AUTH)
MS10	Implementation strategy in place	WP3	1 - KG	9	Implementation strategy in place (LB & LEO: KG)
MS11	Impact Assessment Plan	WP3	9 - 4THYPE	9	Impact Assessment Plan (LB: 4RTHYPE, LEO: AUTH)
MS12	Interim Evaluation	WP3	9 - 4THYPE	18	Interim Evaluation (LB: 4RTHYPE, LEO: AUTH)
MS13	Final Evaluation	WP3	9 - 4THYPE	9	Final Evaluation (LB: 4RTHYPE, LEO: AUTH)
MS14	General principles of successful implementation described	WP4	8 - BAGSFI	9	General principles of successful implementation described (LB & LEO: BAGSFI)
MS15	Summary reports from study visits at oGPs sites finalized	WP4	8 - BAGSFI	10	Summary reports from study visits at oGPs sites finalized (LB & LEO: BAGSFI)
MS16	Common issues from needs and scope (x.1), situation analysis (x.2), interventions and actions (x.3) identified	WP4	11 - AGENAS	15	Common issues from needs and scope (x.1), situation analysis (x.2), interventions and actions (x.3) identified (LB & LEO: AGENAS)

Milestone number[18]	Milestone title	WP number[9]	Lead beneficiary	Due Date (in months)[17]	Means of verification
MS17	Summary report from meetings of policy board	WP4	16 - NIJZ	36	Summary report from meetings of policy board (LB & LEO: NIJZ)
MS18	Complete scope definition of the WP5 implementation sites	WP5	1 - KG	3	Complete scope definition of the WP5 implementation sites (LB & LEO: KG)
MS19	Complete situation analysis (SWOT) of the WP5 implementation sites	WP5	9 - 4THYPE	7	Complete situation analysis (SWOT) of the WP5 implementation sites (LB: 4RTHYPE, LEO: AUTH)
MS20	Define specific interventions and action, for all WP5 implementation sites	WP5	11 - AGENAS	10	Define specific interventions and action, for all WP5 implementation sites (LB & LEO: AGENAS)
MS21	Implementation started -WP5	WP5	1 - KG	15	Implementation started -WP5 (LB & LEO: KG)
MS22	Complete scope definition of the WP6 implementation sites	WP6	1 - KG	3	Complete scope definition of the WP6 implementation sites (LB: KG, LEO: IDIBAPS)
MS23	Complete situation analysis (SWOT) of the WP6 implementation sites	WP6	10 - AEEK	7	Complete situation analysis (SWOT) of the WP6 implementation sites (LB & LEO: AEEK)
MS24	Define specific interventions and action, for all WP6 implementation sites	WP6	11 - AGENAS	10	Define specific interventions and action, for all WP6 implementation sites (LB & LEO: AGENAS)
MS25	Implementation started -WP6	WP6	1 - KG	15	Implementation started (LB: KG, LEO: IDIBAPS)
MS26	Complete scope definition of the WP7 implementation sites	WP7	7 - EUSTRAS	3	Complete scope definition of the WP7 implementation sites (LB: EUSTRAS, LEO: Optimedis)
MS27	Complete situation analysis (SWOT) of the WP7 implementation sites	WP7	16 - NIJZ	7	Complete situation analysis (SWOT) of the WP7 implementation sites (LB & LEO: NIJZ)
MS28	Define specific interventions and action, for all WP7 implementation sites	WP7	11 - AGENAS	10	Define specific interventions and action, for all WP7 implementation sites (LB & LEO: AGENAS)
MS29	Implementation started-WP7	WP7	7 - EUSTRAS	15	Implementation started - WP7 (LB: EUSTRAS, LEO: Optimedis)
MS30	Complete scope definition of the WP8 implementation sites	WP8	5 - RND	3	Complete scope definition of the WP8 implementation sites (LB: RND: LEO: RSD)

Milestone number[18]	Milestone title	WP number[9]	Lead beneficiary	Due Date (in months)[17]	Means of verification
MS31	Complete situation analysis (SWOT) of the WP8 implementation sites	WP8	4 - MZCR	7	Complete situation analysis (SWOT) of the WP8 implementation sites (LB: MCZR, LEO: UHO)
MS32	Define specific interventions and action, for all WP8 implementation sites	WP8	11 - AGENAS	10	Define specific interventions and action, for all WP8 implementation sites (LB & LEO: AGENAS)
MS33	Implementation started - WP8	WP8	5 - RND	15	Implementation started - WP8 (LB: RND: LEO: RSD)

1.3.5. WT5 Critical Implementation risks and mitigation actions

Risk number	Description of risk	WP Number	Proposed risk-mitigation measures
1	Due to COVID-19 crisis, difficulties to organize face-to-face meetings due to restrictions resulting from national emergency measures including travel restrictions, social distancing and confinements	WP1, WP2, WP3, WP4, WP5, WP6, WP7, WP8	The face-to-face meetings planned would be adapted to the COVID-19 situation by either transforming them into virtual conferences, webinars or workshops in the case of big events or into small focus-groups/working events that can follow the social distancing needs and measures. Specific working methodologies will be put in place to make the meetings as productive as face-to-face meetings. It is not expected to have important changes in the budget distribution only an update of the number of travels and final destinations if the large meetings are postponed or cancelled and more small meetings are finally necessary. This will be adapted to match the working plan but it is not expected to sought an amendment.
2	Due to COVID-19 crisis, low participation of clinicians, IT technicians and decision makers in JADECARE	WP2, WP3, WP4, WP5, WP6, WP7, WP8	Local implementation working groups will include stakeholders from different settings (primary care, hospital care, information system department, healthcare directorate etc.) with different profiles, expertise and experience (managers, doctors, nurses, IT technicians). Professionals not dealing (at front line) with COVID-19 will be selected. The size of these meetings will be small enough to fulfil the requirements of social distancing. In addition, virtual meetings will be organized with front line clinicians and staff.
3	Progress starting too late and the project resulting in poor delivery and project outcome	WP1, WP2, WP3, WP4, WP5, WP6, WP7, WP8	Previous work has been done during the preparation of the JA. General management procedures have been designed to detect any deviation from the initial plan and an experienced and robust management team will lead the project. Kick off meeting has been carefully designed to coherently launch all the simultaneous activities.
4	Deliverables or official notifications to the CHAFEA arrive late	WP1	The coordinator will check, 15 days earlier of the deadline the status of any of deliverable to be sent to CHAFEA. In case there is a delay, it will be informed and justified beforehand establishing the real deadline.
5	Financial deviations/ Budget issues don´t allow to develop the activities	WP1	The Budget has been carefully designed, discussed and agreed with all the participants. Considering the option of miss and match the amount of budget indicated for WP5-8 could be transferred from one to other of this WP. A financial manager will lead the evaluation and monitoring of use of resources and justification by all the partners.
6	A partner leaves the project	WP1	All partners have designed by the corresponding health systems in their countries demonstrating

Risk number	Description of risk	WP Number	Proposed risk-mitigation measures
			the commitment to the project. The rest of the consortium will try to assume the partner objectives, responsibilities and resources. In case the responsibilities reallocation is not possible, the consortium will look for other partner with the same profile.
7	Results not disseminated as expected	WP2	The project has included experts in the field that will lead the WP. A strong focus will be put in the creation a solid and catchy visual identity that will be included in the promotional material. The communication team will lead the commitment of all communication departments from entities involved in the project.
8	Few attendees at events	WP2	Promotion of the activities will be a key element of the project as described in WP2. In addition, the policy board included in JADECARE will allow maximizing the participation of policy makers, activities included in WP5-8, involving local teams, will allow the contact with the rest of the stakeholders that will get to know at first hand the details and impact of the project.
9	No agreement on indicators	WP3, WP4, WP5, WP6, WP7, WP8	The impact of the Project will be measured in two levels: a) the Joint Action in overall (including impact on external stakeholders) and b) the next adopters. SMART key performance indicators will be tailored to each next adopter according to the local GGPP implemented to avoid unnecessary duplication or unrealistic indicators. The customization of the indicators will be framed into transfer WPs (WP 5-8) during the definition of specific interventions and action to implement. Leaders of WP3 have a proven track record in evaluation of impact/ interventions/implementations and have designed also indicators to provide key information to partners to correct the limitations and boost the strengths.
10	Evaluation is not feasible	WP3, WP4, WP5, WP6, WP7, WP8	WP3 has been designed to provide a methodological framework for assessing the different adopted features. The WP3 has a thorough plan to monitor the progress of the project as well as the impact by using tailored indicators that will be reviewed and updated if necessary.
11	No real integration in national policies	WP4	JADECARE is going to create stable stakeholders ´ communities where generation and exchange of knowledge will be promoted. Workshops, interviews, questionnaires will be used to identify the barriers and key elements to be considered to really achieve the change. In addition, a policy board will be included in the project where all the policy-oriented stakeholder will find sustainability analysis for the action. Ministries of health

Risk number	Description of risk	WP Number	Proposed risk-mitigation measures
			will be included in JADECARE as partners or as members of the Policy Board. A report on sustainability and integration in national policies will be generated.
12	Sustainability it is not feasible	WP4	All the oGPs are nowadays running in the corresponding countries, where the sustainability has been recognized. The next adopters have the real capacity of implement at long term the selected strategy, national or regional health systems. In addition, Recommendation sand guidance for uptake of GP will be a key task in the project leading to a co-creation of guidelines and standard operation procedures for GP uptake will be co-created considering the idiosyncrasy of the regions. . Actions plans of next adopters will be developed based on common principles and study visits outputs. Task 4.6 will generate the tools to work in this sustainability and how to include the policy representatives in the project.
13	oGPs don´t meet the expectations of next adopters	WP5, WP6, WP7, WP8	All next adopters have participated in dedicated webinars during the preparation of the JA to know in detail the oGP. In fact, the applicants have shown their initial interest in one or several of the oGPs. In addition, next adopters will have the opportunity of tailoring the local GPs by mixing and matching specific oGP features.
14	Professionals, patients and general population don´t participate in JADECARE	WP5, WP6, WP7, WP8	All next adopters have included in the joint action, professionals, centers and patients willing to participate in the preparation and initial piloting of the corresponding GP. All the next adopters will use resources from CHAFEA to develop the project and have committed their own resources to guarantee the development of the activities.
15	GP can´t be understood by next adopters	WP5, WP6, WP7, WP8	Next adopters will have the opportunity to know better the original GP (oGP) in a dedicated workshop during the Kick off meeting by month 1. In addition, study visits will be organized in order to provide next adopters the possibility to acquire deep knowledge on specific aspects of the oGP and establish close contact with the stakeholders involved in the oGP implementation. Besides, a SWOT analysis will be developed to have a clear view of the areas of improvement, priorities and the strategic action required.
16	Cultural, financial, professional, healthcare systems barriers hampered the implementation of GPs	WP5, WP6, WP7, WP8	Key stakeholders for the change are included in JADECARE as CA, AE and belonging to different boards. In addition, SWOT analysis will deliver information on needs and the readiness of the next adopters´ key stakeholders for transferring knowledge, solutions. Specific interventions and actions are designed to deploy implementations in next adopters. The local teams guided by the owners of oGP will extend and develop

Risk number	Description of risk	WP Number	Proposed risk-mitigation measures
			tailored defined Actions plans to promote the implementation of the JA.
17	Different level of digital health and integrated care maturity	WP5, WP6, WP7, WP8	The maturity level of digital health has been analyzed in each of the participating countries as described in section 5.1.5. JADECARE doesn´t aim to implement new solutions in each region but to settle the bases to really implement the digital integrated care solutions at short term. The roadmap for real change and implementation will be developed in JADECARE identifying the barriers, obstacles, necessities and steps to be taken.

1.3.6. WT6 Summary of project effort in person-months

	WP1	WP2	WP3	WP4	WP5	WP6	WP7	WP8	Total Person/Months per Participant
1 - KG	67	1	10	3	13	0	0	0	94
· FFIS	0	0.25	1	1	0	0	0	3.25	5.50
· FPS	0	0.75	2	2	5	5	0	0	14.75
· SCS	0	0.25	1	1	0	0	0	4	6.25
· SACYL	0	1	2	2	0	0	0	14	19
· CSFJA	0	0.25	0.75	1	1	1	0	0	4
· IDIVAL	0	0.75	2	2.25	0	0	0	7	12
· IDIBAPS	0	1	0	2	0	13	0	0	16
· AQUAS	0	1	13	0	0	0	0	0	14
· SMS	0	0.75	1	1	0	0	0	7	9.75
2 - MCA	2	1	0	3	0	0	0	0	6
· ZZJZFBIH	0	1	2	2	7	0	7	0	19
· MHSw-RS	0	1	2	2	0	0	14	0	19
3 - CIPH	2	1	2	1.40	2.80	0	0	3	12.20
· CHIF	0	0	0	0	2	0	0	3.40	5.40
4 - MZCR	2	1	0	4	0	0	0	0	7
· UHO	0	1	2	2	5.34	5.33	0	5.33	21
5 - RND	2	1	2	4	7.50	0	7.50	0	24
· RSD	0	1	0	3	0	0	0	13	17
6 - MSAE	2	1	0	3	0	0	0	0	6
· VH	0	1	2	2	4.60	4.70	4.70	0	19
7 - EUSTRAS	2	1	2	3	0	0	6	0	14
8 - BAGSFI	2	1	2	5.25	0	0	0	0	10.25

	WP1	WP2	WP3	WP4	WP5	WP6	WP7	WP8	Total Person/Months per Participant
· LGL	0	5	0	2.25	0	0	0	0	7.25
· ZTG-GmBH	0	5	0	2.75	0	0	0	0	7.75
9 - 4THYPE	2	1	0	4	15	0	0	0	22
· AUTH	0	1	20	0	3	0	0	0	24
10 - AEEK	2	1	0	5	0	9	0	0	17
· SU-HSMTC	0	19	0	0	0	0	0	0	19
· JFDPK	0	1	2	2	0	16	0	0	21
11 - AGENAS	2	1	0	18.25	3	3	3	3	33.25
· PROMIS	0	1	0	0	0	0	0	0	1
· LOMBARDIA	0	1	2	2	0	0	0	14	19
· UMBRIA	0	1	2	2	14	0	0	0	19
· MhH	0	1	0	3	0	0	0	0	4
· MARCHE	0	1	2	2	0	14	0	0	19
· TOSCANA	0	1	2	2	14	0	0	0	19
· ASL NA2	0	1	2	2	0	14	0	0	19
12 - NVD	0	1	0	0	0	0	0	6	7
· CCUH	2	1	2	4	0	0	0	15	24
13 - LR SAM	2	1	2	4	7.50	0	0	7.50	24
14 - ACSS	2	1	2	2.75	8	0	0	0	15.75
· SPMS	0	0	1	1	4	0	0	0	6
· ENSP/NOVA	0	1	2	1.75	6	0	0	0	10.75
15 - MoHRS	2	1	2	4	15	0	0	0	24
16 - NIJZ	2	1	0	43	0	0	0	0	46
· ZZZS	0	1	2	2	0	0	10	0	15
17 - HSCB	2	1	0	3	0	0	0	0	6
Total Person/Months	99	69	93.75	162.65	137.74	85.03	52.20	105.48	804.85

1.3.7. WT7 Tentative schedule of project reviews

Review number [19]	Tentative timing	Planned venue of review	Comments, if any
RV1	12	Chafea/DG SANTE	As deemed by the PO
RV2	30	Chafea/DG SANTE	As deemed by the PO

1. Project number

The project number has been assigned by the Commission as the unique identifier for your project. It cannot be changed. The project number **should appear on each page of the grant agreement preparation documents (part A and part B)** to prevent errors during its handling.

2. Project acronym

Use the project acronym as given in the submitted proposal. It can generally not be changed. The same acronym **should appear on each page of the grant agreement preparation documents (part A and part B)** to prevent errors during its handling.

3. Project title

Use the title (preferably no longer than 200 characters) as indicated in the submitted proposal. Minor corrections are possible if agreed during the preparation of the grant agreement.

4. Starting date

Unless a specific (fixed) starting date is duly justified and agreed upon during the preparation of the Grant Agreement, the project will start on the first day of the month following the entry into force of the Grant Agreement (NB : entry into force = signature by the Agency). Please note that if a fixed starting date is used, you will be required to provide a written justification.

5. Duration

Insert the duration of the project in full months.

6. Call (part) identifier

The Call (part) identifier is the reference number given in the call or part of the call you were addressing, as indicated in the publication of the call in the Official Journal of the European Union. You have to use the identifier given by the Commission in the letter inviting to prepare the grant agreement.

7. Abstract

8. Project Entry Month

The month at which the participant joined the consortium, month 1 marking the start date of the project, and all other start dates being relative to this start date.

9. Work Package number

Work package number: WP1, WP2, WP3, ..., WPn

10. Lead beneficiary

This must be one of the beneficiaries in the grant (not a third party) - Number of the beneficiary leading the work in this work package

11. Person-months per work package

The total number of person-months allocated to each work package.

12. Start month

Relative start date for the work in the specific work packages, month 1 marking the start date of the project, and all other start dates being relative to this start date.

13. End month

Relative end date, month 1 marking the start date of the project, and all end dates being relative to this start date.

14. Deliverable number

Deliverable numbers: D1 - Dn

15. Type

Please indicate the type of the deliverable using one of the following codes:

R	Document, report
DEM	Demonstrator, pilot, prototype
DEC	Websites, patent fillings, videos, etc.
OTHER	
ETHICS	Ethics requirement
ORDP	Open Research Data Pilot
DATA	data sets, microdata, etc.

16. Dissemination level

Please indicate the dissemination level using one of the following codes:

PU	Public
CO	Confidential, only for members of the consortium (including the Commission Services)
EU-RES	Classified Information: RESTREINT UE (Commission Decision 2005/444/EC)
EU-CON	Classified Information: CONFIDENTIEL UE (Commission Decision 2005/444/EC)
EU-SEC	Classified Information: SECRET UE (Commission Decision 2005/444/EC)

17. Delivery date for Deliverable

Month in which the deliverables will be available, month 1 marking the start date of the project, and all delivery dates being relative to this start date.

18. Milestone number

Milestone number:MS1, MS2, ..., MSn

19. Review number

Review number: RV1, RV2, ..., RVn

20. Installation Number

Number progressively the installations of a same infrastructure. An installation is a part of an infrastructure that could be used independently from the rest.

21. Installation country

Code of the country where the installation is located or IO if the access provider (the beneficiary or linked third party) is an international organization, an ERIC or a similar legal entity.

22. Type of access

VA	if virtual access,
TA-uc	if trans-national access with access costs declared on the basis of unit cost,
TA-ac	if trans-national access with access costs declared as actual costs, and
TA-cb	if trans-national access with access costs declared as a combination of actual costs and costs on the basis of unit cost.

23. Access costs

Cost of the access provided under the project. For virtual access fill only the second column. For trans-national access fill one of the two columns or both according to the way access costs are declared. Trans-national access costs on the basis of unit cost will result from the unit cost by the quantity of access to be provided.

HISTORY OF CHANGES

#	Original submitted	Response and/or content change made to the DoA to be submitted for the Grant Agreement
#1	tables 7.1, table 8, table 7.2, table 9.3, table 10.2.	As requested, moved these tables to the Part A of Annex 1 to the Grant Agreement. Also, some mistakes have been amended.
#2	Description of WPs have updated considering the comments included in the ESR and the revision made by CHAFEA and DGSANTE	Task 1.1, 3.2 and 4.3 have been updated as well as description of WP5-8. T1.1 "Consortium operating procedures and quality assurance" will cover this activity. A clearer description has been included in the T1.1 description: "For deliverables and other documents, it is expected that documents could be associated to one or more tasks of the project and therefore has one or more contributors. Each deliverable has usually a main contributor, which is also the partner responsible for the deliverable. This responsibility is always shared with the WP leader. All the deliverables must be submitted within the deadlines defined in the project. To guarantee the quality of the document a reviewer/s will be assigned per each deliverable according to the expertise in the area. The Reviewer assigned will review the reports and deliverables from each work package and will give feedback and comments in advance of the submission date of the deliverable. The Lead beneficiary of a deliverable will take into consideration the feedback from the reviewer and implement changes (if necessary)." AGENAS is responsible for T4.3 " Merging action plans of the next adopters´ local GP" and TX.3 "Specific interventions and actions" of transfer WPs. The choice of having the same organization leading these tasks is to ensure that the process of preparing the implementation of components from different original GP (mix-match approach) is aligned and coordinated, avoiding duplicities, overlappings and gaps and boosting synergies. At early stage, during the pre-implementation phase, AGENAS will monitor the development of the Action Plans, putting special attention to next adopters who have selected core features from distinct original GP. A total of four study visits (one per original good practice) are planned in the concept, which will be supplemented by workshops and the annual meeting. The study visits are supposed to give all next adopters a practical insight into the best practices and are therefore planned at the beginning of the implementation phase. In addition, workshops, webinar and teleconferences will be organized where the next adopters can address any problems that arise, exchange experiences and get feedback and support from oGPs and partners responsible for the methodological part (Kronikgune, AGENAS, NIJZ). The task 3.2 has been extended with the information on specific support activities: ▫ Workshop at Kick off meeting: the methodology for the scope definition will be explained by Kronikgune ▫ Workshop at study visits: dedicated sessions led by Kronikgune to present the methodology to perform the SWOT analysis and to define local interventions and Action Plans. ▫ Teleconference: to monitor the SWOT analysis planning in each site ▫ Teleconference: to review the output of the SWOT analysis of each site ▫ Webinar: to refresh the methodology to define the local interventions and Action Plans ▫ Teleconference: review the Action Plans of each site ▫ Workshop at 1st Consortium Meeting: next adopters present their local GP and Action Plan and the methodology of PDSA cycles is explained by Kronikgune ▫ Teleconference: to review the planning of the activities (Planning phase of PDSA) ▫ Sessions during the thematic workshops: next adopters present their learnings and experience during the first months of the implementation and Kronikgune provides support and coaching if needed

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		▫ Webinar: the methodology for implementation experience reporting is explained by Kronikgune New KPIs regarding general dimensions and digital transformation have been included in T3.3. Impact evaluation. In the transfer WPs, original GP owners are responsible for providing a detailed description of their GPs, the needs and scope definition and implementations tasks, whereas a next adopter is leading the situation analysis. AGENAS is in charge of the "Specific interventions and action plans" in all transfer WPs. This strategy or methodology seems to be practical and logical because: (i) the original GP representatives can guide next adopters druing the scope definition and implementation as they have experienced the same process in the past; (ii) one next adopter coordinates situation analysis activity and can bring their real experience to help other; and (iii) AGENAS can support next adopters in the final action plan elaboration as they lead T4.3 as well. Having this approach allows original GP to have greater visibility and responsibility in the transfer and adoption process. The role of AGENAS is key for the coordination between WP4 and transfer WPs. AGENAS is responsible for T4.3 "Blending action plans of the next adopters´ local GP" and TX.3 "Specific interventions and actions" of transfer WPs. The choice of having the same organization leading these tasks is to ensure that the process of preparing the implementation of components from different original GP (mix-match approach) is aligned and coordinated, avoiding duplicities, overlappings and gaps and boosting synergies. At early stage, during the pre-implementation phase, AGENAS will monitor the development of the Action Plans, putting special attention to next adopters who have selected core features from distinct original GP. The interdependency between WPs, tasks and deliverables has been clarified in section 7.1, Overview of WPs with the inclusion of a new table.
#3	General and Specific objectives	The policy expectation of reinforce the capacity of health authorities to address the important aspects of health systems transformations successfully has been included more clearly both in the general and specific objectives. The specific objective (number one) regarding this expectation has been reformulated and the target values have been modified. Specific objectives have been updated: "Specific Objectives and process, output and outcome indicators have been defined in section 2.2. A specific objective (number 6) addresses the degree of deployment of digitally enabled integrated person-centred care (DEIPCC) in 24 European Regions with different degrees of maturity. It sets different targets according to the baseline maturity of the regions. There are process indicators such as the number of original Good Practice´ (oGPs) features addressed in transfer process, the number of blended next adopters Good Practices and Action Plans implemented. Output indicator include Increased capacity to implement DEIPCC (including topics such as use of technologies in care services, reorganization of care pathways and building capacity of individuals and communities) and small-scale and large-scale deployment and/or extended institutionalisation of DEIPCC. The outcome/impact indicator(s) is the estimated target population of JADECARE. Surveys and questionnaires to health professionals and patients are an excellent way to receive important feedback about the real experiences and outcomes of the GP adopted. The questions will be figured out in the future, when the information about the implemented core features and progress of the practice are clears. Also, individual interviews can be of profit in some cases to certain key actors of the implementation. This qualitative approach is included in WP3."
#4	Political relevance	The context of the project has been detailed including the actual investment in healthcare in each of the participating countries, as well as the context of the healthcare and the digital health services status.
#5	Methods and means	Description of original GP have been modified so the four of them are similarly written.

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		The table with the interested of next adopters in the original GP has been modified according to the latest changes: Romania, Poland and one of the Spanish regions (Extremadura) have left the Joint Action and the remaining Spanish regions have selected the Danish GP. The description of the Figure 5 has been extended: "Most of the next adopters are willing to work on various dimensions in JADECARE, having the use of technologies in care services (80,77%), use of patient reported data (69,23%) reorganization of care pathways (61,54%), workforce roles and skills with technology (57,69%) and citizen empowerment (57,69%) as the most prominent relevance. Fortunately, the oGPs deal with these areas and their specific core features, which are the transferable elements, provide concrete solutions or strategies. Next adopters will select core features of one or more oGPs in order to tackle with the challenges that the aforementioned dimensions entail." Next adopters have provided information concerning the size of the implementation (geographical area, size of the target population, number of healthcare professionals involved, number of healthcare organizations participating). The table has been inserted in "Next adopters in JADECARE section". Information on the digitalization level of next adopters to support the modernisation of health and social care systems have been described. In the evaluation section, how policy expectations and SMART indicators are associated is described. A table illustrating the relationship between policy expectations, objectives, process indicators, outputs, outcomes and analysis approach has been added.
#6	Deliverables	Some deliverables have been renamed in order to be self-explanatory and descriptions have been modified to be clearer. We have added a new deliverable in WP1 D1.1 Project handbook that have been eliminated from the Milestones We have eliminated the (old) D2.4 Mid-term report on Dissemination and add it as a milestone. Target group, means of communication, timeline, languages and content (main pointshave been described for deliverable D2.3: in addition, interested public, language(s) and content (main points) have been addressed for Layman Report that now is D2.5 instead of D2.6. We have added a new deliverable in WP4. D4.1 “Local Good Practices and Action Plans (see 2.2). The description of D3.1, D3.2 and D3.3 have been further elaborated. The old deliverable D4.1, “Handbook on learning from good practices” is now the D4.2 “Blueprint on learning from good practices". The actual D4.2 deliverable will include information on guidelines and standard operation procedures for good practice uptake, including core elements to assure scale up and sustainability after the end of the project to guarantee further implementation at a European level. Tasks 4.4 and 4.5 have been re-described accordingly. The new D4.1 deliverable "Local Good Practices and Action Plans” ill depict the scope definition, situation analysis and action plans of each next adopter (including merging of action plans where mix-match approach is selected). The deliverables of transfer WPs (D5.1, D6.1, D7.1 and D8.1) will now contain detailed information of the Good practices, including main block and core features identified in T4.1, implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP, and of the implementation process in each next adopter´s site. The operational phase based on PDSA cycles will be described, how the planned activities of the Action Plans have been implemented, the results obtained and the adaptations incorporated to improve the deployment of interventions. The content of the deliverables are described in detail in each WP. All this information has been updated in the deliverable and milestone’s tables as well.
#7	Risks	New risks related to the management of worldwide crisis like the one generated by COVID-19 have been added.
#8	Quality and capacity of hte partnerhip.	The selection of the oGP by the SGPP has been included in the section. Description of partners have been balanced and homogenized, and some mistakes have been corrected.

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#9	Budget	Budget has been updated according with the changes in the selection of the oGP by some entities as well as by the departure of Romania, Poland and Extremadura. Resources allocated to next adopters are not expected to cover implementation costs. The overall budget of the JA (5 million Euros) can realistically only cover management, methodological analysis, knowledge exchange, evaluation and reporting activities. we expect these to be quite similar for all next aopters regardless the final scope of their implementation. Technology procurement, upgrading and implementation, staff training and deployment and other costs cannot be covered. Therefore, all next adopters will have to fund them with their own budgets. The scope and depth of Good Practice implementation and therefore the total amount of money that they will spend will be quite heterogenous and will depend on them. All comments by the Financial Officer are considered in the Budget details: ▫ Although the budget has not been changed, it can be confirmed that implementation activities with national scope only are excluded from the budget. Budget has been updated according with the changes in the selection of the oGP by some entities as well as by the departure of Romania, Poland and Extremadura. All Spanish regions except Extremadura, who leaves the Joint Action, have selected the Danish original Good Practice, so they have the same estimated costs. Changes in the DoA and in the budget have been made accordingly. ▫ Some beneficiaries estimate staff costs for “implementation experts” and it has been confirmed that implementation experts are staff members of beneficiaries/ affiliated entities. ▫ “Unit cost” has not been the model to estimate the travel costs: The transfer and implementation methodology that will be used foresees similar number of face to face meetings, workshops or study visits. It is not a question of facilitating the Project Planning but optimize resources and time available for the whole process. Specific issues such as the constraints that may arise due to special needs or differences in travel fees will be dealt with locally by each partner. Changes may be needed to adapt to the post COVID19 situation but they cannot be estimated yet. A contingency plan has been foreseen and described in the Risk Analysis. ▫ CSFJA has modified its budget. SAS staff members will not allocate hours to JADECARE. ▫ IDIBAPS has added a new staff function, Project Manager. They have modified the budget. Now the total effort is allocated between Project manager (12 PM) and Senior researcher (4 PM). ▫ The 2 affiliated entities of MCA have exactly the same budget because they have similar roles and costs salaries and they have the same tasks to do in their autonomous entities: the Federation of Bosnia and Herzegovina and Republika Srpska. ▫ CIPH has planned more than one senior researcher in this project. They will work for 9,3 PM (in 3 years) in total. ▫ UHO (affiliated entity of MZCR) have modified the description of the functions and has updated the budget. Regional stakeholders will not allocate hours to JADECARE. ▫ EUROSTRAS has modified its budget following the recommendations and has included an audit costs in order to include a certified financial statement , CFS report. Thematic workshops remain, but budget has been adjusted. ▫ BAGSFI and also for their affiliated entities, LGL and ZTG: the different functions have the same monthly rate because, although functions are different, profiles requested for the tasks and responsibilities to be performed are equivalent, so monthly rates are similar. ▫ NOVA has modified the staff function. 2 researchers (master scholarships), will work on the action. ▫ NIJZ has modified its budget following the recommendations and has included an audit costs in order to include a certified financial statement , CFS report.

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#10	Roles and responsibilities	New roles have been defined in sections 5.2, 9.1 and 9.2 to adapt the proposal to the Participant Portal's template and to clarify participants' responsibilities; Leading Beneficiaries and Leading and Co-leading Executive Organizations. Coordination and implementation roles and activities in the Joint Action will be performed by CAs (as Leading Beneficiaries, LB), and AEs. AEs can act as Leading Executive Organisations (LEO) and Co-Leading Executive Organisations. CAs and AEs are responsible for Work Packages and/or Tasks and contribute to the Deliverables and Milestones as described in the JADECARE Joint Action. Responsibilities of all CAs and AEs in charge of WPs, tasks and/or milestones have been further defined and clarified.

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2.1 PROBLEM ANALYSIS INCLUDING EVIDENCE BASE

Life expectancy in the European Union has increased significantly in the last 50 years. In 2016, life expectancy at birth was 81 years across the 28 EU member states[1]. By 2030, 22% of the population will be 65 and over[2], 7% older in 2010. The proportion of people aged 80 years or more is expected to reach 14.6 % by 2100[3]. Advanced age is often linked to multiple diseases with complex needs[4]. In the years to come, the number of people suffering from chronic diseases will increase exponentially. However, the available evidence shows that a sizable number of younger people also suffer from multiple diseases[5].

Chronic diseases affect over one-third of the European population[6]. As a consequence, there is a growing demand for health care services and social care services to help such patients perform their everyday activities. People with chronic diseases, especially those with multimorbidity, need a long-term response, which should be coordinated by different health and social professionals[7]. This creates diverse needs[8] which challenge the patients and health services[9], several specific challenges are affecting the health and care delivery models in Europe.

As the number and complexity of health conditions increase, with overlaying episodes of acute illness, the type and number of care providers contributing to the care of individuals also increases. **Patients with several chronic conditions may visit up to 16 physicians in a single year**[10].

INTEGRATED PERSON-CENTERED CARE

The ageing of the population with the growing burden of chronic conditions and multimorbidity is steadily increasing the demand for a more extended and efficient care and a more intelligent outcome-based delivery of personalized care. Unfortunately, many of the existing European medical models focus primarily on short- and medium-term interventions for single conditions, failing to integrate the care planning of the providers and often overlooking the interconnections between different chronic diseases[11].

The absence of a coordinated approach to health and social care increases the difficulties in aligning and coordination of across care teams and care settings. This seriously compromises the ability of health systems to provide universal, equitable, high-quality and financially sustainable care[12]. It **in specialization with "siloed" and fragmented care approaches, due to poor communication and information sharing**, causing shortcomings and gaps or patients with chronic conditions and long-term care needs.

The evidence suggests that developing integrated person-centered care should generate significant improvements in the care and health of all citizens. This should include enhanced quality and access to care, health and clinical outcomes, health literacy and self-care. The satisfaction of patients and job satisfaction for health and care professionals would also improve, as would the efficiency of services. The overall costs would be reduced[13]. Person-

[1] Health at a Glance 2018: https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf
[2] OECD: Economic, Environmental and Social Statistics. http://dx.doi.org/10.1787/factbook-2009-3-en
[3] Eurostat. Population structure and ageing. http://ec.europa.eu/eurostat/statistics-explained/index.php/Population_structure_and_ageing (Accessed 13 October 2019)
[4] The King's Fund, 'Providing integrated care for older people with complex needs: Lessons from seven international case studies'. http://www.kingsfund.org.uk/publications/providing-integrated-care-older-people-complex-needs
[5] Barnett K, Mercer S, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 2012;380:37-43.
[6] European Commission, Communication from the Commission to the European Parliament and the Council: Taking forward the Strategic Implementation Plan of the European
[7] Piette, J., Richardson, C. and Valenstein, M. (2004) Addressing the needs of patients with multiple chronic illnesses: the case of diabetes and depression, Am J Manage Care, 10: 152–62.
[8] https://link.springer.com/article/10.1007/s11136-015-1102-8
[9] Wagner EH. Meeting the needs of chronically ill people. BMJ 2001; 323: 945–946.
[10] Pham HH, et al. Care patterns in Medicare and their implications for pay for performance. N Engl J Med 2007;356:1130-9
[11] Building a Workable Model for the Holistic Management of Chronic Conditions in Europe, October 2012, EPPOSI AIP-CCM White paper
[12] Nolte E, McKee M, eds. Caring for people with chronic conditions. A health system perspective. Maidenhead: Open University Press/McGraw Hill Education, 2008.
[13] Goodwin, N Dixon A, Anderson G, Wodchis W. Providing integrated care for older people with complex needs; lessons from seven international case studies. The London: The King's Fund; 2014

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centered care identifies health concerns and needs, shared health objectives and healthcare goals, and appropriate healthcare activities, associated with the healthcare process.
This requires that European countries move towards a more integrated person-centered approach[14] to care delivery. This approach should be designed in a way that coordinates services around the needs of the citizens and puts them in the center, enabling them to participate in, and make informed decisions, about their care[15]. Many countries are already implementing some form of integrated care even though the nature and scope of their approaches differ[16]. However, many health systems have already experienced and acknowledged difficulties in introducing good quality integrated care[17].

DIGITAL INNOVATION TO ENABLE INTEGRATED PERSON CENTERED CARE

Innovative solutions are needed to deliver integrated person-centered services based on citizen's needs through new technologies, products and organizational changes. Digital innovation has the potential to facilitate and support these changes by improving the coordination and up-to-date information channels and delivering more targeted, personalized, effective and efficient healthcare[18]. The Communication on Digital Transformation of Health and Care in the Digital Single Market identifies three priorities[19]: (i) secure access of the citizens to their health data, also across borders, (ii) personalized medicine using shared European data infrastructure and (iii) citizen empowerment by employing digital tools for collecting user feedback and person-centered care.
Such innovative digital tools and services have demonstrated that help delivering integrated patient centered care to the population improving the quality of integrated care, for reducing costs and also facilitating innovative models of integrated care[20]. To harvest the full benefits of integrated digitally enabled person centered care, digital health tools need to be integrated into healthcare and social care delivery systems. **However, the difficulties implicit in the design, implementation, transfer and evaluation of integrated care are still to be overcome**.

IMPLEMENTATION AND TRANSFER OF INTEGRATED PERSON CENTERED CARE SOLUTIONS

The journey of care delivery transformation in Europe is still in its first stage. The underlying digital health technologies that will support this transformation need to be purposefully designed, developed, and must demonstrate cost-effectiveness potential. It is a complex program of change which requires adequate methods, processes, tools and techniques[21]. To speed up the adoption of integrated person-centered care solutions in Europe, Member states need to improve their capacity to redesign and improve their healthcare systems. This requires simultaneous operations at three levels: at the system level (strategy, governance and allocation of resources); at the service level (commissioning, operations and service redesign); and at the interface between service users, carers and their care providers (delivery of care in new and better ways)[22].
The systematic incorporation of evidence-based interventions into practice and policy can improve healthcare performance and outcomes[23]. However, population-wide health improvements depend on large-scale implementation of effective health interventions[24]. The transfer and spread of innovation from their sites of origin to other regions could accelerate the progress in Europe. One key lesson learned from the successful cases of implementation of integrated care[25] is that the approach has to be adapted to local context and needs, otherwise he intervention(s) may not deliver the expected benefits. Care authorities should focus their care integration ambitions on local circumstances. Attainment of the broad health system goals, including quality, accessibility, efficiency and equity, are objectives against which to judge new digital health services.[26]
The **EU has launched a series of initiatives to support facing these challenges**, such as the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) with twinning between partners, various Joint Actions such as CHRODIS, CHRODIS Plus, and eHAction, and EU-funded projects ACT@Scale, CAREWELL, BEYONDSILOS, SCIROCCO, SCIROCCO Exchange, SEPEN, C3Cloud or VIGOUR among others.
Following the meeting of the Steering Group on Health Promotion and Prevention and Management on Non-Communicable Diseases (SGPP) in February 2019, four early adopters of **original Good Practices (oGP)** were

[14] WHO, World Health Organization. Framework on integrated, person-centered health services, 2016. http://www.who.int/servicedeliverysafety/areas/people-centered-care/en/
[15] Co-production recognises that people have assets such as knowledge, skills, characteristics, experience friends, family, colleagues and communities." McColl-Kennedy, Janet R., et al. "Health care customer value co-creation practice styles." Journal of Service Research (2012): 1094670512442806.
[16] Nolte E, Knai C, McKee M, eds. Managing chronic conditions - experience in eight countries. Observatory Studies Series No. 15.Copenhagen: World Health Organization, on behalf of the European Observatory on Health Systems and Policies, 2008.
[17] Gröne O, Garcia-Barbero M (2002): Trends in Integrated Care - Reflections on Conceptual Issues. WHO.
[18] 2014 Communication from the European Commission on "effective, accessible and resilient health systems" and the Annual Growth Survey 2016
[19] https://ec.europa.eu/digital-single-market/en/european-policy-ehealth
[20] https://www.ijic.org/articles/10.5334/ijic.3051/
[21] Blueprint 2017
[22] Deliverable 4.2 – C3Cloud project
[23] Foy R, Sales A, Wensing M, Aarons GA, Flottorp S, Kent B, et al. Implementation science: a reappraisal of our journal mission and scope
[24] Durlak JA, DuPre EP. Implementation Matters: A Review of Research on the Influence of Implementation on Program Outcomes and the Factors Affecting Implementation. Am J Community Psychol. 2008 Jun 1;41(3–4):327–50.
[25] EC, European Commission. Tools and Methodologies to Assess Integrated Care in Europe, 2017
[26] Assessing the Impact of Digital Transformation of Health Services Expert Panel on effective ways of investing in Health (EXPH) https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/022_digitaltransformation_en.pdf

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selected to transfer these oGP to other EU Member States (next adopters). These oGPs cover integration, chronic conditions, multimorbidities, frail people and patients with complex needs, self-care, prevention and population health, disease management and case management. **The selected oGPs were**:

- Basque Health Strategies in ageing and chronicity: integrated care (Spain)
- Catalan open innovation hub on ICT-supported integrated care services for chronic patients (Spain)
- The OptiMedis Model – Population-Based Integrated Care (as implemented in Gesundes Kinzigtal) (Germany)
- Digital roadmap towards an integrated health care sector (Region of Southern Denmark, Denmark)

Basque Health Strategies for ageing and chronicity: integrated care good practice is a population model based on preventive interventions, patient empowerment, and personalized medical care. It places particular emphasis on the continuity of care, security, adherence and improving the patient experience. It includes "Integrated Care Organizations" (ICO) with Joint Governance bodies for primary care and hospital, with a defined population catchment area; multidimensional assessment and action for people aged 70 or older (Care Plan for the Elderly). It includes risk stratification and care plans based on the needs for a complex patient, new nursing roles (such as liaison nurses and case managers), safety in polypharmacy management, patient empowerment and self-management and social and health coordination. It is supported by an eHealth strategy and a 24X7 Nursing Call Centre.
The Catalan open innovation hub on ICT-supported integrated care services for chronic patients is conceived to serve the entire population of Catalonia (7.6M citizens). However, the target is chronicity with focus on multimorbidity management and on citizens with complex health and social care needs. Accordingly, it encompasses both vertical (specialized vs. community-based care) and horizontal (healthcare vs. social support) integrations, combining a population-health orientation with a collaborative adaptive case management approach. The practice proposes five blocks, with up to eighteen specific features, for transferability to next adopters. Briefly, the five blocks are: B1- Health risk assessment: population-based and enhanced clinical decision making; B2- Promotion of healthy lifestyles; B3- Vertical and Horizontal integration experiences adopted in Catalonia, B4- Innovative assessment and regulatory aspects and B5- Digital support of integrated care services.
The OptiMedis Model – Population-Based Integrated Care is a management company of integrated care networks, providing advanced data analytics and designing innovative care models with a focus on population health management. Its aim is to achieve the Quadruple Aim, improving population health, improving the patient experience of care, reducing unnecessary costs and ensuring provider satisfaction. The basis of its work is a shared savings contract with insurers and a model including strong stakeholder engagement, electronic integration across providers, patient involvement and empowerment, and data-driven management. The model focuses on patients with high needs and high costs, but also emphasizes prevention, health promotion and public health to generate value for the population in the long run.
The Roadmap towards Integrated Care implemented in the Region of Southern Denmark consists of different parts of an integrated and digital patient-centered approach. The foundation is the SAM:BO[27], which is a regional collaboration agreement between all actors in the health care sector in the Region. The goal of the agreement is to ensure cohesive and integrated patient experiences and the result is among other elements patient care pathways, which are based on nationally adopted standards with more than 65,000 standardized electronic messages transmitted daily in the Region. On top of this foundation are several services, such as the Generic Telemedicine Platform, Digital Health Centre, Tele-COPD and Tele Psychiatry. The common feature is using technology to bring more flexibility and quality to the patients as well as using the clinical resources better.

JADECARE will contribute to innovative, efficient and sustainable health systems, providing expertise and sharing good practices to assist the Member States in undertaking health system reforms. It will enable the participating national authorities and those beyond the Consortium, to benefit from efficient solutions in digitally enabled integrated person-centered care developed by the early adopters of the original Good Practices (oGPs).

2.2 AIMS AND OBJECTIVES OF THE PROJECT

GENERAL OBJECTIVES OF THE PROJECT

The general goals of JADECARE are:

- **To reinforce the capacity of health authorities** to address all the important aspects of health system transformation successfully, in particular the transition to digitally enabled, integrated, person-centered care
- **To support the best practice transfer** from the systems of the "early adopters" to the "next adopters".

[27] Strategic Intelligence Monitor on Personal Health Systems Phase 3 (SIMPHS3) - SAM:BO (Denmark) Case Study Report

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Health authorities will strengthen their capacity for digitally enabled, integrated, person-centered care by improving knowledge in the use of implementation methodologies, adopting a systematic appraisal of the quality of practice transfer and including sustainability elements in the transferred local good practices. Authorities will participate in a community of stakeholders that explores ways to boost and leverage the inclusion of digitally enabled, integrated, person-centered care at policy level.

The transfer of the best practices from early adopters selected by the SGPP will be focused on the preparation of the local environment for the implementation. Depending on local circumstances, the appropriate strategies will be formulated and resources committed. A learning community will be created for developing, collecting and exchanging knowledge through "twinning actions", dedicated seminars and workshops, and other activities.

JADECARE will reinforce the capacity of care authorities to:

- Support the change management and re-organize the existing care models as a result of piloting that will be done in WP5-8. JADECARE will generate data on the impact of the change and establish a common framework and methodology of how integrated care (IC) should be delivered
- Embed digital technologies and tools in the care services: all oGPs are based on the use of digital technologies and tools and the JA will also analyze how the implementation could be done in a broad range of situations from digital illiterate health systems to very advanced ones
- Re-organize patient pathways in sites including the experience and point of view of the patients
- Consider and monitor health workforce roles and skills with digital technologies and data development
- Build the capacity of individuals and communities to participate in the care process
- Empower citizens in active participation in healthcare decision making, including the use of patient reported data
- Analyze new payment methods
- Evaluate new performance assessment methods

The scope, scale and extent of these general objectives will be customized for each of the next adopters according to their needs and their interest in local strategies and action plans.

SPECIFIC OBJECTIVE(S) OF THE PROJECT

The objectives of the Project will be established at two levels: A) the Joint Action in overall and B) the next adopters practice implementation.

- (A) At Joint Action level, Specific Objectives address ambition, impact, deployment and management. Each of them has process, output and outcome indicators defined. Objectives 1 to 4 address the ambition and impact of JADECARE and are mainly related to the policy expectation of reinforcing the capacity of health authorities to successfully address important aspects of health system transformation, in particular the transition to digitally-enabled, integrated, person-centred care. Objectives 5 to 7 address the policy expectation related to supporting best practice transfer. Objective 8 deals with the usefulness of the project.

Specific Objective 1	**Target value**
To support and reinforce digitally enabled integrated person-centered care (DEIPCC) in 24 European settings with different degrees of maturity	
Process Indicator(s)	
Number of oGPs´ features covered in transfer process	8
Number of next adopters Good Practices and Action Plans	23
Action plans implemented including pathway reorganization, digital technologies and tools, change management and training and research programs measures	80%
Output Indicator(s)	
Increased capacity to implement DEIPCC.	15 Settings (countries, regions, or areas)
Small-scale deployment DEIPCC.	7 Settings
Large-scale deployment and/or extended institutionalization of DEIPCC	1 Setting
Outcome/Impact Indicator(s)	
Estimated target population in JADECARE	50,000 people

Specific Objective 2	**Target value**
JADECARE is useful for governments´ commitment to support for further building the capacity to deliver integrated person-centered care.	
Process Indicator(s)	
Number of MoHs of JADECARE competent authorities represented in the Policy Board	17
Number of MoH (or national focal points for Health Programme at EC) from MSs that do not participate in JADECARE	5
Number of DG Sante and CHAFEA representatives	2

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Policy dialogues of Policy Board members	3
Output Indicator(s)	
Reports including recommendations to next adopter's sustainability plans	3
Outcome/Impact Indicator(s)	
Level of perception that JADECARE will support further building up the capacity of national and regional authorities to organize and deliver integrated person-centered care including integration in policies, as expressed by Policy Board members	80%

Specific Objective 3	**Target value**
To create a community of stakeholders that includes caregivers, healthcare experts, academia, industry, policy makers and /or general public.	
Process Indicator(s)	
Number of meetings with stakeholders Number of presentations at scientific and policy discussion events	>20 >40
Output Indicator(s)	
Estimated audience of JADECARE dissemination channels	1,000
Outcome/Impact Indicator(s)	
Level of perception that JADECARE guidelines and results have impact in policy setting, and scientific, industrial and general debates and fora	90%

Specific Objective 4	**Target value**
To improve next adopters´ digital transformation	
Process Indicator(s)	
Analysis of digital situation is performed in next adopters' sites Establishment of specific objectives regarding digital transformation are set in next adopters Action Plans	23 23
Output Indicator(s)	
% Sites with Changes in digital services are confirmed (digital health system infrastructure; data analytics and use of technologies, citizen empowerment tools and patient reported data.	80%
Outcome/Impact Indicator(s)	
Perceived improvement of digital services by end users	80%

Specific Objective 5	**Target value**
To support next adopters in facilitating the sustainability of the practice with plans for actions at local/regional/national level	
Process Indicator(s)	
Elements of sustainability are addressed in all individual implementation action plans Establishment of local/regional/national networks among next adopters and stakeholders identified to be important to assure sustainability	23 23
Output Indicator(s)	
Sustainability strategy and action plan of next adopters' practices	23
Outcome/Impact Indicator(s)	
Perceived probability that the developed practice will be sustainable after end of JADECARE, as expressed by members of local/regional/national networks among next adopters and stakeholders identified to be important to assure sustainability	80%

Specific Objective 6	**Target value**
Perform a systematic appraisal of the quality of the transfer and implementation process, understanding, evaluating and reporting the experience of adopting oGPs in heterogeneous next adopter sites.	
Process Indicator(s)	
Scope definition, situation analysis and PDSA cycle performed on schedule	80%
Output Indicator(s)	
CFIR and SQUIRE 2.0 reports on adoption of good practices	23
Outcome/Impact Indicator(s)	
Blueprint on learning from good practices	1

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Specific Objective 7	Target value
To improve knowledge and skills of transfer methodologies and tools	
Process Indicator(s)	
Number Study visits	4
Number Thematic workshops	12
Output Indicator(s)	
Number of professionals participating in different knowledge exchange actions	200
Satisfaction with knowledge exchange actions	80%
Outcome/Impact Indicator(s)	
% of professionals that improve in knowledge and skills	80%

Specific Objective 8	Target value
Quality, compliance and usefulness	
Process Indicator(s)	
% surveys completed (acceptance rate & perceived usefulness)	80%
Output Indicator(s)	
Satisfaction with the project progress	80%
Outcome/Impact Indicator(s)	
% stakeholder consider Project useful	90%

- (B) At next adopters' level SMART objectives and key performance indicators will be tailored to each site according to the local Good Practice and Action Plans defined and implemented. They will be defined in the transfer Work Packages (WP 5-8). They will consider general dimensions and digital transformation.
  Regarding general dimensions, the objectives will cover:
  - scope and degree of adoption of original Good Practices (oGPs),
  - specific process, pathway reorganization and change management,
  - the involvement and commitment of key stakeholders,
  - the implementation experience,
  - continuity and sustainability of the practice.

  Regarding digital transformation, SMART objectives and KPIs will cover:
  - digital health system infrastructure,
  - risk stratification and data analytics,
  - use of technologies including Electronic Health Record, personal health folder and electronic prescription,
  - citizen empowerment and use of patient reported data,
  - innovation initiatives on integrated care reorganization of care pathways, workforce roles and skills
  - training and research programs.

  Next adopters will set SMART objectives (specific, measurable, appropriate, realistic and time-bound)
    - Specific: A clear description of the aim:
    - Measurable: Precisely defined and easily quantified
    - Appropriate: It should fit the local needs, capacities and culture of the target group
    - Realistic: There must be a reasonable chance that the objective or aim can be reached
    - Time-bound: It must be related to a certain time period

2.3 STAKEHOLDER - TARGET GROUPS

As described in the Blueprint Digital for transformation of Health and Care for the Ageing Society [28], the "integrated care" does not evolve naturally and needs a deep transformation of care delivery mechanisms not only from the point of view of health care providers and professionals but also considering the whole society. **Thus, it is critical to reach all stakeholders to create a long-lasting community** where multidisciplinary teams, including patients, formal and informal caregivers are established and processes for collaboration are set-up. The necessary policies, technology tools/platforms and skills should be available to assure sustainability and replicability of the innovative models provided by this Joint Action. The list of stakeholders within and beyond those involved in JADECARE is given in the following table:

TABLE 1. JADECARE STAKEHOLDERS

[28] https://ec.europa.eu/digital-single-market/en/blueprint-digital-transformation-health-and-care-ageing-society

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Stakeholders	Role in JADECARE	Methods to reach the group	Number
Regional / Local Health systems	Seven regional healthcare systems are going to participate in JADECARE as Competent Authorities (CAs). In addition, 15 regional healthcare services are going to be involved in the project as Affiliated Entities (AE). Those CAs and AEs are going to participate actively in all Work Packages (WPs) acting as next adopters and also as owners of the oGPs to be transferred.	National/Regional/local early adopter health systems will involve extended regional teams (WP5-8). Local teams will choose the final core features of good practice to be transferred. In WP4 a learning community will be created and supported to promote knowledge generation/exchange. All health systems will be involved in the tasks indicated in WP4, for replicability and sustainability.	23
National Health systems/ Ministries-Healthcare decision makers	The CAs have been nominated by the corresponding Ministries of Health of their countries, so they will be informed of the project progress. The institutions from national health systems level from Bosnia and Herzegovina, Czech Republic, Estonia, Hungary, Italy, Latvia, Lithuania, Portugal, Serbia and Slovenia will participate in the project either as CA or AE.	A Policy Board will be created, led by NIJZ, in which the corresponding Ministries of Health of all participating countries will be involved.	17
Health Policy makers and experts	JADECARE will attempt to engage them in fora/committees beyond the health systems involved in the project. EIP-AHA and Horizon Europa partnership events and meetings will be an essential forum for JADECARE project discussion	Other European health systems also will be invited to participate in the annual stakeholder forum. They will have access to JADECARE deliverables, including the Blueprint on learning from good practices (D4.2) and the Report on sustainability and integration in national policies (D4.3). WP2, WP3 and management activities will make a special effort to participate in European events (high-level events of the EU Health Program, EU Health Summit). The project will produce a roadmap for the changes needed to introduce integrated care.	20
Health professionals and other operators	The Regions participating in JADECARE will include in their teams' the clinicians, nurses, IT staff and managers. A real commitment of professionals is critical to achieve an effective change in healthcare services. Creation of teams with the rest of the stakeholders will be a fundamental part of the project.	Healthcare professionals will actively participate in all the WP. They will play a key role in the implementation and transfer of the good practices, detecting the barriers, the key factors (next adopter working groups NAWG). The new role and skills development will be shared with wider groups of professionals through planned communication and dissemination channels.	250
Patient organizations	Patients will be the participants (regional teams) and potential users of the designed services in the new models. They will take part in the meetings described in WP5-8, as well as in activities included in WP2.	The project website will provide updates on the project background, aim and status; articles in the lay press or publications by the participant Health Systems will be focused on the impact on the patients. Specific patient organization will also be contacted during regional meetings.	23
Social entities working on the field representing the general population	NGOs, active civil associations, key leaders/associations in the participating countries and regions will be included in the local stakeholder networks supporting the changes in integrated care and maximizing the impact of the JA.	Representatives will take part in the regional meetings, in WP5-8 and in dissemination activities. They will actively participate in the local dissemination activities to guarantee the social impact and acceptance of the new models.	23
Industry: Digital health tools/services and platforms developers, ICT health sector.	Will take part through the participating health systems as ICT developers or collaborators in the development/maintenance and integration of the necessary	JADECARE will invite the key industries/developers to the stakeholder forum and to the regional events to consider how to enhance the competitiveness of EU industry to create economic growth opportunities.	15

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Stakeholders	Role in JADECARE	Methods to reach the group	Number
	tools/platforms for the digitally enabled integrated care.		
Scientific community	Will participate in scientific fora and meetings. Representatives of some of selected relevant projects and initiatives will be invited to join in WP2 activities.	JADECARE will participate in relevant scientific events at the European and international levels. In addition, partners from other related projects will be directly invited to participate in the events organized by JADECARE.	20
Specialized media	Will boost the dissemination and impact of the JA.	Press releases on the main progress and results of the project will be produced.	10
Universities and training organizations(next generation of healthcare professionals, researchers, engineers, ICT developer)	The next generation of professionals will guarantee real change and the sustainability of integrated care. A change in culture can only be achieved through their education and involvement.	JADECARE will target universities and training organizations and present the JA achievements and results. Stakeholders read the scientific publications in international peer-reviewed scientific journals; the new generation professionals will be reached via presentations at national and international congresses and conferences. They can influence under- and postgraduate training programs.	50
Third Party Payers, Official Audit Bodies, Health Technology Assessment Agencies and other public or private regulatory or standards organizations	They have an important role in defining the basket of services and reimbursement schedules, analyzing efficiency or proposing new procedures, services, drugs or devices. They are key stakeholders in designing and implementing the sustainable transfer of good/best practices, as well as in de-commissioning the old models.	Stakeholders will be invited to analyse and consider possible ways of effective preparation to meet the requirements of payers and reimbursement authorities. Stakeholder will be engaged at the local and European level meetings and workshops.	30

2.4 POLITICAL RELEVANCE

Joint Action on implementation of digitally enabled integrated person-centered care (JADECARE) is perfectly aligned with the objectives of the **Third Programme of the Union Action in the field of health**, as well as with one of the main areas included in the Societal challenge 1 of H2020. The challenge tries to generate solutions to the rising demand for health, social and informal care services in the ageing population with a growing burden of chronic diseases and reduce health inequalities.

JADECARE will enable the participation of national authorities but also involve, if possible, those from outside the Consortium, to benefit from efficient solutions in digitally enabled integrated person-centered care developed by the early adopters. This should reduce duplication of effort and increase value for money, by promoting innovative solutions in the field of integrated health care. JADECARE will demonstrate the impact of the digitally enabled integrated person-centered care solution in health systems around Europe. Even more importantly, it **will generate the knowledge necessary for successful design and implementation of digitally enabled person-centered care solutions**, mainly thanks to work done for the transfer (WP5-8) and evaluation (WP3) of the GP. The JA will support the development of sustainability plans as part of action plans and implementation reports. It will indicate how the involved Member States could support sustainability and integrate the results in their national policies, including the visibility of European Union co-funding and institutions outside JADECARE (EIT HEALTH, other Member states, or International Organizations).

JADECARE is **perfectly aligned with three out of four priority areas included in the Work Program for 2019**. It will directly generate and share country-specific and cross-country knowledge by identifying and sharing the experience of early and next adopters in the design and implementation of integrated care solutions. The project will also contribute to the structural support of health systems and generate links to the digital single market. This will be made possible by the participation of 17 different European countries interested in the implementation of new policies for digitally enabled person-centered care and can align their strategies with the recommendations generated in the Joint Action. JADECARE will help to promote health and prevent the impact of non-communicable diseases by providing measures to the health systems around Europe to organize and deliver integrated person-centered care. But it also will contribute to improve the health of European citizens and reduce health inequalities, encourage innovation

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in health and increase sustainability of health systems, focus on themes that address current health issues across Europe and support and encourage cooperation between European countries.

CONTRIBUTION TO THE ANNUAL WORK PLAN

JADECARE project will contribute to the objectives of the **Thematic priority 3.4. of Annex I** to the Third Health Programme Regulation. It will help to develop innovative, efficient and sustainable health systems, providing expertise and sharing good practices to assist Member States in undertaking health system reforms. It will set up a methodology for pooling the expertise of these 17 Members States. The Work Plan divided into eight work packages deploys the blueprint designed to ensure the desired impact of JADECARE. It will provide evidence-based advice on effective and efficient investment and innovation in health systems, based on the experience of the four original Good Practices in digitally enabled integrated person-centered care. The four oGPs have been selected by the Steering Group on Health Promotion and Prevention and Management of Non-Communicable Diseases (SGPP) as the most interesting and promising practices to transfer to other countries.

JADECARE is led by Kronikgune as Competent Authority from Spain and the **owner or early adopter of the selected practice** Basque Health Strategies in ageing and chronicity. Kronikgune will lead the WP5. IDIBAPS (affiliated entity to Kronikgune) is the owner of the Catalan open innovation hub on ICT-supported integrated care services for chronic patients. IDIBAPS will lead the WP6. The owners of the oGP OptiMedis Model-Population-Based Integrated Care, will be subcontracted by Eurométropole de Strasbourg (France), the leader of WP7. The procurement procedure without prior advertising or competitive tendering is subject to the articles L.2122-1 and R.2122-3 of the French public procurement code, in accordance with EU regulations. The Region of South Denmark, owner of the oGP Digital Road and the leader of WP8 is an affiliated entity of the Danish Competent Authority, North Denmark Region.

Based on the broad experience of these early adopters (and other partners in the project) in implementing/transferring practices from setting to another, JADECARE will progress beyond state of the art in transferring good practices. The methodology to be used allows customizing the transfer and adoption process to the specific needs and context of the next adopters. This will take into account existing programs and activities and the priorities, strategies, assets and resources. It **allows the transfer of a whole oGPs, parts of an oGP or a mix-match of two or more of the oGPs**. The maturity level of the next adopter will also be considered as will the features to be transferred and the specific assets needed to do it. This is a more realistic model than the more academic proposals that envision that a good practice can be transferred as such to an area with a completely different context, means and conditions. A detailed analysis of needs, scope, situation and implementation plans including sustainability elements will be performed for each of the next adopter sites to ensure the feasibility, effectiveness and sustainability of the oGP transfer. This means that although the initial interests have been expressed during the preparation of the JA, the **precise features and interventions to be implemented in each next adopter site will be defined after the first tasks in WP4, 5, 6, 7, and 8**. The progress and impact of this approach will also be evaluated in WP3, and sustainability-related outputs by WP4.

JADECARE will create and share the knowledge and capacity on how to design and successfully implement sustainable digitally enabled integrated person-centered care solutions. To this purpose, **JADECARE will follow the implementation strategy developed in the JA CHRODIS Plus** [29], adapting it to the particularities of the next adopters to transfer the four oGPs previously mentioned to 23 next adopters. The implementation strategy contains methods and techniques used to enhancing the adoption, implementation, monitoring, reporting and sustainability of an intervention[30]. It will promote the systematic introduction of evidence-based interventions into practice and policy and hence improve health[31]. These interventions cover a wide range of areas such as change management and reorganization of the existing care models, embedding digital technologies and tools in care services, reorganization of patient pathways, health workforce roles and skills with digital technologies and data, building the capacity of individuals and communities to participate in the care process, citizen empowerment, use of patient reported data, new payment methods, performance assessment of new care models and digital solutions.

JADECARE will deploy activities to prepare the local environment for implementation, customizing them to the different needs and levels of maturity of the next adopters. **Purposely designed "twinning actions"** have been included in the WP5-8. This will facilitate the establishment of local/regional/national networks for the implementing partners and the stakeholders important for assuring sustainability.

As the following sections will show, JADECARE has been built based on results of earlier work in the EU Health Programme, the EU Framework Programmes for Research and Innovation as well as EU initiatives such as the European Innovation Partnership on Active and Health Ageing (EIP AHA) as:

[29] JA CHRODIS plus implementation strategy at www.CHRODIS.eu
[30] Curran GM, et al. Effectiveness-implementation Hybrid Designs. Med Care. marzo de 2012;50:217-26.
[31] Foy R, et al. Implementation science: a reappraisal of our journal mission and scope. Implement Sci IS. 2015;10:51.

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- Tools for deploying integrated care from EU projects (e.g. ACT@Scale and SCIROCCO), SANTE's Integrated Care Resource Centre and the work of the EIP AHA. Sirocco Maturity Model will be used in WP5-8, to analyze among others the core features and context characteristics.
- Guidance on the design, implementation and assessment of integrated care, from the work of the EU expert group on Health Systems Performance Assessment. It has been followed used to design the Evaluation framework. In addition, the CFIR (Blended Framework for Implementation Research) methodology selected in the project PROACT (Integrated Technology Systems for ProACTive Patient Centered Care) will be followed in the WP 5-8.
- The guidance on the transfer and scaling-up of GP, developed by the Joint Action CHRODIS PLUS will be used to design the GP transfer and adoption, as will the Guidance for best practice transfer from the twinning projects SCIROCCO Exchange and VIGOUR.
- The JADECARE leader has participated in the Joint Actions CHRODIS and CHRODIS Plus, the guidance concerning the management of multi-morbidities produced by these Actions has been followed in the generation of the oGP of Basque Country and will be taken into account in the final configuration of the GPs to be adopted.

The JADECARE project will:

- **Support the good practice transfer from the systems of the "early adopters"**, Kronikgune, Idibaps, OptiMedis and Region South Denmark to the "next adopters" from the 17 health systems participating in the JA. The "early adopters" Spain, Germany and Denmark will include other areas of their countries to be "next adopters" of one of the four oGPs or their combinations. The project will combine the experience of the "early adopters" and the "next adopters". The information generated by all participating entities will develop knowledge that will lead to the development of the blueprint for digitally enabled integrated care and the creation of best practices transfer methodology.

Reinforce the capacity of health authorities to successfully address the transition to digitally-enabled, integrated, person-centered care. JADECARE will generate a network involving for the first time both "next adopters" with "early adopters" including in all the cases, organizations with direct responsibility for organizing and delivering care. The results obtained in WP5-8 will show the next adopters to implement the GPs and develop solutions on how to ensure sustainability (Month 13-36). The implementation will start, and specific interventions will roll out based on PDSA according to their maturity level, resources available and time frame of the project. WP4 will provide guidance to reinforce the capacity of health authorities to successfully address important aspects of health system transformation.

ADDED VALUE

Areas – where to achieve EU added value	Mechanisms- how to achieve EU-added value
Impact on target groups	JADECARE will have a direct impact on all the targets groups that have been identified as stakeholders by helping to change the model of care provision. JADECARE will settle the basis to implement the integrated scale at large scale at national regional and local health systems by knowing how to really transfer experiences that are working and to create innovative/tailored practices based in the oGPs. This will have a direct impact not only in healthcare professionals but also on patients, carers, general population as well as the industrial sector.
Long-term effects and potential multiplier effects, such as replicable, transferable and sustainable activities	JADECARE has been conceived to last beyond the three years of the project. The methodology used in WP5-8 and the activities included in WP4 will support the sustainability and replicability of JADECARE. Elements of sustainability will be addressed in the implementation action plans and reports. The methodologies used in JADECARE for GP transfer could be applied in other fields of public health. The long-term effect of JADECARE will be supported by involving the stakeholders who can provide political support and commitment to integrated care as members of the consortium or participating in governance bodies.
Contribution to complementarity, synergy and compatibility with relevant EU and EU Member States policies and programs	All CAs and AEs participating in JADECARE are politically committed to the implementation of digitally enabled integrated person-centered care. However, the real implementation and knowledge of integrated care vary a lot from setting to setting in the 17 participating countries. The opportunity to tailor and adapt the oGPs selected in other areas of Europe will facilitate and generate knowledge exchange and strengthen networks. In addition, several of the participants are involved in other initiatives associated with integrated care: Key members of EIP-AHA, Health System Performance Assessment Group or other H2020 projects and initiatives.
Workforce education and training	As the systems of care are transformed, various roles need to be adapted or created and new skills developed. With changing demands, competencies, talent and experience must be retained, and the care systems need to become 'learning systems' to improve productivity and increase success rates. JADECARE will support a redesign of health and social care

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Areas – where to achieve EU added value	Mechanisms- how to achieve EU-added value
	professionals' roles and will identify new roles and new ways of monitoring chronic patients. Based on early adopters' experience and the key issues pinpointed by the next adopters, new pathways and learning networks will be generated.
Collaboration, networking and building trust	The large number of changes needed to deliver integrated care at a regional or national level presents a significant challenge. It requires reorganization of services and care processes and alignment of purposes across diverse organizations and professions. The participants must show the willingness to collaborate and put the interest of the overall care system above individual incentives, as will be demonstrated in JADECARE. The networks for healthcare providers and other agencies and authorities will improve active cooperation and increase trust among stakeholders. JADECARE will facilitate the collaboration between the stakeholders, they will have the chance to participate in the activities included supporting the knowledge transfer, learning and generating further evidence on integrated care.

PERTINENCE OF GEOGRAPHIC COVERAGE

JADECARE will involve partners from 17 European countries reaching almost 40 different Regions in providing a comprehensive view of the idiosyncrasies and differences at the European level. JADECARE includes various countries that have begun their respective journeys toward integrated care at **different times. The level of penetration, adoption and/or maturity of integrated care** in a country does not depend solely on time elapsed since the initiation of the implementation of integrated care policies. Indeed, there are many factors that have to be considered while designing such integrated care systems if we are to achieve successful implementation. Among others, the financial design of the system; governance and stewardship of the health system, workforce composition, roles and numbers of professionals have to be considered. The characteristics of the top-down (policies, strategies) and bottom-up approaches (programs, projects) have to be analyzed; program governance models; training for managers and clinical staff, among other factors. To tackle all these elements and account for the existing limitations, JADECARE includes the health systems from all European countries, covering different funding systems (Beveridge and Bismarck) and considering the different pace of adoption of Integrated Care[32]. In addition, JADECARE includes partners with different Gross National Income (GNI) (11 out of 17 are under the 90% of average GNI) and different levels of maturity of digitally enabled health care systems.

Some partners such as Estonia, Latvia, Lithuania, Czech Republic, Hungary, Croatia, Serbia, Slovenia, and Bosnia and Herzegovina show large differences in the application of IC at the national level. Some of them have been focusing on the integration of social and health services using telemedicine and eHealth solutions and that will benefit from the implementation of the new oGPs identified and piloted by Spain, Denmark and Germany, where others have a limited experience in the field of integrated care in health systems.

JADECARE is going to provide a realistic view of the idiosyncrasies at the European level. The project will include by including not only different health systems, but also present social, organizational, religious, ethical and economic different points of view. This will guarantee that the analysis of the barriers, key factors, frameworks and indicators will generate a useful roadmap to guide the change in integrated care is management in Europe.

CONTEXT OF THE PROJECT WORK

Policy-makers and care providers share a key concern with patients: ensuring that the health services deliver the best possible care and that it is safe, effective and responsive to the needs of patients. Yet, there is a large variation in healthcare resources both within and across countries, as can be seen in the following table, where the percentage of gross domestic product devoted to expenditure on health range from 5,9 (Latvia) to 11,2 (France and Germany).[33]

TABLE 2. HEALTHCARE RESOURCES IN COUNTRIES PARTICIPATING IN JADECARE

HEALTH RESOURCES	Current expenditure on health, per capita, US$ purchasing power parities (current prices, current PPPs)	Current expenditure on health, % of gross domestic product	Physicians, density per 1 000 population (head count)	Nurses, density per 1 000 people (head count)
	2018	2018	2017 (or nearest year)	2017 (or nearest year)
Bosnia i Herzegovina*	957	9.6	2.0	5.0
Czech Republic	3058	7,5	3,7	8,1
Denmark	5299	10,5	4,0	10,0
Estonia	2231	6,4	3,5	6,2
Finland	4228	9,1	3,2	14,3

[32] Health system performance assessment- Integrated Care Assessment (20157303 HSPA) 2018

[33] Busse R, Klazinga N, Panteli D, Quentin W Improving healthcare quality in Europe: Characteristics, effectiveness and implementation of different strategies (OECD 2019) https://apps.who.int/iris/bitstream/handle/10665/327356/9789289051750-eng.pdf?sequence=1&isAllowed=y&ua=1

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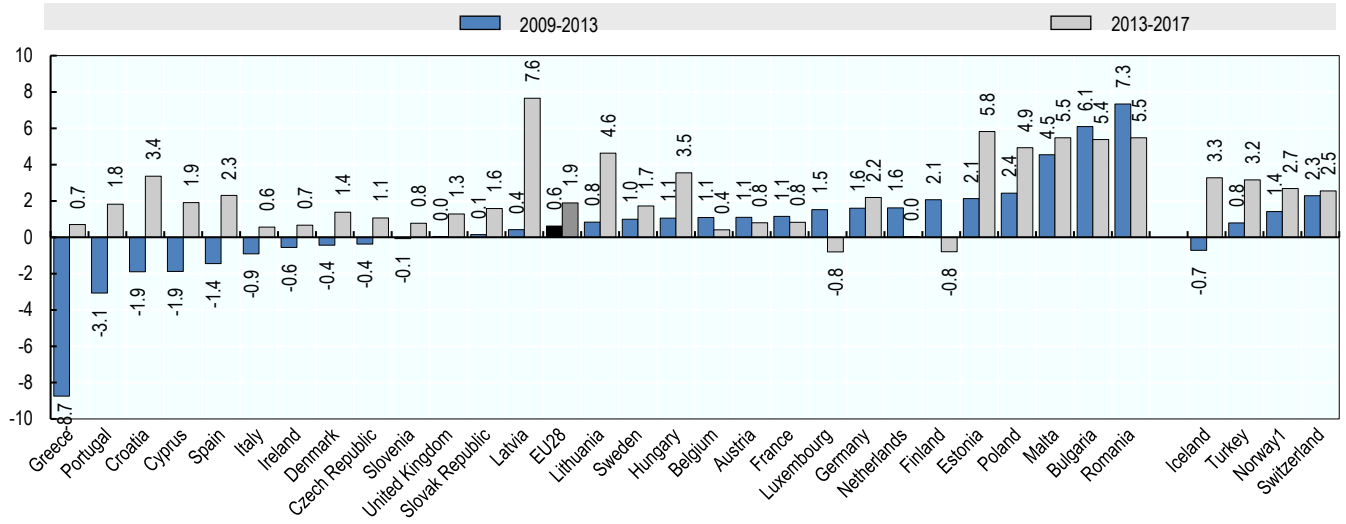
HEALTH RESOURCES	Current expenditure on health, per capita, US$ purchasing power parities (current prices, current PPPs)	Current expenditure on health, % of gross domestic product	Physicians, density per 1 000 population (head count)	Nurses, density per 1 000 people (head count)
	2018	2018	2017 (or nearest year)	2017 (or nearest year)
France	4965	11,2	3,2	10,5
Germany	5986	11,2	4,3	12,9
Greece	2238	7,8	6,1	3,3
Hungary	2047	6,6	3,3	6,5
Italy	3428	8,8	4,0	5,8
Latvia	1749	5,9	3,2	4,6
Lithuania	2416	6,8	4,6	7,7
Portugal	2861	9,1	5,0	6,7
Serbia*	1312	10.4	3.1	4.5
Slovenia	2859	7,9	3,1	9,9
Spain	3323	8,9	3,9	5,7
United Kingdom	4070	9,8	2,8	7,8
OECD AVERAGE	**3994**	**8,8**	**3**	**8,8**

OECD Health Statistics 2019 http://stats.oecd.org/Index.aspx?DataSetCode=SHA.*WHO https://www.who.int/countries/en/ data from 2014 and 2016

The 2008 economic crisis had a clear impact on the healthcare expenditure in most countries, the recover can be seen from 2013 onwards.



Annual average growth rate (real terms) in per capita health spending, 2009 to 2017 (or nearest year) Source: Health at a Glance: Europe 2018 - © OECD 2018

The data from European countries show that it is possible to improve local services through innovation; however, more needs to be done to ensure that these improvements benefit the population at large. Increasingly, the innovation in health services involves the development, introduction and mainstreaming of new technologies, which traditionally have had a high failure rate in the health care sector.[34] Digital health (eHealth) tools have been proposed to improve access to health care services and enhance care co-ordination and integration. They can enable self-management, support decision-making and monitoring, perform risk analysis, and facilitate proactive interventions. Digital health tools have been implemented in all countries, but the levels of maturity differ between the employed programs[35] and JADECARE provides a comprehensive overview of the situation of Europe, as can be seen in the following table.

The table below presents the social, cultural and economic context of the next adopters´ countries associated with digitalization (several sources)[36].

[34] Nolte E How do we ensure that innovation in health service delivery and organization is implemented, sustained and spread? WHO Regional Office for Europe 2018 http://www.euro.who.int/__data/assets/pdf_file/0004/380731/pb-tallinn-03-eng.pdf?ua=1

[35] Baltaxe E, Czypionka T, Kraus M, Reiss M, Askildsen JE, Grenković R, Lindén TS, Pitter JG, Rutten-van Molken M, Solans O, Stokes J, Struckmann V, Roca J, Cano I. Digital Health Transformation of Integrated Care in Europe: Overarching Analysis of 17 Integrated Care Programs. J Med Internet Res 2019;21(9):e14956.DOI: 10.2196/14956

[36] SmartHealthSystems International comparison of digital strategies. BertemsmannStiftung, https://www.bertelsmann-stiftung.de/fileadmin/files/Projekte/Der_digitale_Patient/VV_SHS-Studie_EN.pdf eHealth – Future Digital Health in the EU https://www.espon.eu/sites/default/files/attachments/Final%20report.%202019%2003%2025_final%20version_0.pdf , Country Health Profiles http://www.euro.who.int/en/about-us/partners/observatory

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TABLE 3. SOCIAL, CULTURAL AND ECONOMIC CONTEXT OF THE NEXT ADOPTERS

Country	Social, cultural and economic context
Bosnia and Herzegovina (Bismarck)	According to the Constitution of Bosnia and Herzegovina, Bosnia and Herzegovina consists of two entities, the Federation of Bosnia and Herzegovina and the Republic of Srpska. Brčko District BiH was established in 2000, through international arbitration, with powers largely similar to those entities. Organization, provision and financing the health care is under responsibility of the Federation of Bosnia and Herzegovina, the Republic of Srpska and the Brčko District of BiH. Health care sector in Bosnia and Herzegovina consists of health care systems organized at entity, cantonal and Brčko District level. This could be characterized as significant fragmentation given the fact that the systems are organized differently in the Federation of BiH, Republic of Srpska and Brčko District. In terms of the organizational structure and management, these systems operate at the level of entities, cantons and Brčko District, which complicates the way health care services are provided, increases management and coordination costs and adversely affects the rationality of management of healthcare When it comes to their financing, the health care systems in Bosnia and Herzegovina have been encountering serious challenges for a rather long time. Typically, almost every year, expenses exceed the income of health insurance funds in both Entities and cantons
Croatia (Bismarck)	Croatia has among the lowest health spending in EU and stagnating last 10 years. This has caused a high out-of-pocket spending in the country. Prevention, primary care and long-term care are undervalued. According to the Europe´s Digital Progress Report (EDPR) 2017, Croatia ranks 24th out of 28 EU Members States. The report tracks the progress of digitalisation. In this same report, Croatian citizens are above EU average in the category of Internet users. But, Croatia has no strategy in place to address its digital skills challenges. In fact, education, activities and initiatives that are being conducted, are mostly of a private character or ICT business sector
Czech Republic (Bismarck)	Though health spending in the Czech Republic is under average in EU, the availability of full spectrum of health services has been for long compensated by the effort of highly qualified personnel at healthcare providers. The nationally equal system, with several public insurances providing however essentially the same services, with large number of various kinds of ownerships of providers demonstrates apparent reluctance to changes be they in care organization, reforms or just sharing information, as well as when it comes to cooperation with social care domain. Adjustment to changes in demand for services evoked esp. by ageing population is therefore becoming issue in some regions and medical specialties. Electronisation is one of the most fundamental themes in the framework of discussions on future of the Czech healthcare system. The fact that general society is becoming more and more digitized, seems to make it all the more obvious that the Czech healthcare system (primarily as compared to other developed countries) is lagging behind. There are various challenges in establishing services and tools for effective collaboration and sharing health information between various healthcare providers mutually, and also with patients. The healthcare in the Czech Republic needs increase pace in digitalization. Nowadays, all Czech hospitals use hospital information systems internally (although these vary in quality). It is necessary that the electronisation of health care be implemented in a comprehensive way. For this purpose, The National eHealth Strategy (adopted in 2016) formulated set of goals and measures for the development of electronic healthcare for the period by 2020, which has helped to make important initial steps in digitalization.
Denmark (Beveridge)	Denmark organizes its healthcare through a public-health service that is available to the entire population and is performed at a regional or municipal level. Up to 2006, the central government and the Ministry of Health were only permitted to formulate the framework legislation, the objectives, and the recommendations, and to (co)fund the system. Counties and municipalities were responsible for establishing a catalogue of services, as well as organizing and ensuring the healthcare service. The data saved in EHRs may also be used for secondary purposes, such as for research or quality controls, as long as these purposes do not conflict with the law on the processing of personal data or general health law. This does not require the clear consent of the patient. Most universities offer general IT courses, including with respect to health IT, in order to train current and future professionals in new digital solutions. Some hospitals and other public institutions also offer similar training measures.
Estonia (Bismarck)	In March 2015, the National E-health Strategy was launched, establishing several objectives: 1) user-centric and science-based precision services; 2) holistic case management and integrated service network; 3) improved service performance and quality; 4) optimized service access and professional time use via tele-solutions.
France (Bismarck)	The French healthcare system is organized as a social-insurance system. With the introduction of mandatory insurance in 2000, the statutory health insurance system now compulsorily covers the entire population. Membership is primarily based on the criterion of employment and there is no mandatory insurance threshold. Family members who are not in the labor market are co-insured. Private health insurance provides complementary coverage for services not

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Country	Social, cultural and economic context
	provided by the public system. For historic reasons the health insurance fund landscape is broken down by profession, however it offers a near uniform catalogue of services.
Germany (Bismarck)	In Germany, the federal government sets the conditions determining medical care throughout the country. The country's national healthcare system is underpinned by the principles of decentralization and self-governance, which results in formal responsibility for the provision of healthcare resting on the shoulders of the individual federal states.
Greece (Bismarck)	Greece's health care system is a mixed system comprising elements from both the public and private sectors. In the public sector, a national health service type of system coexists with a social health insurance (SHI) model. In 2011, the National Organization for the Provision of Health Services (EOPYY) was established. It acts as the sole purchaser of health care services for patients covered by the publicly financed National Health System (known as ESY). The private sector includes profit-making hospitals, diagnostic centers and independent practices. Financing is through a mix of public and private resources, including SHI and tax, which account for approximately 30% each, with users' private spending making up the remaining 41%. Health expenditure in 2015 was 8.4% of GDP (compared with the EU average of 9.5%); however, in the context of drastically reduced GDP since the onset of the economic crisis, expenditure has fallen substantially (by one fifth) since 2010[37].
Hungary (Bismarck)	Health spending in Hungary is well below the EU average and the gap widened over the past decade. In 2015, Hungary spent EUR 428 per capita (7.2% of GDP) on health care, about half the EU average of EUR 797 (9.9% of GDP). Only two-thirds of health spending comes from public sources. The high level of out-of-pocket spending contributes to a comparatively high share of households facing catastrophic health expenditure. Life expectancy at birth in Hungary increased by nearly four years between 2000 and 2015, to 75.7 years, but still remains almost five years below the EU average of 80.6 years (according to available data in 2017).
Italy (Beveridge)	A major healthcare reform in 1978 transformed Italy's social security system – which at the time had around 100 different health insurance funds and a highly varied scope of services – into a centrally run state healthcare service. Further reforms in the 1990s and early 2000s decentralized this system once again. Since then the regions have been responsible for local healthcare provision, absorbing a large share of funding. The Health Ministry, which functions as a point of liaison and orientation, has the task of defining healthcare principles, framework conditions and a certain level of care for the regions. This includes guidelines and legislation regarding digital health. The regions are obliged to adhere to the ministry's defined guidelines and level of care. However, they are completely autonomous, free to organize and administer their own regional systems
Latvia (Beveridge)	The National Health Service (NHS) is the operating direct administrative institution subordinate to Ministry of Health. It was established on 1st November 2011. NHS took over the functions formerly carried out by The Centre of Health Economics and Health Payment Center. The Health Care Financing Law regulates health care services paid by the state. The persons who are not mentioned, receive medical services at a charge in accordance with the pricelist of a medical institution or the pricelist of services which are to be paid for, provided by a medical specialist. It is possible to receive health care services paid by the State only in the medical institutions (not depending on the form of ownership or property), which have concluded an agreement with The National Health Service (NHS).
Lithuania (Bismarck)	The organization of the health system of Lithuania is modern and characterised by institutional stability. The country has been steadily pursuing policies designed to better tackle the burden of chronic diseases, including for instance the development of primary care. Remarkably, and despite the fact that Lithuania spends little on health, the population benefits from quasi-universal coverage and key metrics suggest access to care is broadly adequate. The main challenge Lithuania continues to face however is that the health of the population is not improving as fast as it has in comparable countries and many outcome indicators place it among the poor performers of the OECD. There is scope to improve the efficiency of resources currently allocated to the sector as well as the quality and outcomes of care. Additional investments in health are probably also warranted and would not necessarily undermine system's sustainability but they need to be systematically geared towards addressing the challenges identified[38].
Portugal (Beveridge)	Portugal has a centralized, state-managed national healthcare service which provides services to all citizens. Five regional health authorities were established in the 1990s, although they are only responsible for financing the area of outpatient care, with state authorities retaining responsibility for hospitals and their financing. The population has a choice of various healthcare systems, although some are reserved for certain professional categories (e. g., public servants, military personnel, police officers, bankers). Around a fifth of the Portuguese population also take out private insurance, for which premiums may be claimed on tax.

[37] Health systems in transition. 2017.
[38] https://www.oecd.org/health/health-systems/OECD-Reviews-of-Health-Systems-Lithuania-2018-Assessment-and-Recommendations.pdf

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Country	Social, cultural and economic context
Serbia (Bismarck)	Since the beginning of the twenty-first century macroeconomic and political reforms, alongside with economy strengthening, led to rapid growth of health spending in Serbia. This trend has reached essentially a plateau level since the beginning of the global macroeconomic recession, recording fluctuations in 2008–2016. In Serbia, all the money directly or indirectly is provided by the citizens through financing the state budget, compulsory health insurance, direct payment "out-of-pocket," financing from the community funds, donations, loans, etc. The health care system in Serbia is funded through a combination of public finances and private contributions. The most important source of health care financing is the National Health Insurance Fund of the Republic of Serbia. Due to the essential absence of private health care insurance, private funding is more or less completely based on out-of-pocket payments
Slovenia (Bismarck)	Slovenia has a public health care system based on compulsory health insurance provided by ZZZS. This insurance includes more than 99% of population. Specific public-private mix is characteristic for the provision of health care services. Public healthcare network includes private providers with concession and public providers (especially hospitals, health care centres). Private providers outside public network represent less than 10% of the market.
Spain (Beveridge)	Since the 1980s, Spain has had a universal public healthcare service which from 2002 has been entirely planned and executed at the regional level. The 17 regions gained financial autonomy in 2009 and since then have been able to raise their own taxes to finance the system. The central Spanish state's function is now limited to coordination between the regions, the creation of a service catalogue and medication policy. Employees in public service additionally have a supplementary care system which offers some privileges in medical care. Financing occurs through fiscally financed allocations from the state to the regions. They, in turn, use funds from their own various regional tax coffers. There is no earmarked healthcare tax, merely a few specifications that provide information on the amount of funding the healthcare system should receive. In 2015, overall health expenditure amounted to 9.2 percent of GDP, slightly below the EU average.

All partners in this Joint Action strive to establish effective health systems by transition from the traditional hospital-centric approach to community based and integrated care structures, putting the focus on person-centered care, improved chronic disease management capacity and, crucially, on prevention measures. There are many different unmet needs in various countries and socioeconomic income groups. Up to a fifth of health spending in Europe is inefficient and could be used for other care needs. Unnecessary admissions consume over 37 million hospital bed days each year.[39]

The EU Member States are expected to suffer from considerable strain on public spending on health and long-term care in the coming years and decades due to the fast population ageing and moderate economic growth. Better coordination in the development of digital health solutions could help improve access and efficiency in health service delivery. Considerable efforts put into the implementation of eHealth solutions could enhance the efficiency of processes, increase collaboration and improve integration of care. Targeted investments in these areas offer promising opportunities to increase the resilience of the health system in the future. Further analysis can be performed using sources such as the OECD/EC produced Country Health Profiles, a comprehensive resource covering the latest health policy challenges and responses in each country. [40]

[39] Health at a glance OECD 2018 https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_factsheet_en.pdf
[40] https://ec.europa.eu/health/sites/health/files/state/docs/2019_companion_en.pdf

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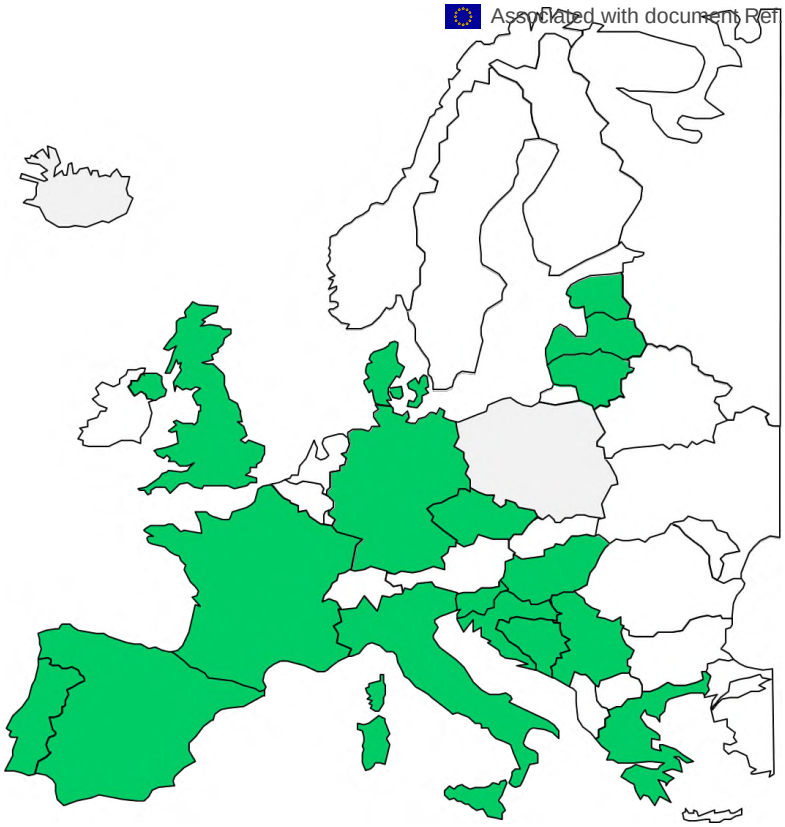

FIGURE 1 JADECARE GEOGRAPHIC COVERAGE

The JADECARE project has been designed to support the digital transformation of healthcare. The local context, the maturity of integrated care models, legal frameworks, culture/values and relevant leaders are going to be considered for each of the 23 next adopters in 15 European Countries.

The processes involved in introducing innovation range from adoption, implementation, sustaining, spreading or diffusion, dissemination and scaling up. These processes overlap in complex ways, which means that service innovation is almost never straightforward.[41] The methodology in JADECARE allow approaching the transfer in different contexts, taking into account socioeconomic, cultural, legal, the current models and the maturity of health systems. The analysis of these aspects will be the key tasks of WP5-8 during the first 13 months of JADECARE. The Next Adopters Working groups (NAWGs) will play the main role in the transfer process. NAWG will be responsible to lead the process of analyzing, designing, monitoring, evaluation and reporting of the implementation in each setting. Next adopters are not obliged to fit in a specific GP; they can use a "mix and match" approach where they can select the parts of each GP best suited to their real circumstances (expectations, necessities….)

In the first phase of the transfer and adoption, the needs and scope will be defined based on the requirements, expectations, strategic objectives, realistic possibilities and existing local interventions of the next adopters. Study visits will be organized at oGP sites so the adopters will be able to acquire a deep understanding of the oGP and establish a robust and durable network with the stakeholders from the oGPs. Thus, both types of adopters should be able to understand the real conditions of the first implementation and appreciate the differences/similarities, weaknesses/strengths in both cases. A SWOT analysis of the core features selected from the oGP will be conducted by each next adopter, where the two perspectives, the original GP-related and implementation-related, will be analyzed.

One of the key aspects of JADECARE is the interests of the participants in the implementation of the oGP. Although the implementation may not involve a large number of participants, the process carried out will follow strict ethical standards. One of these issues is users' privacy, confidentiality and consent. Kronikgune will provide general rules and procedures based on their experience of implementing the oGP in the Basque Country and the experience in previous and current integrated care projects. If necessary, they will help to the generate the informed consent and follow the procedures included in the directive 2004/27/EC (based on the Directive 95/46/EEC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals regarding the processing of personal data). All measures will be taken to ensure the confidentiality of participants in the intervention and, specifically, to follow the new General Data Protection Regulation (GPDR) (UE) 2016/679 (27th April 2016). In WP1, the legal and ethical surveillance and management will be the core tasks of the project (Task 1.4 and 1.5).

[41] Nolte E How do we ensure that innovation in health service delivery and organization is implemented, sustained and spread? WHO Regional Office for Europe 2018 http://www.euro.who.int/__data/assets/pdf_file/0004/380731/pb-tallinn-03-eng.pdf?ua=1

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2.5 METHODS AND MEANS

ORIGINAL GOOD PRACTICES

JADECARE intends to reinforce the capacity of health authorities to address the important aspects of health system transformation successfully, in particular the transition to digitally-enabled, integrated, person-centered care. The project will support the best practice transfer from the early adopter systems to the next adopters.

JADECARE is concretely focused on the transfer and adoption of four Good Practices, so-called **original GPs** (oGPs): Basque Health strategy in ageing and chronicity: integrated care (Basque Country, Spain), Catalan open innovation hub on ICT-supported integrated care services for chronic patients (Catalonia, Spain), The OptiMedis Model-Population-based integrated care (Germany) and Digital roadmap towards an integrated health care sector (Region of South Denmark) (Figure 2).

The description of the main blocks (B) and core features (CF) of the four oGPs are presented below:

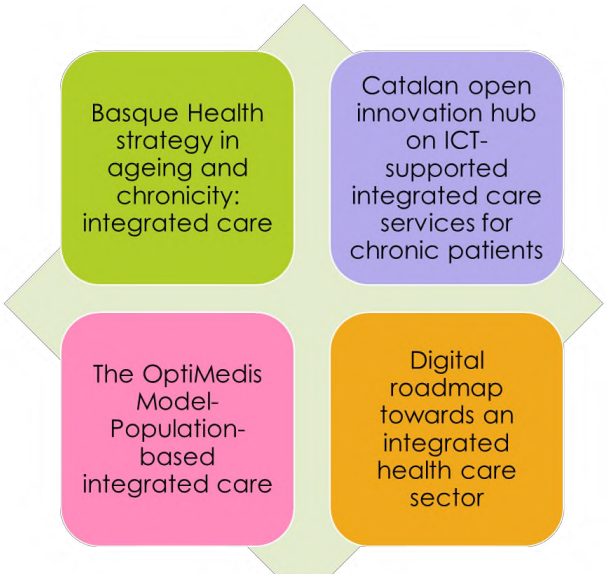

FIGURE 2 JADECARE OGPS

BASQUE HEALTH STRATEGY IN AGEING AND CHRONICITY: INTEGRATED CARE (BASQUE COUNTRY)

B1- Risk stratification

The objective of the Risk Stratification (RS) is to classify a population according to their future health needs, and thus be able to implement Integrated Intervention Programs (IIP) that fit those needs. It predicts the future healthcare cost during the following 12 months. The future health cost is used as a "proxy" indicator of the need for health care. The stratification in the Basque Country:

- Identifies and classifies the patients according to their risk of developing future problems.
- Identifies patients with the greatest need for care
- Predicts the consumption of health resources over the next twelve months of the identified population

- B1- CF1- Stratification Data extraction process and construction of dashboard

Data are obtained from the Electronic Health Record from all active patients (at least one day) during the calculation period (1 year). The cost of each patient is estimated with his/her diagnosis and his/her pharmaceutical prescriptions. The process has moved away from a time-consuming and laborious procedure (3 months to 6 months) using the requests for extraction of data, coming from multiple, scattered and complicated data sources. The new calculation process is automated and offers fast data extraction (less than one-hour file extraction using ACG Grouper). Data sources include Primary Care, Hospital Basic Minimum Set of Data, Diagnosis-Related Groups (DRGs), outpatient appointments and tests, Emergency Department, day hospital, costs and others. These dynamic calculations can be easily adapted to include new data sources.

The information is processed using ACG Grouper. A customized version of the Johns Hopkins' Adjusted Clinical Groups Predictive Model (ACG-PM) is used[42,43]. The ACG system makes it possible to group ICD diagnostic codes and drugs (ATC system) into groups of diseases and morbidity variables, which are the variables that are finally introduced into the model.

The prediction of the patient costs forthe following period is conducted using “R”, obtaining the Predicted Cost in the Estimated Period (next year) per Patient and the Predictive Index = Predicted Cost / Average Total Cost. The future healthcare cost is transformed into the so-called predictive index (PI), which corresponds to the quotient obtained by dividing the expected healthcare cost in each individual by the expected average healthcare cost in the stratified population. It is a number with a lower limitof zero The higher the number, the greater the risk (probability) of resource use. The PI can be different for each update depending on the data of the patients in the preceeding year. The population is grouped in different risk strata.

- B1-CF2- Classification of patients

The stratification of the patients uses the population model of the Kaiser Permanente Pyramid[44]. The population is classified in four groups according to the presence (or absence) of chronic disease, with a special focus on the top

[42] Orueta JF, Nuño-Solinis R, Mateos M, Vergara I, Grandes G, Esnaola S. Predictive risk modelling in the Spanish population: a cross-sectional study. BMC Health Serv Res. 2013 Jul 9;13:269.
[43] Assehs White paper; www.assehs.eu
[44]https://www.researchgate.net/publication/259583721_Improving_Chronic_Illness_Care_through_Integrated_Health_Service_Delivery_Networks

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5% high-cost chronic patients associated with to next year's health costs. The patients are assignedto each stratum according to their Predictive Index (the risk levels are denoted by different colours: red, orange, yellow or green). Different interventions are designed for each stratum:

- The "Case Management" stratum includes 5% of the chronic population, with a high predictive index of resource consumption. It is represented by a red triangle. This group corresponds to high-risk users who require complex interventions or case management.
- The "Disease Management" stratum groups constitute 20% of the chronic population, with a predictive index of intermediate resource consumption represented by an orange triangle. These are the peoplewith chronic conditions requiring constant medical attention, and those whose lifestyle makes them relatively intensive users of the system.
- The stratum of "Self-management" groups includes 75% of the chronic population, with the lowest predictive index of resource consumption, represented by a yellow triangle. These are the patients with chronic pathology but in good health.
- The "Promotion and Prevention" stratum, represented by a green triangle, groups the rest of the population with nochronic pathology .

Integrated Intervention programs are customized according to each citizen stratum. They are meant to be deployed in emergency room visits, hospital admission and general practitioner visits. In order to facilitate and enable the use of risk stratification information, and thus perform proactive intervention, the information is transferred to each citizen's Integrated Electronic Health Record (IEHR), including : (i) a tag with the stratum of the risk pyramid in which the citizen is found. It relates to the value of the Predictive Index, the numeric value of the IP and the date in which the stratification is carried out; (ii) an "alerts" section identifying the IIP corresponding to that patient (if any).

- B1-CF3- Stratification in the framework contract

Stratification is a very powerful tool to promote the shift of mind frame necessary for switching from financing health activities to planning and financing health needs. It has been useful for identifying target populations for health care interventions. The Basque Health system uses a framework Contract to regulate the relation between the Health Department and the Integrated Healthcare Organizations (IO). It contains criteria of population coverage, services provided, activities, quality criteria and funding. Risk stratification is used to define actions that favor a population approach in the context of integrated social and health care and to refine the evaluation of the implementation of effective interventions with proven impact on health. This is used to adjust the Key Performance Indicators (KPI) of an IHO and the results. It is also used to adjust the capitation funding model.

B2- Integrated Care in the Basque Country

A clear strategic vision[45] towards the challenge of ageing, chronicity and dependency has provided explicit support, leadership and capacities to transform the health system towards integrated care in the Basque Country. An integrated care strategy has been deployed, focusing on clinical and functional organizational integration. It deploys an integrated care model capable of providing continuity of care both at health and social care levels. To this purpose, a number of processes and tools have been developed and implemented.

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

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

- B2- CF1- Creation of Integrated Healthcare Organizations

A plan to achieve structural integration has been developed and the concept of IHO introduced. An IHO blends a hospital and primary care centers (integrating the governance bodies) in one organization with a defined population catchment area. The objective is to achieve less fragmented, more coordinated, efficient and higher quality care. Organization performance measures include security, effectiveness, equity, patient centered care, accessibility and waiting lists, and efficiency.

- B2- CF2- Deployment of integrated communication and information systems

The Basque public healthcare provider, Osakidetza, has invested heavily in digitalization and e-Health by deploying a variety of services to support integrated care and the interoperability between communication and information systems. This provides non-face to face care focused on prevention, monitoring and health advice. The ICT platforms and communication channels align actions, avoid duplication of effort and bridge gaps in patient care. Several relevant tools are now in use:

One of these is the Integrated Electronic Health Record (IEHR) "Osabide", a unified and shared clinical information system accessible to all healthcare professionals. It contains all health-related information for each patient, facilitating service delivery and the provision of new forms of healthcare. It has been also extended to public nursing homes and residences in the Basque Country. Primary health and social care teams have been established in all the organizations

[45] http://www.euskadi.eus/web01-s2osa/es/contenidos/plan_gubernamental/xleg_plangub_13/es_plang_13/index.shtml

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and initiatives, such as "InterRAI CA"[46], allowing to share diagnoses and care plans to ensure the interoperability of health and social information systems.
Osanaia is a tool created for the management of nursing care, to set up and manage personalized nursing care plans. It integrates information from the primary, specialized care and mental health care.
The electronic Prescription service, Presbide has also been deployed and integrated as a module within the IEHR systems (Osabide) and is operating in all the pharmacies in the Basque Country.
The Personal Health Folder (PHF) allows the citizens to access to their health data or records securely and enable communication with professionals. The citizens can enrich their PHF through self-tracking programs or uploading documents. The Osakidetza App is a digital tool focused on citizen empowerment, it supplies access to their Personal Health Folder, appointments, eHealth call center, the School of Health, other Apps and give feedback by surveys.
Osarean supports the e-Health call center, run by dedicated nurses on a 24X7 basis and manages e-health services such as follow-ups of some integrated plans and tele-alarm calls.
Telehealth integrates the information of all telemonitoring devices and sensors that measure patients' clinical parameters at home, facilitating patient follow up, care adherence and enhancing patient-professional communication

- B2- CF3- Care coordination and communication between health providers

A series of pathways for population groups classified according to their risk and condition have been deployed including all levels of care, disciplines and actions coordination for multimorbid patients, patients with diabetes mellitus, heart failure, chronic obstructive pulmonary disease, bronchiolitis, palliative care and oncology patients.
In particular, the Complex Multimorbid Program consists of an integrated pathway that aims to provide complex patients with several co-morbidities, resulting in coordinated multi-level and multidisciplinary care in all IHOs of the Basque Country. The Program delivers:

- Coordination and communication between professionals
- Patient-centered care based on the empowerment of the patient/caregiver, and health status monitoring
- ICT tools to enable the implementation of the interventions

It defines WHO is involved in caring for and supporting patients, WHAT functions these actors perform, and HOW different ICT tools facilitate the delivery of these activities. Thus, the multimorbid patients with complex health and social care needs at high risk of hospital or care home admission, can achieve a reasonably good quality of life and improved their clinical outcomes. The process has several different phases: identification of frail elderly patients; comprehensive baseline assessment; therapeutic plan definition; programmed follow-up; patient stabilization at home, integrated care during hospitalization; and coordinated hospital discharge.
To support care coordination, new figures and roles have been introduced: a "liaison nurse" in hospitals, "case manager/advanced skill nurse" in health centers and an e-Health advanced skills nurse. The integrated care pathway includes amongst others :

- Stratification of patients into different levels of interventions
- Interdisciplinary working team: nurse care manager, GP, social worker and specialists
- Care manager role: case management, coordination with GP, support patients in the hospital, Emergency Department, the discharge process
- Consultant specialist role: support of primary care in decision-making
- Follow-up outpatients to facilitate early detection of worsening
- Making care transition support a priority: coordination between the primary care and the hospital, contacting the patient 24-48h after discharge
- Using virtual or in-person multidisciplinary case meetings to facilitate communication between care providers
- Strengthen the patient self-management techniques, especially through motivational interviews

<u>B3- Patient empowerment</u>
Osakidetza has developed a series of online services and information resources to facilitate citizen access to health services and improve their capacity to make decisions and manage their illness.

- B3- CF1- Deployment of a School of Health

Osakidetza has organized a School of Health, "Osasun Eskola"[47], to reinforce self-care skills of patients and caregivers, develop programs of health education (face-to-face and online), for healthy people and chronic patients, to train caregivers of dependent patients who request it and advise patient associations.
The aim of the School is to preserve and promote health by teaching people to make responsible decisions that affect health-disease process.
"Osasun Eskola" is also working on training programs for professionals. The programs should help to acquire educator competences, both face-to-face and virtually.

- B3- CF2- Empowerment programs for chronic and/or multimorbid patients

[46] http://www.euskadi.eus/gobierno-vasco/-/noticia/2017/innovando-en-el-modelo-de-atencion-sociosanitaria-en-euskadi-interrai-ca-como-embrion-de-la-h-sociosanitaria-vasca/
[47] http://www.osakidetza.euskadi.eus/osasuneskola/es/

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"Paziente Bizia-Paciente Activo"[48] is a self-care education program for people suffering from chronic diseases or those responsible for chronic patient care. It consists of peer education workshops, run by chronic patients or by their informal caregivers. The participants are taught how to understand the disease and the habits or behaviors that will help to improve health, status of the patient, how to take responsibility for their health and to make appropriate decisions.

The Program demonstrates the tools and skills that make it easier for citizens to be more active and responsible for the care of their own health. It shows how to face problems, propose objectives for changing habits, communication and relaxation techniques, emotional management. It also provides information about the diseases, physical exercise, nutrition and appropriate use of medication.

The KronikOn[49] program targets complex chronic patients and their caregivers. It consists of a basic set of four 2-30-minute sessions at a health center or in the patient's home. Primary and secondary care nurses provide essential information to help patients in understanding their condition, to identify areas for improvement and to explore and agree upon the best methods of self-care. The primary care nurses systematically follow-up the health status of their patients on a monthly basis by phone calls and use a validated questionnaire.

In addition to KronikON program, Osakidetza offers a battery of empowerment services to complex chronic patients, such as online Health School, information through the PHF, corporative applications etc. Complex chronic patients are classified according to their health literacy using the VACS scale[50] ("Valoración de Competencia en Salud") and then they are provided with the appropriate empowerment services. The empowerment level of these patients is assessed using the indicators of the Nursing Standard Taxonomy (NANDA, NIC and NOC). This taxonomy is included within the Osanaia, the tool created for the management of nursing care which is embedded the Integrated Electronic Health Record. The specific indicators for assessing empowerment are:

- Does the patient know the disease signs or symptoms?
- Does the patient avoid the behavior that can promote disease progression?
- Does the patient follow the recommended treatment?
- Does the patient know who to call in case of needs?

By scoring each of these indicators systematically over time, nurses can evaluate the progress in the empowerment of the patients and try to suggest specific actions if there is room for improvement.

CATALAN OPEN INNOVATION HUB ON ICT-SUPPORTED INTEGRATED CARE SERVICES FOR CHRONIC PATIENTS (CATALONIA)

B1- Health risk assessment: population-based and enhanced clinical decision making.

A core strategic asset in the Catalan scenario is the regional population-based health risk assessment tool, named GMA (Adjusted Morbidity Groups), developed and adopted in Catalonia[51,52,53] which is fully operational for health policy purposes and for clinicians in the workstation of primary care. It is updated every six months and used to elaborate the health risk strata pyramid of the general population of Catalonia with a threefold purpose: i) Support decisions on healthcare services and policies; ii) Identify subsets of patients with high risk of undesirable events (case finding strategies) that may require preventive interventions; and, iii) Contribute to enhanced clinical decision support through multisource predictive modelling.

The GMA tool predicts individual citizen risk based on multi-morbidity information gathered from the Catalan Health Surveillance System (CHSS). It is a publicly-owned open algorithm (CatSalut and Ministry of Health), not based on experts opinions, which explains its high flexibility and transferability. The latter has been demonstrated by its adoption by thirteen out of the seventeen regional healthcare systems in Spain, covering 92% of the overall Spanish population, approximately 38 million citizens.

The GMA algorithm shows higher performance and applicability for prediction of healthcare resources utilization in primary care than other well-known indices54. The input for the GMA algorithm is a text file containing information about the health problems (diagnoses) of the insured. The required fields are: i) identification of the insured; ii) diagnostic classification used; iii) code of the health problem; iv) date of diagnosis; v) birthdate; and, vi) sex of the insured. The output fields that the GMA algorithm generates are: i) Identity of the insured; ii) Adjusted Morbidity Group Code; iii) Number of chronic diseases present; iv) Number of organic systems affected by chronic disease; v)

[48] https://www.osakidetza.euskadi.eus/pacienteactivo/
[49] https://www.osakidetza.euskadi.eus/kronik-on-programa-paciente-cronico-complejo/ab84-oescon/es/
[50] VACS. Modelo desarrollado por el Instituto Albert Jovell de Salud Pública y Pacientes (Universitat Internacional de Catalunya), junto con SEDAP (Sociedad Española de Directivos de Atención Primaria) y ESTEVE.
[51] Dueñas-Espín I, Vela E, Pauws S, Bescos C, Cano I, Cleries M, et al. Proposals for enhanced health risk assessment and stratification in an integrated care scenario. BMJ Open. 2016 Apr;6:e010301.
[52] Monterde D, Vela E, Clèries M, grupo colaborativo GMA. Los grupos de morbilidad ajustados: nuevo agrupador de morbilidad poblacional de utilidad en el ámbito de la atención primaria. Atención Primaria. 2016;48:674–82.
[53] Vela E, Tényi Á, Cano I, Monterde D, Cleries M, Garcia-Altes A, et al. Population-based analysis of patients with COPD in Catalonia: A cohort study with implications for clinical management. BMJ Open. 2018;8:e017283.
[54] Monterde D, E. Vela, M. Clèries, L. Garcia-Eroles, J. Roca and P. Pérez-Sust. Multimorbidity as a predictor of health service utilization in primary care: a registry-based study of the Catalan population. BMC Family Practice. 2020 (in press). https://doi.org/10.1186/s12875-020-01104-1

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Total relative weight of the insured (complexity); and, vi) Clinical label summary of the set of relevant diseases identified in the insured.

As described, the use of the GMA grouper provides allocation of each citizen into the regional risk stratification pyramid. The four main strata usually identified are: i) GMA-1 corresponds to 50% of the population, with a lower complexity level; ii) GMA-2 or low risk stratum: it corresponds to 30% of the population, which has higher complexity than the previous risk stratum; iii) GMA-3 or moderate risk stratum: it corresponds to 15% of the population, which has greater complexity than the previous risk stratum; and, iv) GMA-4 or high-risk stratum: it corresponds to 5% of the population, which has the highest complexity level.

- B1- CF1: Assessment of transferability, and identification of steps for adoption, according to intellectual property rules, of the Catalan population-based risk stratification tool into the ecosystem of the next adopter.

The experience acquired with the process of transferability of the GMA within Spain will facilitate to define appropriate strategies customized to the characteristics of the next adopters.

- B1- CF2 - Health data management strategies (Catalan Health Surveillance System, CHSS).

The steps followed to build-up the CHSS, its characteristics, as well as the different data management strategies followed in Catalonia will be transferred to next adopters. The potential of data exploitation within the strategies defined in the current, 2016-2020 and future, 2021-2025, Catalan Health Plans will be shared with the next adopters. The CHSS includes updated registries of the region of Catalonia (ES) (7.5M inhabitants) from Primary Care, Hospital-related events (hospitalizations, emergency room consultations and specialized outpatient visits), Pharmacy, Mental Health, Socio-sanitary services and other items (home-based respiratory therapies, dialysis, outpatient rehabilitation and non-urgent healthcare transportation) since 2011. It allows analyses of the use of healthcare resources, pharmacy consumption, prevalence of key disorders and population-based health risk assessment. It is of note that although integration of CHSS registry data with electronic medical records is not yet in place, it constitutes the main strategic goal since January 2017.

- B1- CF3: Development of enhanced risk prediction modelling for health policy purposes and/or clinical risk prediction

On-going activity of the Catalan oGP is to build on the specificities of the GMA, incorporating additional clinical variables and social determinants, to improve the predictive ability of the GMA, and increase the support of clinical decision making[1,3]. Practicalities of enhanced multisource clinical predictive modelling, including: i) clinical information, ii) GMA scoring, iii) patient's self-tracking data, and, iv) disease-related biological mechanisms, to guide decision-making in the clinical arena have shown high potential[1] and are curently being worked out and tested.

B2- Promotion of healthy life styles

The design and implementation of proper policies to foster healthy life styles to prevent multimorbidity constitute a major goal. Likewise, patient empowerment to increase self-efficacy and tertiary prevention of episodes of exacerbation is a key unmet need to improve health-related quality of life, increase survival and reduce avoidable use of healthcare resources. These are central aspects to be taken into account in the deloyment of integrated care strategies. However, accessibility and poor adherence are major limitations for cost-effective interventions addressing such goals. The approach adopted in Catalonia is to learn from the implementation of preventive perioperative interventions, specifically from the deployment of prehabilitation in high risk candidates to major surgical procedures. The strategy has been fostered by two major factors. Firstly, the high burden of periooperative complications, including deaths, on healthcare systems[55]. Secondly, the time-limited period (average 4 weeks) of the intervention facilitates the analysis of the factors modulating adherence and effectiveness of the implementation. The results have indicated a high potential for healthcare value generation and for transferability to other clinical scenarios. A three-step approach is proposed to next adopters.

- B2- CF1- Transferability of the prehabilitation program

Prehabilitation is a preventive intervention targeting high risk candidates for major surgical procedures carried out preoperatively, average 4-week duration, aiming at reducing complications and enhancing postoperative recovery. It combines: (i) exercise training and promotion of physical activity; (ii) nutritional balance; and; iii) psychological support.

The intervention is currently deployed as a mainstream service[56,57] and cross-country transferability at EU level is being tested through an ongoing EIT-Health project (2019-2021). The outcomes of a recent co-design process provide robust grounds for lean design of a future personalized perioperative care service at regional level covering three phases: prehabilitation, in-patient care, and post-discharge rehabilitation. There is solid evidence indicating the potential

- B2- CF2- Perioperative care with a population-health approach

[55] Dmitri Nepogodiev D, J Martin, B Biccard, A Makupe and Al Bhangu. Global burden of postoperative deaths. The Lancet. 2019; 393 (10170): 401

[56] Barberan-Garcia A, Ubré M, Roca J, Lacy AM, Burgos F, Risco R, et al. Personalised Prehabilitation in High-risk Patients Undergoing Elective Major Abdominal Surgery : A Randomized Blinded Controlled Trial. Ann Surg. 2018;267:50–6.

[57] Barberan-Garcia A, Ubre M, Pascual-Argente N et al. Post-discharge impact and cost-consequence analysis of prehabilitation in high-risk patients undergoing major abdominal surgery: secondary results from a randomised controlled trial. Br J Anaesth. 2019;123(4):450-456.

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Design and testing of digitally-supported, community-based perioperative care services customized according to patients' risk levels is underway.

- B2- CF3- Rehabilitation of chronic patients

Lessons learnt in the deployment of prehabilitation services are extremely useful for designing and testing cost-effective rehabilitation programs for chronic patients, including oncology candidates, aiming at achieving high levels of accessibility and program's adherence.

B3- Vertical and Horizontal integration experiences adopted in Catalonia

Innovative practices are continuously emerging in the region leading either to testing or, for those that are successful, to large scale deployment. The current block (B3) includes four initially selected examples successfully assessed in the EU project ACT@Scale[58]. Each of the experiences encompasses the different dimensions highlighted in: (i) change management and reorganization of the existing care models; (ii) embedding digital technologies and tools in care services, re-organization of patient pathways; (iii) health workforce roles and skills with digital technologies and data; (iv) building the capacity of individuals and communities to participate in the care process; (v) citizen empowerment; (vi) use of patient reported data; (vii) new payment methods; (viii) performance assessment of new care models; and, (ix) digital solutions. Brief description of the four selected experiences indicated belwo, can be found in[8]:

- B3- CF1- Programme for chronic and frail patients (Badalona Serveis Assistencials, BSA).
- B3- CF2- Support for complex case management including home hospitalization, transitonal care and vertical&horizontal integration supported by digital tools (Health District Barcelona-Esquerra, AISBE)
- B3- CF3- Healthcare support programmes for nursing homes (MUTUAM, Barcelona).
- B3-CF4- Integrated Care for admission avoidance of subacute and frail patients (PS Pere Virgili, Barcelona).

The analysis of implementation strategies following the CFIR approach and identification of KPIs for long-term follow-up of the service beyond the initial deployment phase are available for most of the interventions[59].

B4- Innovative assessment and regulatory aspects

This block includes three different items of healthcare performance assessment and experiences, as well as ongoing work, on regulatory issues.

- B4- CF1- Catalan Health Plans and Practicalities of healthcare delivery assessment

The Catalan oGP has had a well-blended background for the design and deployment of five-year period Regional Health Plans over the last thirty years. The last two programs 2011-2015[60] and 2016-2016[61] focused on the deployment of integrated with an emphasis on the digital transformation of the health system. The region is currently actively designing the 2021-2025 Health Program. Moreover, Catalonia is producing both recommendations and innovative information on practicalities of healthcare delivery assessment (Nextare) based on the evaluation framework [9] taking into account: (i) Health outcomes assessment with a Quadruple aim approach; (ii) Evaluation of service implementation (CFIR); (iii) Assessment of maturity (Sirocco); and; (iv) identification of service specific key performance indicators.

- B4- CF2- Regulatory aspects associated with patient' self-tracking data

TIC-Salut has generated recommendations/standards for patients' self-tracking data using Apps and taking into account interoperability with the regional personal health folder, La Meva Salut[62]

- B4- CF3 - Regulatory aspects of health data management for research purposes and quality assurance purposes.

Health data management across institutions for research purposes in Catalonia is regulated under the umbrella of the PADRIS program, run by AQuAS[63]. Regulatory aspects of health data management for quality assurance and service innovation purposes are currently being addressed in Nextcare under the auspices of TIC-Salut, which plays the role of regional authority on health data privacy. In 2020 a new Joint Action on Data Protection on how the GDPR will be applied to health information is planned.

B5- Digital support of integrated care services

Digital support of health services in Catalonia involves regional interoperability among an extensive network of healthcare providers with highly heterogeneous health information systems. It is of note that a well-developed health information exchange system is in place. This is the role of the shared regional health record (HC3) which consists of a series of health information exchange platforms linking publicly-paid heterogeneous healthcare providers at regional level. Within this mature scenario, in addition to HC3 (B5-CF1), two key tools are fully blended and implemented across the entire region: i) B5-CF2, Primary Care electronic medical record (eCAP) and the Electronic

[58] ACT@Scale (2016-19) – Advancing Care Coordination and Telehealth at Scale [Internet]. Available from: https://www.act-at-scale.eu/
[59] Baltaxe E, Cano I, Herranz C, et al. Evaluation of integrated care services in Catalonia: population-based and service-based real-life deployment protocols. BMC Health Serv Res. 2019;19(1):370
[60] Government of Catalonia M of H. Health Plan for Catalonia 2011-2015. 2012. Available from: http://salutweb.gencat.cat/web/.content/home/el_departament/pla_de_salut/documents/arxius/health_plan_english.pdf.
[61] Department of Health. Catalonia Health Plan for 2016-2020 (in Catalan). 2016. Available from: http://salutweb.gencat.cat/web/.content/home/el_departament/Pla_salut/pla_salut_2016_2020/Documents/Pla_salut_Catalunya_2016_2020.pdf.
[62] Modol JR. Navigating Towards Self-Care: The Catalan Public Patient Portal. In: Aanestad M, Grisot M, Hanseth O, Vassilakopoulou P, editors. Information Infrastructures within European Health Care: Working with the Installed Base. Cham: Springer International Publishing; 2017. p. 173–92.
[63] Public Data Analysis for Health Research and Innovation Program (PADRIS) http://aquas.gencat.cat/en/ambits/analitica-dades/padris/

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Prescription; and ii) B5-CF3, the Personal Health Folder (La Meva Salut, LMS) also interoperable with HC3. All these basic tools are governed by the eHealth (eSalut) Office. The steps followed for the development of these three items, their current status and future evolution will be shared by the practice.

It is of note that the region is currently developing an ambitious ICT plan for the full digital transformation of the health system with an emphasis on cloud-computing and artificial intelligence (AI). Some of these aspects are covered by B5-CF4. Within this umbrella will be sharing experiences testing digital tools to support: i) col·laborative work among stakeholders across health and social care tiers, as well as implementation of adaptive case management and digital tools for patients' self-tracking information. Finally, B5-CF5 addresses the ongoing ICT deployment strategic plans for the period 2020-2023. The characteristic features proposed for the transfer are listed below:

- B5-CF1 - Regional information exchange platform (HC3)
- B5- CF2- Primary Care electronic Medical Record (eCAP) and Electronic Prescription
- B5- CF3- Personal Health Folder (La Meva Salut)
- B5- CF4- ICT tools supporting adaptive case management & col·laborative work[9]
- B5- CF5- Cloud-based strategies (SISCAT program)

The first three items, B5-SF1 to B5-SF3, correspond to mature digital support tools already fully adopted at the regional level. Moreover, the oGP proposes the conceptual approach recently reported in[64] to assess the maturity of digital transformation.

THE OPTIMEDIS MODEL-POPULATION-BASED INTEGRATED CARE (GERMANY)

The model is based on the Triple-Aim approach, according to which three aims are pursued simultaneously: 1. Improving the patient experience of care (including quality and satisfaction), 2. Improving the health of populations; and 3. Reducing the per capita cost of health care (Berwick, Nolan, Whittington 2008). The innovative nature of the program, with its strong reference to theoretical models and up-to-date scientific literature and its rigorous evaluation, means that the HK model is a useful model for other countries to adapt and expand. The business model of HK has some distinguishing characteristics: at its core is the value-oriented population-based shared savings contract based on the Triple Aim Approach. Crucial components of this approach include a) the fact that a specific population, representative of a typical risk pool and covered by the integrated care system, can be identified—thereby minimizing the risk of adverse selection, b) the support of an "integrator" who has the know-how and competences to guide the development and implementation of population health improvement programs and c) that there are economic rewards from the production of the improved health status instead of a mere increase of services.

B1 - Shared savings contract with reimbursement/commissioning organizations

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

- B1- CF1- identifying current contractual arrangements and assessing possibilities for value-based contracting
- B1- CF2- defining data standards and appropriate outcome measures
- B1- CF3- designing the valued-based payment framework
- B1- CF4- constructing the analytical model to execute the contract

B2 - A model including strong stakeholder engagement

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

- B2- CF1- Identifying and liaising with stakeholder groups
- B2- CF2- Creating appropriate governance structures

B3 - Electronic integration across providers

[64] Baltaxe E, Th Czypionka, M Kraus et al. Digital Health Transformation of Integrated Care in Europe: Overarching Analysis of 17 Integrated Care Programs. J Med Internet Res 2019; vol. 21: iss. 8. e14956

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A variety of digital tools are designed for specific indications, whether for asthmatics, people with slide-beds or people suffering from depression. However, it is increasingly recognized that improving health requires measures that often go beyond the responsibility of a single organization (hospital, practice, rehabilitation etc.). In order to influence the health of the population, an understanding of the determinants of health in the life cycle is necessary and, based on this, the derivation of measures for a comprehensive population health management (PHM). PHM differs from classical support services for the chronically ill in several respects: It includes several chronic diseases and conditions, considers co-morbidities, includes proactive health promotion management, includes predictive models for health development and - based on these - strategies for case management of high-risk patients as well as for personal health management at population level for people with a low risk of disease or morbidity. PHM requires a constant exchange of data from all health care providers as well as other sources of data on population health. Moreover, PHM is not only an IT suite, but requires a regional manager who derives relevant decisions for the clinical and non-clinical management of health potentials from the multitude of data. OptiMedis is IT agnostic and helps regions procure and deploy the most appropriate IT solution.

- B3- CF1- Assessing state of current health IT integration and IT tools in use
- B3- CF2- Market assessment on tools adequate to improve IT connectivity of providers
- B3- CF3- Training with providers to assess incentives for IT deployment and usability assessment
- B3- CF4- Patient access to their data (Open Notes approach)

B4 - Patient involvement and empowerment

The patient-centered care approach is paramount to the success of the OM model and embedded at three levels: at the structural level, in the planning of interventions, and in the interactions between physicians and patients.
At the structural level, patients are represented in patient advisory boards, which elect their representatives on a biannual basis and are given the opportunity to contribute to identifying and developing new programmes. At the level of intervention planning there is a strong focus on shared-decision making and self-management support, which is embedded in design and development. At the level of individual interactions of patients with health professionals, patients joining first undergo a comprehensive health-check based on which they may be offered to participate in any of the health promotion and disease prevention programmes HK. Patients are also given the opportunity to develop health-related goals, which are discussed with the doctor and then monitored over time, accompanied by individual support and participation in patient education and self-care programmes as needed. In order to support the patient-centered care approach, physicians, other health professionals and practice staff are offered training. Underlying all these efforts is an understanding of the patient as a co-producer of their health (Batalden P et al 2015).

- B4- CF1- Patient advisory boards
- B4- CF2- Shared-decision making tools and self-management support
- B4- CF3- Comprehensive health checks and health-related goals
- B4- CF4- Providing training on incentives and tools to implement patient centered care

B5 - Data-driven management

Effective Information and Communication Technology (ICT) is vital to allow data-driven management (Hammersley et al., 2006), to ensure that the correct information is exchanged in a timely manner and understood, while at the same time laying the foundation for stable cooperation and changes. Data must be processed in a way that it can trigger a continuous learning and improvement process[65] (). “Business Intelligence” (BI) is often used as generic term for this: “Business Intelligence is the process of transforming data into information and, through discovery, into knowledge“[66]. OptiMedis provides overarching management support, business intelligence and health data analytics, whereby the data driven health analytics propel both the planning of health programs and guide local practice improvements via feedback reports to participating physicians. These reports are based on a balanced scorecard approach, which uses structure, process and outcome indicators and is designed to be interactive in that it allows users to select indicators to retrieve more detailed information. Some indicators are supported by targeted improvement activities. For example, the dashboard indicates problematic prescription behavior (e.g. a high proportion of drug prescription according to the PRISCUS or FORTA D classification models for potentially hazardous prescriptions for older people) (Holt S et al 2010, Kuhn-Thiel AM et al 2014). This indicator is supported by two-monthly geronto-pharmaceutical consultation meetings for which physicians prepare a patient case report and which discusses potential problems jointly with a pharmacologist to optimize medication regimes. The infrastructure utilized to produce the dashboards has the capacity to integrate and transform multiple data sources (such as claims data, health records, patient survey), to analyze the potential effectiveness of a program or identify high-risk patients and provide automated benchmark reports to participating physicians. This business intelligence solution was awarded with the Best Practice Award Business Intelligence by the German Business Application Research Center (BARC) The DataWarehouse Approach includes suite of analytical tools that support improvement processes in integrated health care networks. Diverse data can be integrated via various ETL (extract, transform, load) processes

[65] Kupersmith et al., 2007; Vijayaraghavan , 2011
[66] Behme, 1996

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in the Core Data Warehouse (MS SQL Server). Thereby data are brought into relational connections, standardized (and subjected to quality checks, cleansing and normalization. After this stage data are via additional ETL processes prepared for the analytical database, among others e.g.

- insurance selections[67] ,
- risk adjustment methods like propensity score and exact matching[68],
- relative time references (i.e. for example what happened a quarter prior or post enrolment on a Disease Management Program),
- model and scenario calculations (e.g. risk structure equalization schemes calculations[69], disease-related expense attribution models) and
- predictive modelling approaches

- B5- CF1- Potential analysis tool
- B5- CF2- Performance dashboards
- B5- CF3- FORTA tool to identify over- and underutilization regarding prescriptions

B6 – Prevention, health promotion and public health

In order to reach the Triple Aim, a set of activities and programmes were established, which all draw on a common set of underlying features: a) individual treatment plans, b) care planning based on the Chronic-Care Modell (Barr VJ et al 2003), c) patient coaching. The following Prevention and Health Promotion Programmes that have been developed so far: Strong heart (programme targeting heart failure), Healthy weight (for metabolic syndrome, including diabetes), Good prospects (care services for children), In balance (blood pressure), Strong muscles – solid bones (osteoporosis), Staying mobile (treating early stage rheumatism), Strong support - healthy back (chronic back pain), Better mood (depression), Good counselling (help, advice and support in critical times), Psycho Acute (acute psychological issues), Disease management programmes, Smoke-free Kinzigtal (including pre-surgery smoking cessation), Social support (to reduce stress where patients are in critical situations) , Liberating sounds (in tune with music) and, a self-management training programme (based on the Stanford Chronic Disease Self-Management Programme).

- B6- CF1- Individual treatment plans and care programmes
- B6- CF2- Care planning based on Chronic care model
- B6- CF3- Patient coaching

DIGITAL ROADMAP TOWARDS AN INTEGRATED HEALTH CARE SECTOR (REGION OF SOTH DENMARK)

The Roadmap towards Integrated Care consists of different elements that together make up the foundation for digital and cross sectorial communication. One of the key success factors is a strong collaboration between the different organizations in the regional eco-system of academia, knowledge institutions and private companies; a focus on user involvement of both professionals and end-users in co-designing solutions and implementation processes. Moreover, a good public-private partnership and preferably an agile one as well as a strong IT infrastructure to make digital communication possible.

B1-Cross sectorial digital communication: standards and agreements

The objective of electronic standards is to make sure that the various IT systems and organizations can reuse the data which is exchanged. The messages are the most frequent text-based clinical messages in the Danish health care system, e.g. discharge letters, referrals, lab test orders, e-prescriptions and reimbursement from public health insurance and are all in the high 90’s percentile when it comes to usage. The agreements made between the health sectors ensure that the responsibility is clear, and collaboration is formalized.

- B1-CF1: Health Agreements: The main road towards Integrated Care consists of three lanes. First the lane of our health agreements, which describe the responsibilities and communication between the three sectors (hospitals, municipalities and GPs) and are revised every 4 years. In these agreements special emphasis is typically made on the elderly and patients with a chronic or complex condition. Patients with a chronic condition are categorized into 4 categories according to the complexity of their disease as well as their self-care ability. These categories have different care pathways where specific responsibility has been divided between the caregivers. Current mandatory health agreements between municipalities and regions on coordination of care address a number of topics related to admission and discharge from hospitals, rehabilitation, prevention, psychiatric care, information technology (IT) support systems, and formal progress targets. Agreements are formalized for municipal and regional councils at least once per four-year election term, generally take the form of shared standards for action

[67] Hauner et al., 2003; Windt et al., 2008
[68] Rosenbaum and Rubin, 1983; Austin, 2011; Stuart 2010
[69] Pimperl, 2014

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in different phases of a patient's journey within the system, and must be approved by the Danish Health Authority. The degree to which the regions and municipalities succeed in reaching the goals is measured by national indicators published online.

- B1-CF2: Messaging Standards: The electronic communication between these three organizations consists mainly of national standards for electronic messaging, visualized by the second lane. These standards were first developed in 1995 and are now widely implemented in Denmark and maintained by MedCom. Through the years, MedCom has developed more than 150 standards, profiles and web services consisting of 'the good letters' which are all being used increasingly. At the same time, new standards are being developed an all of them are implemented with IT vendors within the healthcare sector. MedCom's standards secure that the various IT systems and organizations can reuse the data which is exchanged. The messages cover the most frequent text-based clinical messages in the Danish health care, e.g. discharge letters, referrals, lab test orders, e-prescriptions and reimbursement from public health insurance and are all in the high 90's percentile when it comes to usage. For example:
  - All GPs keep electronic health records (EHRs), and 98 per cent exchange records electronically.
  - GPs receive all laboratory test results from the hospitals electronically.
  - 99 % of all prescriptions are sent electronically to the pharmacies.
  - 97 % of all referrals to hospitals are made electronically.
  - All referrals to medical specialists and psychologists are made electronically.

B1-CF3: SAM:BO Agreement, which is the third lane, is the agreement that blends the Health Agreement and the electronic standards. In here a description of which messages are to be sent at which point of the care pathways guides the sectors in setting up the correct communication procedures. The success of this system has largely been due to the long haul of organizational collaboration, which is then translated into electronic communication. This constellation is unique to the Region of Southern Denmark and makes sure that the agreements are clear and implemented. It was fist implemented in the Region in 2009. Although most communication travels along the main road there are also cases where more than standard information is needed and where we have some cases of digital health projects with the focus of even more cross-sectorial communication.

<u>B2- Cross sectorial digital communication: Additional solutions to support complex disease areas</u>

A roadmap approach has been used in explaining the Region of Southern Denmark's ICT solutions using personas to exemplify a turn off the main health roadway for specialized health treatment at different health services in their life course and how the Region's ICT approach supports integrated care across different healthcare services in the region. This is an informative visible approach for easier understanding of how ICT can work within complex healthcare systems. The following projects are all examples of additional solutions for more complex disease areas that require even more digitally enabled cross-sectorial communication.

- B2-CF1: Tele-COPD: At least 200.000 people in Denmark suffer from COPD and the number is on the rise. COPD is primarily caused by smoking and secondary by conditions in the work field. 20 % of all acute admissions are caused by COPD and we know that the earlier the disease is diagnosed the easier it is to treat and slow down. That is why we see telemedicine in the area of COPD as a supplement to the treatment. In our current work with expanding telemedicine for COPD patients the purpose is to reduce the consultations and admissions as well as making sure that the patients feel safe at home. The national initiative is focused on patient education, early detection of symptoms and an increase in quality of life. The aim is to include approximately 2.600 patients with COPD in telemedicine usage in the Region. In the project 22 municipalities, 4 hospitals and a large number of GP's are included in the Region of Southern Denmark. As part of the implementation a large effort to inform the patients on home-monitoring is being made – including pamphlets and videos with information on what to expect. The patients will be offered devices to measure oxygen levels, pulse and weight at home. The collection and distribution of the information will be in line with the national procurement of telemedicine that has just been finished, with a range of 5 suppliers for the citizens' view.
- B2-CF2: Tele-psychiatry: In 2013 we opened the Tele psychiatric center in the Region with the ambition to develop and evaluate digital communication and devices for patients with a psychiatric diagnosis. One of the projects the center has been involved in was the European Union funded MasterMind, which stands for: MAnagement of mental health diSorders Through advancEd technology and seRvices – telehealth for the MIND. The project's focus was telemedicine within the psychiatry – more specifically telemedicine for treatment of depression. Depression is a disease with high incidence and social costs in Europe, but also an area with proven clinical effectiveness of ICT (information and communication technology) in its treatment. The aim was to offer a patient-centered treatment course and ensure that the patient has access to high-quality treatment in their immediate environment. The MasterMind project implemented cognitive behavioral therapy through digital services for almost 5,000 depressive adults in eleven European countries and implemented collaborative care through video conference for patients with depression, who were treated by general practitioners.

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Videoconferences were used to create networks between the health professionals in order to make it easier for them to support each other and to share knowledge. In addition, video conferences could be used for offering specialist treatment in remote areas. In that way, patients with depression gained access to therapy if they had internet access. After the end of the project, the tele psychiatric solutions are still in use by most of the partners, and many have decided to upscale their service for more diseases and users. In Denmark, internet psychiatry is still an option for patients with panic disorder, social phobia, other phobias and light to moderate depression. The solution is now national, and it is managed by Tele psychiatric Centre in the Region of Southern Denmark.

- B2-CF3: My Patient Journey: “My Patient Journey” is an app developed at Odense University Hospital to facilitate digital communication between the hospital departments and patients. The app also helps patients find and keep track of information from the hospital and gives them a better overview and experience in communicating with the hospital. It also the Region’s selected tool for collection of PRO-data such as filling out questionnaires and recording experiences which is a strategic focus point for the Region. The solution is used in 44 separate hospital departments in the region, and more than 37,000 patients use it. Some of the functionalities and content of the solutions are Appointments, Notifications, Questionnaires, Voice-recording of consultations, Courses, Diary, Medical passport, Messages and My data. The key to the app is the variety and the flexibility to combine the relevant functionalities for a specific department, pathway and patient type. Another key is the focus on the importance to co-create the solutions with the users, both the healthcare staff, the patients, the relatives and truly design the solution for the users and their needs.
- B2-CF4: Online physical rehabilitation: Another similar app is the online physical rehabilitation platform that allows rehabilitation therapists in the hospital or municipality to design a training program from a range of exercises to fit the patient. The exercises are short videos of trained therapists showing how to do the exercise and the patients can access these videos on their mobile devices and register their pain level when they have finished. This gives the care professionals a better feeling of the patients’ progress and when to have a consultation or edit the training program and it gives the patients the freedom to train at home at their convenience. They can also use the app to see their own progress, chat with the therapists and fill out questionnaires. The solution is used in a number of the Regions’ hospitals and municipalities – and has a positive business case as well as satisfied users.
- B2-CF5: Digital Health Centre: The main tasks of the municipal health centers are to provide health promotion and disease prevention aimed at the citizens. This is e.g. done through guidance and counselling on a healthy lifestyle. The focus is on providing tools, motivation and support for self-managing a change of their lifestyle and routines. They also create network possibilities for citizens, as well as provide knowledge to health organizations in the civil society. They also support rehabilitation after interventions at the hospital and offer preventive home visits to citizens above the age of 75. The health centers have nurses, dieticians, physiotherapists and doctors. The current challenge for the health centers is the increase in the number of at-risk citizens, difficulties engaging the citizens in patient education (for geographic, economic, physical or time reasons) and maintaining lifestyle changes. The Digital Health Centre is a partnership between 5 municipalities, the Diabetes Association, Heart Association and the Region of Southern Denmark through the Health Innovation Centre and the department of cross-sectional cooperation. The vision of the Digital Health Centre project is to develop and integrate digital solutions in the courses of the healthcare centers. Under this vision, several subprojects are unfolded. Patients can join from home, where they can see pre-recorded information, participate in webinars gain knowledge by reading short texts, and chat with both health care professionals and other patients. The systematic use of digital solutions should result in: flexibility, motivation and resource optimization and patient empowerment. Since the smaller municipalities can join together to produce content to the online-platform and therapists can be used to a wide range of citizens from different areas resources can be better used. Patients that do not like to be in physical sessions with others can join and they have the possibility to go back and revisit the information when they are motivated to implement a change.
- B2-CF6: Geri Toolbox: With the aim of reducing acute admissions, the GERI Toolbox contributes to early detection and timely intervention for elderly citizens with multi-morbidities and loss of functional capabilities. Home care nurses use in-home clinical equipment (incl. a mini laboratory) and telemedicine technology. This allows GPs to receive basic objective health information that supports early clinical decision-making and timely intervention. The acute nurse brings the GERI Toolbox, packed in a small easy-to-bring roller suitcase, and the measurements are transferred to a common IT platform (Generic Telemedicine Platform) which homecare, the GP and eventually the hospital can access. The focus in this project is on simplification of communication, the possibility of early detection and treatment as well as a reduction of acute admissions. The Generic Telemedicine Platform (GTP) ensures that the demands of the future healthcare sector are met in relation to the increase in collected data from the citizens’ own homes. Data will be used by clinicians in hospitals, municipalities and GPs. The GTP can collect home monitoring-, sensor- and PRO data and show the data in a uniform and recognizable way, so that clinicians can get an overview of the individual citizen and use the collected data in treatment planning. Through the GTP data collected by the citizens in their own home will be accessible to all healthcare providers involved in a course of treatment. They can access the same data and knowledge. The data is integrated

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with the electronic patient journal in the Region of Southern Denmark, which is the core system for the clinicians. This makes it easier to test and offer telemedicine solutions to citizens.

NEXT ADOPTERS IN JADECARE

Digital innovations, if designed purposefully and implemented on the basis of cost-effective criteria, can contribute to improvements in the effectiveness, accessibility and resilience of health systems. They can provide tools to support the modernization of health and social care systems and their adaptation to the challenges mentioned above. They can facilitate the implementation of new care models as part of health systems reforms, together with the related organizational changes in care delivery, financing modalities or workforce skills.[70]

eHealth is believed to have great potential to improve integrated care[71]. A digitalized information infrastructure that ensures timely and reliable sharing of clinical and other information can improve health outcomes and efficiency, and also create a repository of valuable data for researchers and system managers.

A recent study[72] comparing the digitization of healthcare systems in 14 EU Members States and three OECD countries, has demonstrated that the countries digitize their healthcare systems at very different speeds. Estonia and Denmark rank at the top of the index, whereas France and Germany trail behind. The top countries of the Index are leading in all three areas examined: policy activity and strategy, technical implementation and readiness and the actual use of data.

Enabling people to access, and interact with, their electronic medical record (EMR) is an important feature that can help people become more involved in their health and their care.[73] Most countries report a unique patient identifier is used within electronic health records.[74] One in eight EU residents (13%) made an appointment with a health care practitioner on line in 2016, up from one in twelve (8%) in 2012.

Many countries in Europe are already implementing EMRs in all health care settings, including primary care. In 2016, the proportion of primary care practices using an EMR was approximately 80% on average in 15 EU countries, although there are wide variations. While an EMR was used in all or nearly all primary care practices in Denmark, Estonia, Finland, Greece, Spain, Sweden and the United Kingdom, its use was much more limited in Croatia and Poland. In Denmark and the United Kingdom, the proportion of primary care practices using an EMR doubled between 2012 and 2016.[75]

Some countries report comprehensive record sharing within one “country-wide” system designed to support each patient having only one electronic health record. This is the case for example of Estonia, France, Greece, Latvia, and the United Kingdom (Northern Ireland). In these countries, plans call for patient records to be shared among physician offices and between physicians and hospitals regarding patient treatment, current medications, and laboratory tests and medical images. Some have already achieved this functionality, while others are progressing toward it. Other countries have EHR systems, but within it, some key aspects of record sharing are sub-national only (Spain). Croatia and Denmark report that some aspects of record sharing are comprehensive at the national level. [76]

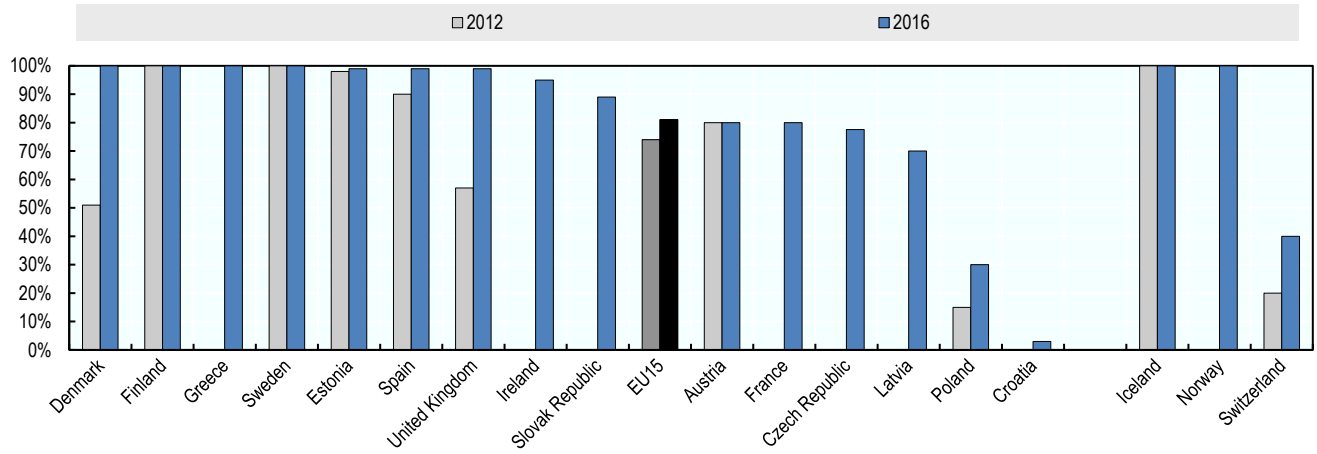

FIGURE 3 Percentage of primary care physician offices using electronic medical records, in 2012 and 2016. health at a glance: europe 2018

[70] Blueprint on the transformation of health and care in Europe. https://ec.europa.eu/digital-single-market/en/blueprint-digital-transformation-health-and-care-ageing-society

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[75]Health at a Glance: Europe 2018, OECD 2018 https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

[76] Oderkirk, J. (2017), "Readiness of electronic health record systems to contribute to national health information and research", OECD Health Working Papers, No. 99, OECD Publishing, Paris, https://doi.org/10.1787/9e296bf3-en.

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In most countries, the patients are able to see the information contained in their electronic record (the only exceptions being Croatia and the Czech Republic), and in some of these (Denmark, Estonia, France, Greece, Latvia and Spain), they are also able to interact with their record, for example to add or amend the information.[77]

The level of use of digital healthcare solutions and services is quite variable in the European Union[78]. The largest number of patients making an appointment with a practitioner via a web site can be found in Denmark, Spain and Finland. In 2016, in these countries, more than 35% of patients used the Internet to book a medical examination with a practitioner. In Germany, France and Italy, the percentage of patients fixing an appointment online was less than the EU average (16%), 12%, 11.9% and 10%, respectively as can be seen in the following figure:

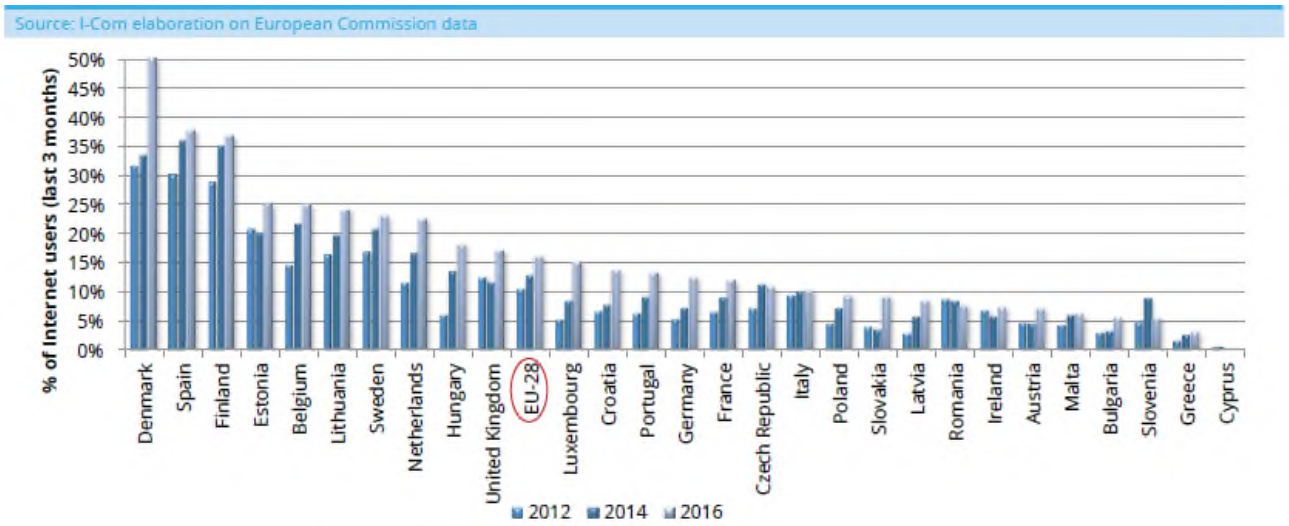

FIGURE 4 TREND IN INTERNET USE IN EUROPE: Source: Institute For Competitiveness 2017

The level of preparedness for e-health and digital healthcare in Europe varies[79]. The figure below refers to an index based on the dimensions, internet use in the healthcare sector, infrastructure development and security and privacy:

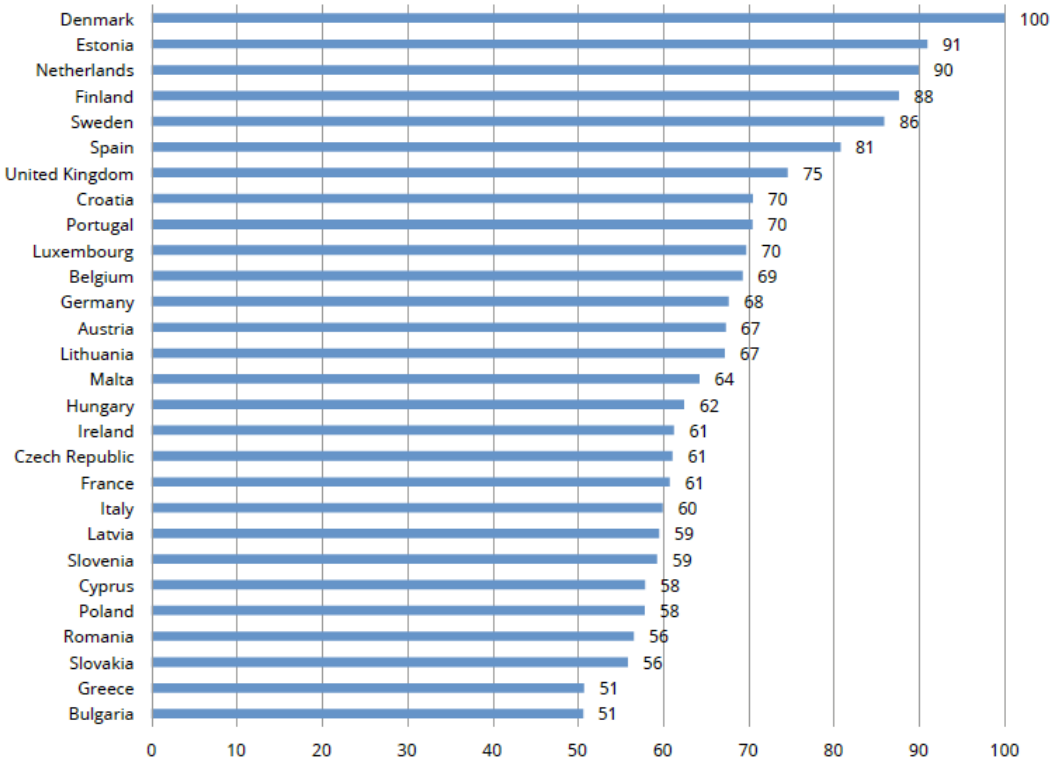

FIGURE 5 PREPAREDNESS FOR eHEALTH IN EUROPE: I-COM INDEX. Source: Institute For Competitiveness 2017

[77] Oderkirk, J. (2017), "Readiness of electronic health record systems to contribute to national health information and research", OECD Health Working Papers, No. 99, OECD Publishing, Paris, https://doi.org/10.1787/9e296bf3-en.
[78] EU STUDY 6.117 Digital Health
[79] I-com. DIGITAL HEALTH The impact of Big Data & AI on EU healthcare systems https://www.i-com.it/wp-content/uploads/2017/12/Studio-Digital-Health.pdf

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Most countries are transitioning from paper-based prescriptions to ePrescribing, but the implementation of ePrescribing varies greatly across the EU. In 2018, over 90% of prescriptions were transmitted to community pharmacies electronically in Estonia, Denmark, Portugal and Spain. However, ePrescribing has not been implemented in several countries (such as France or Germany), these countries have stated that they plan to start implementing ePrescribing at the regional or national levels over the next few years.[80]

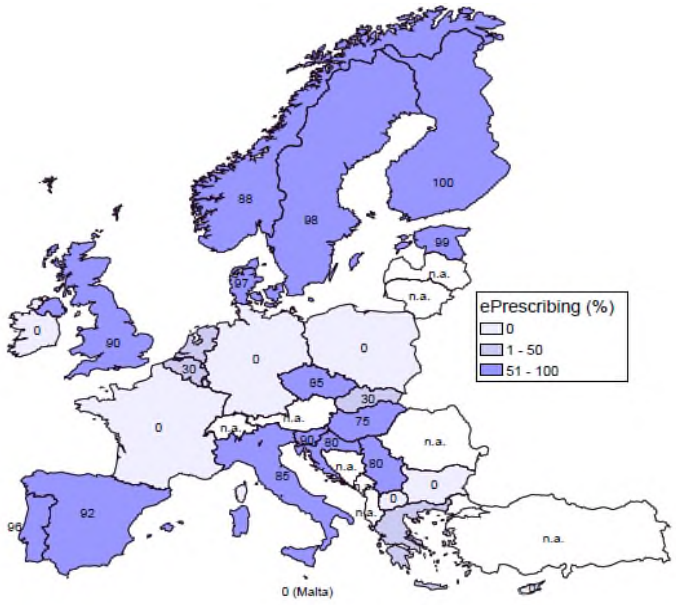

FIGURE 6 Percentage OF ePrescriptions in community pharmacies*2018. Health At A Glance: Europe 2018 - OECD 2018*

According to a survey among the relevant stakeholders in Europe, funding is perceived as the major challenge in eHealth development. Interoperability and workforce concerns are ranked as the number two and number-three challenge. Clearly, for health authorities, tackling interoperability is the main challenge. Healthcare providers arealso concerned about a lack of sufficiently skilled employees and comliance with IT security requirements. eHealth priorities differ by country/region: EMR implementations are a top priority in Germany (54%) and the United Kingdom (37%), while they are of lower priority in more EMR-mature countries like Italy (23%) and Spain (12%). In countries where healthcare providers are typically more digitally mature, the patient is already receiving increasing attention from eHealth professionals.[81]

The table below presents a brief description of the situation in the next adopters´ countries (different sources[82])

TABLE 4. DIGITAL HEALTCARE SOLUTIONS IN JADECARE'S NEXT ADOPTERS´

Country	Digital healthcare solutions
Bosnia and Herzegovina (Bismarck)	In 2014, T-Systems Hungary with its partner from the Federation of Bosnia and Herzegovina (FBiH), Medit was commissioned by the Health Insurance Institutes of three FBiH cantons to implement the second phase of the implementation of a uniform integrated healthcare system for all healthcare facilities of three FBiH cantons: Tuzla; Zenicko-Dobojski and Unsko-Sanski cantons. Within the project, T-Systems delivers hospital information systems and other related medical software, as well as hardware through its local partner and supports its maintenance. A further extension of the current licenses in Tuzla, Zenicko-Dobojski and Unsko-Sanski cantons and Sarajevo is foreseen in the very near future. Based on the services provided by T-Systems Hungary there is a cloud-based, unified information systems on cantonal level. This system supports secure access to health data and radiology images for healthcare providers of various levels and for the patients themselves. The system provides the basis for the local eReceipt, eCard and eDoctor system. Going beyond the cantonal system, the aim of the project is to create a unified integrated eHealth system on a federal level. As the interconnection of the deployed information systems are guaranteed, the new system works as a regional EHR system, open to further developments and creates a stable base for a country-wide EHR system.

[80] Health at a Glance: Europe 2018, OECD 2018 https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf
[81] Annual European eHealth Survey 2019 https://europe.himssanalytics.org/sites/himssanalytics_europe/files/eHealth%20TRENDBAROMETER%20-%20HIMSS%20Analytics%20Annual%20European%20eHealth%20Survey%202019.pdf
[82] SmartHealthSystems International comparison of digital strategies. BertemsmannStiftung, https://www.bertelsmann-stiftung.de/fileadmin/files/Projekte/Der_digitale_Patient/VV_SHS-Studie_EN.pdf eHealth – Future Digital Health in the EU https://www.espon.eu/sites/default/files/attachments/Final%20report.%202019%2003%2025_final%20version_0.pdf , Country Health Profiles http://www.euro.who.int/en/about-us/partners/observatory

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Country	Digital healthcare solutions
	The National Health Policy Strategy Plan priorities in the Federation of BiH are: ▪ Strengthening themechanisms to bolster efficient and informed health management ▪ Aligning legislative framework with reform objectives and European Union regulations ▪ Strengthening the protection of patient and provider rights ▪ Improving management of the health system ▪ Strengthening primary health care focusing on health promotion and prevention ▪ Strengthening public health functions ▪ Improving human resources for health ▪ Bolstering the pharmaceutical sector's ability to ensure access to safe, quality, and cost-effective drugs ▪ Improving health information systems and technology management ▪ Improving health contracting, procurement, and payment ▪ Increasing health insurance coverage In 2019, Health Insurance Fund of the Republic of Srpska signed a contract with a consortium (MMS Code Banja Luka, Lanaco Banja Luka, Ericsson Nikola Tesla Zagreb) to develop integrated health care information system for all health care institutions in Republic of Srpska (55 primary health care centers, 14 general and specialized hospitals and university clinical hospital). The integrated health care system's cornerstone is establishment of the central component with electronic medical record and electronic medical digest for each citizen of Republic of Srpska. Each facility (70+) gets access to information system assets and data via web applications and web services. The system establishes automated communication between several data repositories to minimize repeated data entry and prevent errors. E-prescription and e-receipt are again functional (after initial partial implementation in period 2009 – 2014). Two data centers were established (primary and backup location) and fully equipped (servers, storage, etc.) in Banja Luka and Bijeljina; new communication equipment and 3000 workstations are procured for health care institutions, to replace aging and obsolete equipment. The system development is finished and now is in testing phase. This system is to replace information systems in primary health care centers that is operational in all facilities since 2009.
Croatia (Bismarck)	Development of eHealth solutions is still one of the national priorities Central Health Care Information System in Croatia (CEZIH) with more than 17,000 users and a large number of information systems makes a good basis for informatization of the entire health care system in Croatia. All participants in the system send data into the central database in real time and receive advanced reports on operation of the health care system from that database. In fact, there is a: ▪ Well-established nation-wide ePrescription system established in 2011. Complete national coverage was achieved, and a significant step was made towards "paperless office". Over 50 million of e-prescriptions are issued. Over 50 million of e-prescriptions are issued through CEZIH system each year. ▪ Well-established nation-wide eHealth Records system (EHR) on the level of primary care with implemented software for: preventive activities for chronic diseases - diabetes mellitus, hypertension, COPD and obesity; rational therapy prescribing for the elderly – „chronic patient panels". A large number of health reports are still produced by manual data processing. ▪ Some secondary health care services included - eLab, eAppointment system In Croatia, telemedicine service, i.e. medical services provided from a distance through information and communication technologies, are currently provided at the primary, secondary and tertiary level of health care.
Czech Republic (Bismarck)	The government established a National eHealth strategy of the Czech Republic 2016-2020. The main objective of the program "Health 2020" is to improve state of health of the population and to reduce the incidence of illnesses and premature death. Another objective is the stabilization of disease prevention, starting up effective cooperation mechanisms between the various departments which will work in the long-term. As a general summary of the measures, the National Strategy for Health 2020 is further elaborated in various implementation documents (action plans) established in accordance with sixteen set themes of protecting and promoting public health and disease prevention, state of health of the population of the Czech Republic and other topics of public health and health care organizations. One of the themes and at the same time a separate action plan is the Action Plan no. 11 Computerisation of Health which formulates four strategic objectives: 1) Increasing citizen involvement in the care of their own health, prevention. 2) Increasing the efficiency of the healthcare system. 3) Increasing the quality and accessibility of health services. 4) Creation and development of information infrastructure and electronic healthcare management. e-Prescription has already been implemented nationwide (used by oved 90% MDs in March 2020) and infrastructure for access and viewing of the patient´s medication record is being built so that it should be possible to use it gradually from June 2020.

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Country	Digital healthcare solutions
	On 1 January 2020, the Ministry of Labour and Social Affairs and the Czech Social Security Administration (CSSA) launched an electronic sick note system. COVID-19 crises in 2020 has led not only to introduction of some nation-wide specific services (such as Smart Quarantine) but also catalysed and speed up preparation of organizational framework and introduction of digital services supporting distant care and communication between patients and healthcare providers (incl. teleconsultations). Further steps in digitalization of healthcare in the Czech Republic has been outlined in Strategic Framework "Health 2030", endorsed by MoH in 2019.
Denmark (*Beveridge)*	With over 20 years of experience in the field of digital health, the Danish company MedCom has been responsible for the development and distribution of electronic means of communication in healthcare since 1994. It plays a central role in the intersectoral communication of individual health services. Another driving force is the National Board of eHealth, which has the objective of building national ICT infrastructure and continuously developing it. It also establishes the required standards for the interoperability of the various regional systems that are used in most physicians' practices and in many hospitals. As the hospitals rely mainly on regional or local systems that cannot always communicate with the EHRs in physicians' practices, a national medication database was implemented, the Shared Medication Record. This provides information on patients' current medication and their vaccination status. The final cornerstone of the Danish digital health system is the health information portal sundhed.dk. Since 2004, the Ministry of Health, the regions (in their capacity as major financial stakeholders), and the municipalities have run this portal, kept it up-to-date, and have used it to bring together the aforementioned databases. There are also a number of additional services, e.g. a national ePrescription server. This allows the electronic transfer of prescriptions as well as their cancellation by the treating physician. The Danish Digital Health Strategy is aligned with two further overarching framework plans: the digitalization strategy of the Danish public sector (Digital Strategy 2016-2020), and the Citizen and Patient Involvement Strategy. Together these form the foundation for the far-reaching, comprehensive digitalization of Danish society, simplified access to various public services, as well as a cost-efficient, user-friendly and secure healthcare system. The national Digital Health Strategy, which has been formulated as a guideline for the healthcare sector, does not mention health IT directly. However, it does refer specifically to the national digitalization strategy, ensuring that these two strategies are very well coordinated with each other. This probably indicates that, from a Danish perspective, digitalization is a means rather than an end in itself. The central access point for all public digital services is NemLog-in, which is integrated with sundhed.dk, among other services. This was developed in 2007, as part of a joint project involving counties, municipalities, and the central government, in order to provide the public with access to a wide array of digital applications. It represents one of the measures that was taken in the course of Denmark's digital development and was stipulated in the former digital strategy. All of Denmark's citizens can be authenticated with their NemID and receive secure access to their health data. Physicians also have a healthcare professional ID, which they need to use to access patient data. All care sectors of the Danish healthcare system are 100 percent digitized and connected to the data network of MedCom
Estonia (Bismarck)	Estonia is a leader for eHealth solutions in Europe. With its X-Road infrastructure, which enables secure data exchange between all actors in the healthcare system (and the entire public sector), Estonia is one of the most digitally advanced countries in Europe. The Estonian National Health Information System (ENHIS)20 is the core of Estonian eHealth, being operative since 1 September 2008. It is a national central electronic database for processing health records of all patients receiving healthcare services from any Estonian healthcare service provider. All officially recognized healthcare service providers must by law upload their patients' EHRs on the ENHIS and patients can view all of their EHRs stored on the ENHIS on the patient platform "My E-Health". The identification of the patient takes place by logging in with an electronic national identification card or through mobile phone-based identification (mobile-ID). Any Estonian healthcare professional can access ENHIS data for any patient (only for the purpose of providing healthcare services) if the healthcare service provider that employs the healthcare professional has a valid Estonian activity license or can be denied access if a particular patient has prohibited access to his or her ENHIS data. The e-Prescription model is very advanced in Estonia. https://e-estonia.com/solutions/healthcare/e-prescription
France (Bismarck)	In 2004, the French government laid the legislative cornerstone for the development of an electronic health record – the Dossier médical personnel (DMP). The goal: unrestricted web access to patient data at any time, from any location. A government agency, ASIP Santé, led the program and was monitored by information security authorities. The agency for the modernization of the information system infrastructure in hospitals coordinated adjustments to individual applications to make them DMP-ready. France's first strategy for the digitalization of the healthcare sector was released in 2016 and focused on selected services for the support of healthcare provision, and above all improvements in cost effectiveness

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Country	Digital healthcare solutions
	and decision-making for physicians using big data and telemedicine services. Digital health is regarded as an integrated component of general healthcare rather than just an "add-on." The legislation passed in this context creates the necessary framework for the regions, who decide for themselves which type of services and solutions they wish to implement locally. At the national level, digital health is not driven by political parties or particular individuals. The regions assume responsibility for incremental piloting and project evaluations. Implementation plans and corresponding schedules were by the government for the reintroduction of the DMP in 2016, the introduction of regional ePrescriptions and telemedicine services, and for the expansion of the French health information portal santé.fr, but not for an interoperability strategy. While the ASIP Santé is responsible for the establishment and dissemination of the interoperability framework, it still remains largely incomplete. No standards have yet been completely enforced, and there is no defined timeframe for mandatory rollout. While some healthcare facilities have introduced certain guidelines and standards related to documentation of clinical data, implementation lags a long way behind. Fewer than 25 percent of all physicians in the outpatient and inpatient care sectors structure their clinical notes in a standard way using prescribed terminology guidelines
Germany (Bismarck)	Since 2010 as part of its eHealth initiative, the Federal Ministry of Health has held regular meetings with a number of stakeholders to identify and address implementation hurdles to digital applications such as telemedicine. At these meetings, the government and stakeholders have developed various measures designed to reduce these barriers. The stakeholders generally include all self-governing bodies involved with providing standard healthcare as well as the major associations representing companies that provide ICT and IT solutions for the healthcare sector. The most significant outcomes of these meetings include a national telemedicine portal, a list of criteria for projects addressing the future of eHealth and a planning report on interoperability. The key elements of this report are reflected in Germany's eHealth Act. There are no comprehensive, binding targets, guidelines or deadlines for a digital healthcare system as a whole. But the eHealth Act does regulate specific applications individually. Although there are legislative plans for the National Association of Statutory Health Insurance Funds to take on financial responsibility for the digitalization of Germany's healthcare system, the government has not allocated for a digital health budget or established a dedicated digitalization authority. gematik's mandate is limited to developing the telematics infrastructure and the electronic patient card. The German healthcare system features electronic documentation across all sectors. However, there is no national framework underpinning the exchange of data; instead, this takes place mostly through separate and individual networks (e.g., KV's Safenet). Electronic records and their content remain for the most part stored within a specific institution and are not shared with third parties. In 2020, the Digital Supply Act (DVG) facilitates a range of innovations to improve the German health system. • Extended doctor-on-call service: As of January 2, 2020, the medical on-call service (Ärztliche Bereitschaftdienst) is now available round the clock, offering callers medical assistance or emergency doctors' appointments. • Apps by prescription: For the first time ever this year, doctors in Germany will be able to prescribe health-orientated apps to their patients. Any costs incurred will be reimbursed by statutory health insurance. The Federal Institute for Drugs and Medical Devices will check the quality and safety of the applications; the developers then have one year to prove that their app improves the quality of care. • Online doctor consultations: The DVG promotes the use of online consultations. Doctors will be allowed to actively promote digital consultations on their websites (before they were only allowed to discuss them in private conversations). • Digital prescriptions: In order to reduce paperwork in the healthcare system, the "pink paper prescription" will be gradually replaced with an electronic variant. • Digital sick notes: The paper certificate that must be issued in triplicate by doctors whose patients wish to take sick leave, is set to be replaced by a digital version from 2021. • Electronic patient records: From 2021, all state-insured patients will be able to receive a digital copy of their medical records from their insurer, if they wish. The file will include observations, diagnoses, vaccination histories and doctor's letters. The patient then has the power to decide which information should be kept in the file, and what they want to delete.
Greece (Bismarck)	Healthcare in Greece is provided by the national health system (NHS). It consists of a universal health care system provided through national health insurance, and private health care. During the past few years, a multitude of eHealth services has been introduced, in line with European Union (EU) priorities, to control costs and improve services in a secure manner. These include ePrescription and eReferral for primary care, eConfirmation for insurance status verification, eReimbursement, eAppointment for booking doctors' appointments for primary care, and a business intelligence system (Bi-Health) that automates online retrieval of operational data for the Hellenic Ministry of Health (MoH).

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Country	Digital healthcare solutions
	Despite the fact that significant progress has been made to effectively link hospitals, regional health systems, and primary care, still no uniform access to a patient's EHR is available. This is because information systems were set up in the public health sector independently of each other and not in a coordinated way. Notwithstanding the positive effects of the introduction and use of the electronic medical record (EMR) in medical practices, and the benefits obtained, considerable barriers still exist to EHR information exchange. The level of digitization of EMRs in the Greek NHS is not recorded in a systematic manner, and progress made is not reported accurately. This is besides the increasing efforts made in the recent years to establish new information infrastructures for eHealth in Greece aiming towards improving healthcare efficiency and overcoming existing communication barriers[83].
Hungary (Bismarck)	The Hungarian national eHealth platform (EESZT) electronically stores information about the patients, connects all the Hungarian healthcare providers (such as hospitals, pharmacies, general practitioners) making it easier for physicians working in different institutions to access all important health information about the patient. Medical documents, related to all the treatments a patient has received, shall be sent to the system, building up a complete patient case history. EESZT is integrated with existing systems, therefore clinicians, GPs and pharmacists can use their own health information systems (HIS). By using EESZT the physicians can rely on a detailed picture of the patient, which allows for more precise medical decisions, greatly enhancing patient safety. On the other hand, the availability of previous diagnostic results greatly reduces the number of repeated diagnostic procedures. On September 1st, 2017 the possibility to join EESZT was opened for all the Hungarian healthcare providers. By November 1st, 2017 every healthcare provider of the Hungarian public health system was obliged by law to provide the data they generate about each patient to the EESZT. The general public can also benefit from the developments through a specific portal: eeszt.gov.hu. Citizens are able to access all their medical records through the so-called "government gateway" or "Client Gate", which is the official central electronic administration web service of the country. The portal allows citizens to view their medical record, electronic prescriptions, health care encounters etc. In order to protect sensitive medical data, the portal allows citizens to grant and restrict access to health professionals and to review the access log to their data. The development of EESZT is an ongoing process, new services and processes are in process and will be finished by the end of 2020.
Italy (*Beveridge)*	In Italy, a joint committee made up of representatives of the Health Ministry and the individual regions is responsible for the introduction and monitoring of electronic healthcare services through the National Health Information Network (NSIS). The first step in this direction came in 2004 with the inception of a common digital health policy and corresponding definition of digital health architecture. After a 2008 government evaluation revealed major disparities in regional distribution of appointment booking systems and electronic health records, by 2012 a number of laws were passed and amended to introduce digital health services nationwide. Since 2015, for instance, every healthcare organization has to provide electronic health records that are configured according to certain national guidelines. Since 2010 the law has regulated the electronic transmission of certificates of incapacity to the National Institute for Social Security and employers, for instance, as well as the use of ePrescriptions. Here there are two different infrastructures available: a national and a regional gateway. One major objective of the Italian digitalization strategy within the healthcare sector is to reduce paper documentation. Italy currently has an overall healthcare strategy in which the state of digitalization in the healthcare system is a key topic. Since 2008, digital health has been a focus for future developments in the country's healthcare sector and is listed as one of the priority areas of the national "Strategy for Digital Growth / Development 2014-2020." The healthcare system is established at various levels. The Ministry of Health is responsible for the development and implementation of new national strategies for healthcare, while direct service provision falls to the various regions. With respect to the differences between the regions, there is also a range in the scope of digital (health) services that have been made available in recent years. Of Italy's 20 regions, only five have not yet introduced centralized regions electronic health records. While development of Italy's digital health system is limited at the national level, it is well advanced in some regions. There are regional EHR systems that collect information on the health of patients – seven regions have implemented this, a further ten are still in the pilot phase and four regions do not yet have mature systems (as at 2017). However, these EHRs are subject to regional limitations in terms of data exchange. Currently there are government efforts to merge the regional databases into one uniform national EHR.
Latvia (*Beveridge)*	One of the main objectives of the NHS is to implement the e-Health program according to the policy decided by the State (now carrying several co-funded projects by ERDF (European Regional Development Fund): electronic health record; e-booking; e-prescription etc.

[83] Towards the Development of a National eHealth Interoperability Framework to Address Public Health Challenges in Greece

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Country	Digital healthcare solutions
	E-health is a health program for more efficient use of information and communication technology tools. The main objectives of e-health development are to: improve health, promote individual control of their health; reduce wasted time spend on patients contacts with medical institutions; increase the effectiveness of the health care, providing health care specialists with a quick access to necessary patient health data; reduce the amount of information that health care specialists need to enter into the documents; increase the amount and usability of a structured information; increase effectiveness of medical institutions; increase health care data reliability and security. From 1 January 2018 the sick-leave certificates and prescriptions for state compensated medicines will be only issued electronically. E-health in Latvia today: Patients can easily access care records using state e-services' portal (authenticated with ibank information, electronic signature). These e-services are: "My state paid healthcare services"; "My general practitioner"; "My newborn children data"; "My data within the diabetes mellitus patients' register". E-health solution architecture. E-health solution architecture is developed as modular system, which consists of three layers: The first layer - for business users, who integrate with systems using their business systems; The second layer - is our system which includes all core models; The third layer - is national e-governance infrastructure for data exchange with registries. The recording of the medical information about the resident will start at the moment when the medical institution or physician visited has started work (data entry) on E-health. Thus, part of the medical information will be available to the resident only in time, as the medical institutions and doctors become more active users of the E-health system.
Lithuania (Bismarck)	In Lithuania national digital health strategy and development is coordinated by the Ministry of Health. National health ICT services are funded by state budget and available investment programs. National Healthcare Insurance Fund finances healthcare services and allows ICT development at regional level. Lithuanian national digital health platform ESPBI was launched in 2016 after development stage in 2009-2015. Main objective was to create one national health record for the patient and involve health care professionals in digital health services. National platform ensures storage and exchange of EHR, ePrescription and medical images. Simultaneously, during 2009-2015 several other national components were developed: registers of licenses of health care professionals and health care institutions, register of medicines and other, online appointment booking system for outpatient consultations and other. Health care institutions developed hospital information systems which are integrated with national digital health platform. It resulted in full access and management at national level of these EHR records: referrals, discharge letters, visit descriptions, prescriptions, birth and death certificates and other. National digital health service covers 100% of insured patients, 100% pharmacies and almost 100% healthcare institutions. Access to national digital platform is ensured via electronic identification of health care specialists and patients. Further development of Lithuanian digital health system is planned with implementation of country wide digital health services: mobile application for patients, mobile application for nurses delivering home care, teleconsultation services, further integration of appointment booking system with patient EHR and referrals, exchange of digital health records.
Portugal (*Beveridge)*	One of the goals of Portugal's 18th government was that every citizen would have an electronic health record (EHR) by 2012, and that it would be accessible in electronic form. In December 2009 the Health Ministry established the Digital Health Agency (Serviços Partilhados do Ministério da Saúde, or SPMS), a public body tasked with the provision of "shared" or networked electronic services in all facilities of the national healthcare service. Its role in Portugal is to drive the distribution and development of digital healthcare services. The National Commission for Clinical Information Technology (Comissão para a Informatização Clinica) was established in 2011 to develop and roll out a national health information platform and a summary document containing clinical data, or clinical patient summary (Resumo Clinico Único do Utente, or RCU2). These goals were reached in 2012. Portugal's national digital health strategy, the 2016 National Strategy for the Health Information Ecosystem 2020 (ENESIS 2020), aims primarily at improving the cost effectiveness of the entire healthcare system through digital solutions. A further goal is a combined strategy for meeting overall health policy objectives with the help of centralized digital solutions. As Portugal is administered centrally, authority in the healthcare sector is not delegated to the regions. Although to date there has been no nationwide, unified, legislation with precisely calibrated impact with a view to the opportunities and risks of big data in the healthcare sector, the rollout of a national network for exchange of health information is supported strategically and conceptually by the ministry and the SPMS. It bears responsibility for telemedicine services and applications, mHealth and the Portuguese Platform for Health Data. Portugal has taken part in international data exchange projects in the past and has created national framework conditions to enable exchange of patient data with other EU countries, particularly the patient summary, under the umbrella of epSOS
Serbia (Bismarck)	Serbia has benefited from several projects aligned towards the development of a national foundation for eHealth. A community assistance for reconstruction, development and stabilization project, called

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Country	Digital healthcare solutions
	"Development of HIS for basic health and pharmaceutical services", initiated the development of electronic health records for Serbia. This was furthered by the Ministry of Health's Serbia Health project, which also developed a database of health resources and classifications and realized HIS in four hospitals. Next, a hospital information system project focused on standardization and expansion of the infrastructure. This project integrated data delivery in health care and extended the HIS to another 10 hospitals, covering the health care needs of 30% of the population and moving towards a national HIS. Serbia has also established an eHealth Unit in the Ministry of Health and amended the Law on Health Care and Health Care Insurance Act.
Slovenia (Bismarck)	The operation and the functions of eHealth solutions are regulated by the special 'Healthcare Data Records Act' – HDRA since 2000. This act covers the collection, processing, archiving and usage of data and database management in the entire field of healthcare in Slovenia, including all eHealth services, relevant stakeholders and beneficiaries. Management of eHealth ICT infrastructure in Slovenia is centralized on the national level and managed by the two institutions – Health Insurance Institute of Slovenia (ZZZS) and the National Institute of Public Health (NIJZ). The primary eHealth platform in Slovenia is z-Vem which serves as the access point for both the electronic health records (EHR) and patient health records (PHR). The eHealth architecture is designed around z-Vem platform which connects healthcare providers and users, incorporates Central Repository of Patient Data (CRPD) with EHR and PHR and allows data exchange via dedicated network zNet. All healthcare service providers are obliged to send relevant data to CRPD. In addition to this 'national' infrastructure, all hospitals have for their own internal business and professional needs, their own ICT solutions and related infrastructure, which is not yet fully integrated into the national eHealth system. Patients can access their own data via digital certificate. Medical personnel have access to these data via their own professional health eID card restricted according to their privileges. The eHealth solution landscape is by large the result of the implementation of the National eHealth Project launched in 2005 and successfully finalized in 2018. NHP has been focusing on the infrastructure, solutions and services, consolidating the fragmented digitization efforts developed by individual institutions, which represent the backbone of the national eHealth information system in Slovenia. All solutions and services that were developed on a national level, are now available for the whole state and accessible to all healthcare service providers in the country (of which some, i.e. ePrescriptions, are mandatory for healthcare providers).
Spain (*Beveridge)*	The federal, decentralized structure of Spain's healthcare system means that any form of national initiative requires agreement between the central government and the regions within the forum of the Interterritorial Council of the Spanish National Health Service (Consejo Inter-territorial del Sistema Nacional de Salud, CISNS). The need for a minimum electronic dataset of health-related data to be used and exchanged throughout the regions was recognized as early as 2002. However, this idea was only decided upon in 2010, and even then, it was non-binding. Since 2015, there has been no uniform national strategy for the digital health sector, which has fallen victim to ongoing economic and government crises. The Digital Agenda for Europe 2015-2020 has served as a guideline for further development since that time. The decentralized system and the number of participating actors has hampered efficient implementation. While 77 percent of all Spaniards have an electronic medical record, usage is effectively restricted to their region of residence. This also restricts usage of the electronic health record, which remains unable to share its information with other regions. Attempts to make the system interoperable date back to 2009. Spain's digital healthcare strategy is not chiefly focused on developing and improving the digital healthcare service in its current state. There have been successful efforts toward digitalization and implementation of digital services in the healthcare sector at the regional level. Patient data management services have a high degree of digital functionality with respect to data protection, security and processing, but under present conditions there is no facility for individual patients to determine who can and cannot access their personal data. Spain is currently in the midst of increased national efforts to have the regions assume responsibility for adopting international standards of health IT in relation to the coding, storage and use of data. Corresponding standards are applied in all regions, although not to the same extent. Each of the Spanish regions has an electronic health record from which a legally defined minimum dataset is automatically extracted in the form of the Historia Clínica Digital Sistema Nacional de Salud, a patient summary that can be exchanged nationally. The EHR systems can interact with national health registries for the coordination of healthcare for chronic diseases, for instance. Catalonia, Andalusia, the Basque Country and Valencia are particular pioneers in this field.

Political leadership in digitization does not imply just the top-down ordering of the measures to be applied. Good health policy means providing a clear framework that fosters acceptance and drives developments. Centralized forms of digital health implementation are found only in a few countries. Regionally organized healthcare systems are often

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most effective in integrating digitization into routine care delivery. Digital strategies should be policy oriented to the needs and imperatives of the individual health systems – such as improving quality of care and services, increasing patient safety, or facilitating access to care in rural areas. To advance the digital transformation, it is best to focus first on the individual, well-prioritized services: Countries with a proven record in digitization target specific treatment pathways – such as diabetes – or focus on "simpler" processes such as introducing ePrescriptions or a nation-wide electronic emergency data record. In contrast, large-scale, all-encompassing programs tend to fail.
Co-design is an effective means of promoting user acceptance; resistance to the changes inflicted by digitalization is common in many countries. The physicians, in particular, often oppose such changes strongly. As a result, many countries have recognized that promoting acceptance is of strategic importance and that it requires using appropriate resources. JADECARE approach is based on the principle that digital processes and solutions should be tailored to the needs of users. They should be co-designed by end-users and key stakeholders alike, whose involvement should be integrated into the development process. This also applies to the formulation of digital strategies (e.g., through the inclusion of focus groups) and the conceptualization of products. Unnecessary planning failures and costs associated with a pure digital health technology push should be avoided.

The 23 next adopters in 15 Member States participating in JADECARE have expressed their interest in adopting specific features of one or more original GP regarding digitally enabled personalized integrated care. The summary of these interests is shown below (in green):

TABLE 5. NEXT ADOPTERS´ INTEREST IN ORIGINAL GOOD PRACTICES

Country	Next adopter	Basque Health strategy	Catalan open innovation hub	The OptiMedis model	Digital Roadmap – R. S. Denmark
Bosnia and Herzegovina	Institute for Public Health of the Federation of BH				
Bosnia and Herzegovina	Ministry of Health and Social Welfare -Republic Srpska				
Croatia	Croatian Health Insurance Fund				
Czech Republic	Univ. Hosp. Olomouc				
Denmark	The North Denmark Region				
Estonia	Viljandi Hospital				
France	Eurometropole de Strasbourg				
Greece	School of Medicine, Aristotle University of Thessaloniki				
Hungary	Jahn Ferenc South-Pest Hospital and Clinic				
Italy	Azienda Sanitaria Locale Napoli 2 Nord				
Italy	Lombardy Region				
Italy	Tuscany Regional Health Agency (ARS)				
Italy	Azienda USL Umbria 1				
Italy	Marche Region				
Latvia	Children`s Clinical University Hospital				
Lithuania	Ministry of Health				
Portugal	Central Administration of the Health System				
Serbia	Ministry of Health of Republic of Serbia				
Slovenia	Health Insurance Institute of Slovenia				
Spain	Consejería de Salud y Familias Junta de Andalucía				
Spain	Servicio Cántabro de Salud				

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Country	Next adopter	Basque Health strategy	Catalan open innovation hub	The OptiMedis model	Digital Roadmap – R. S. Denmark
Spain	Gerencia Regional de Salud de Castilla y León				
Spain	Servicio Murciano de Salud				

There is a possibility of **selecting different oGPs results in an scenario where some next adopters will work on only one oGPs, whereas others will deal with more than one(mix and match approach)**. Therefore, the JADECARE transfer strategy needs to consider both scenarios. The logic and the structure of the WPs are defined accordingly.

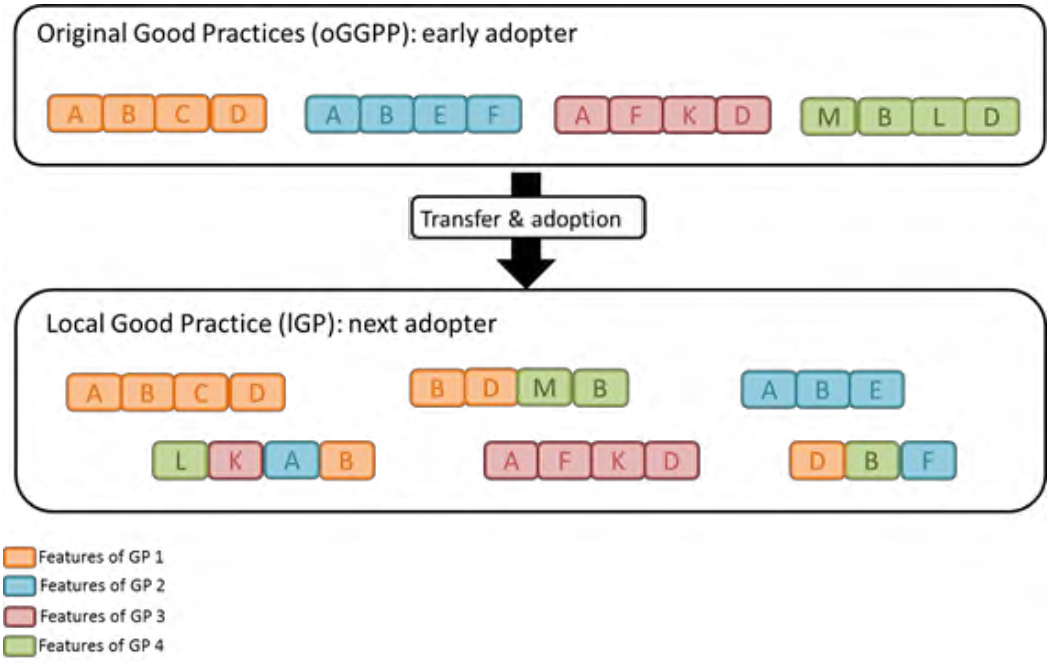

FIGURE 7. JADECARE TRANSFER STRATEGY

Next adopters do not only choose different transfer strategies but also present different levels of **maturity for deploying integrated care services and their ambitions and expectations** for to the local Practice implementation in JADECARE. Some next adopters might have not initiated integrated care deployment or only some first steps, while others might be half-way in the process or appear ready for a scale-up. Consequently next adopters, depending on their local resources and political support, they might commit to an increase in the implementation capabilities, to a small-scale or large-scale implementation during JADECARE. **Special attention will be paid to the contextual factors and establishing coherence when the blocks are taken from more than one oGPs**.

To evaluate the maturity of the next adopters for deploying digitally enabled integrated care and assess their ambitions, a survey was launched. The 23 next adopters completed the questionnaire, which allowed to map their aptitudes and potential for JADECARE project.

They were asked to perform a self-assessment of their maturity for deploying integrated care services (policies, strategies and guidelines; health system infrastructure; digital transformation including Electronic Health Record, personal health folder and electronic prescription; and training programs and research and innovation initiatives on integrated care). As it can be seen in the next figure, most of them had been involved in deploying integrated care: eleven adopters had taken initial steps, 6 were already in the half-way in the process and 5 were ready for a scale-up.

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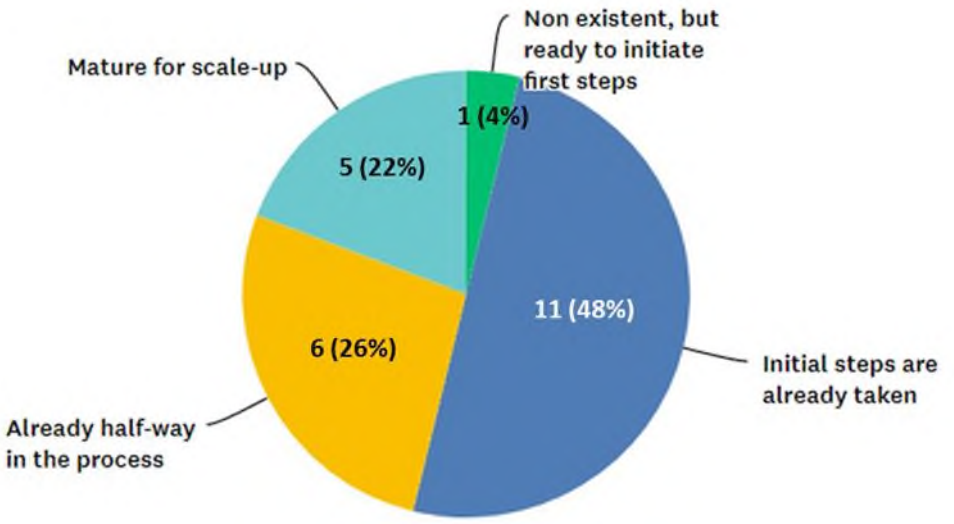

FIGURE 8. MATURITY OF NEXT ADOPTERS. INTEGRATED CARE DEPLOYMENT

The respondents showed a remarkably wide variety of areas of interests is remarkable among next adopters and ranges from change management, re-organization of care pathways and introduction of technologies into care services to citizen empowerment and new payment methods. **Most of the next adopters are willing to work on various dimensions in JADECARE**, having the use of technologies in care services (78%), use of patient reported data (65%) reorganization of care pathways (61%), workforce roles and skills with technology (52%) and citizen empowerment (57%) as the most prominent relevance. Fortunately the oGPs deal with these areas and their specific core features, which are the transferable elements, provide concrete solutions or strategies. Next adopters will select the core features of one or more oGPs in order to tackle with the challenges that these dimensions entail.

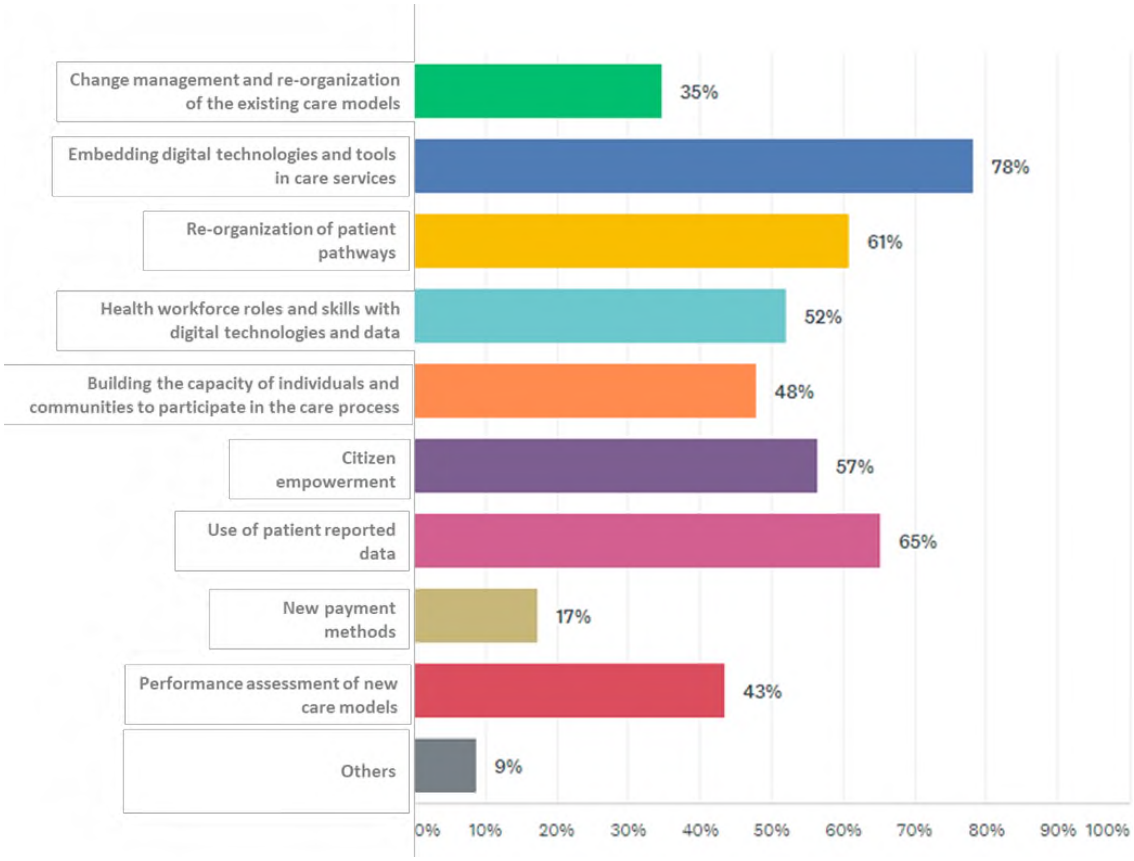

FIGURE 9. AREAS OF INTERESTS OF THE NEXT ADOPTERS

In terms of commitment and ambition for implementation during JADECARE, most of the next adopters **aim at small-scale implementation** (15), whereas others (7) are interested in increasing the capacity (knowledge, management development, plans etc.) of the design and successfully implementation of digitally enabled integrated person-centered care. Only one next adopter intends to scale-up interventions at the system level.

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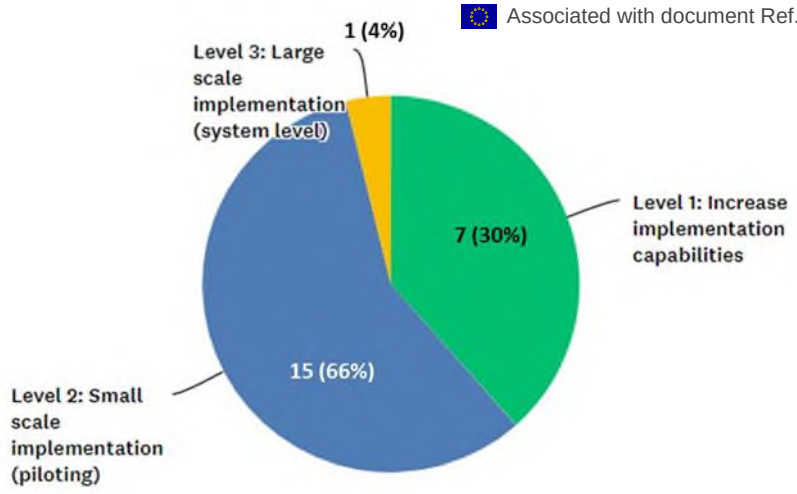

FIGURE 10. COMMITMENT AND AMBITION OF THE NEXT ADOPTERS

Thus, the JADECARE next adopters have estimated the size of the implementation on their site (Table 3). Table 3 presents the variety of implementation sizes and target populations, according to the type of approach (increased capabilities, small-scale or large-scale deployment). These figures must be seen as the first estimate. More than 50.000 people will be directed involved. A large number of professionals and healthcare centers are going to directly participate in JADECARE in the next adopters' projects. Moreover, well over five million people in the participating countries can potentially benefit from JADECARE. The exact numbers will be obtained once the first situation analysis and action plans in the next adopter regions are approved.

TABLE 6. SIZE OF IMPLEMENTATION OF JADECARE´

Country	Geographical area of GP implementation	Population directly involved	Target population after JADECARE	Health professionals involved	Healthcare organizations involved
Bosnia and Herzegovina	Bosansko-Podrinjski canton	2,533	25,336	Around 10% of staff: MD: 48; Primary Care Nurses: 169; Other health workers: 9	Health Centers: 2 Public health institute: 1
	Republic of Srpska	16,000	200,000	8 GPs from primary health care center 8 Nurses from primary health care center	One primary health care center directly involved in piloting Ministry of Health and Social Welfare in Government of Republic of Srpska as an adopter and lead for transformational practice
Croatia	Local, Capital city of Zagreb, Croatia	30-50 people will participate	10.000 patients in the region	20 (2-3 GP's,2-3 specialists in pneumology)	CIHF, CIPH, 3-4 general practices and 1-2 hospitals (total=7-10)
Czech Republic	Jeseník / Olomouc Region	2 000 – patients and other users	Population in Jeseník District is 38 000 (targeted for the pilot activity), Population is Olomouc Region has 633 000 in habitants (targeted for complex local Good Practice - lGP), 33% of the population has one or more chronic diseases (incl. cancer) and they are primary target of the	100 GPs 30 cardiologists 15 diabetologists 60 nurses 30 case managers	1 Jeseník Hospital - Jesenická nemocnice a.s. Internal medicine department – cardiology and diabetology 5 GP´s in Jeseník district 3 Primary care health centres in Olomouc Region 1 University Hospital Olomouc (UHO)

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Country	Geographical area of GP implementation	Population directly involved	Target population after JADECARE	Health professionals involved	Healthcare organizations involved
			lGP. Czech Republic has 10,65 million inhabitants (targeted by Strategic Framework “Health 2030”).		
Denmark	Regional	3,000	There were 320.000 cases of diabetes in Denmark in 2018.	2 endocrinologists 2 diabetes nurses	1 hospital
Estonia	Local-Regional	TBD	Viljandi county with 47087 inhabitants National coordination model, the potential target population is up to 1 328 000 people	3 specialist doctors	1 public hospital
France	local and will cover the rural area of Saverne (North of Strasbourg) and part of the city of Strasbourg.	1500	In the Region: Grand Est = 5,5 million inhabitants In the Country: 66,5 million inhabitants	Strasbourg: 1 paramedical coordinator, 1GP, 2 nurses, 2 psychologist, 1 dietician, 4 sport instructors specialized in adapted physical activity, 1 prevention coordinator. Saverne including 2 GPs, 1 patient education coordinator, 1 dietician, 1 sport instructor, 1 nurse, 1 sophrologist	University Hospital of Strasbourg Hospital of Saverne Regional Health Agency Local Health Insurance organization (Caisse Primaire d’Assurances Maladie)
Greece	The city of Thessaloniki. The "City of Thessaloniki" consists of six Municipalities and one Municipal Unit (from the Municipality of Pylea - Chortiatis), which constitute the Thessaloniki Planning Group (PCT)	TBD	Target population is the total number of habitants of the city of about 750.000 which are using the health care services. The total number of habitants in northern Greece that could benefit from the adoption of Good practice in the region of 4 the Health District is of 1.500.000 habitants and a large number of tourists mostly from Europe visiting the area during summer.	Hospital doctors (all specialties) 500 GPs 40 Hospital Managers 2 Nursing personnel 350	2 Hospitals in the City of Thessaloniki 2 Health Care Centers in the City of Thessaloniki
Hungary	20th district of Budapest, Budapest, Pest County, Central Hungary Region	TBD	20th district of Budapest (Pesterzsébet) 65.611 inhabitants 352.157 inhabitants, according to the participant hospital’s territorial supply obligation	3 psychiatrists 4 psychologists	1 public hospital 1 outpatient care center 32 GPs
Italy-Napoli	Local.	120 people	The population group represents 14.26% of the total population. The	n. 1 Medical Director n. 2 manager administrative	n. 13 primary care centres, n. 10 specialized ambulatory care

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Country	Geographical area of GP implementation	Population directly involved	Target population after JADECARE	Health professionals involved	Healthcare organizations involved
			elderly who are not self-sufficient represent 2.6% of the population over 65 years, equal to n. 5,923 people	n. 12 managers reference contact n. 4 researchers, technical staff	n. 5 Hospitals
Italy-Lombardia	Regional and Local (Local area not decided, yet)	The pilot cohort might be a specific cluster of the 300,000 citizens affected by long term chronic conditions and currently enrolled in the regional "Taking Care" Reform Program.	About one third of Lombardy population 10.060.000 citizens of which 2.333.780 65 and over, of which 1.810.000 are affected by long term chronic conditions The target population after JADECARE might be around 3.300.000 The target population during JADECARE Pilot will be defined with the selected Territorial Institution.	2-3 specialists, 2-3 case managers and some GP will be involved, coordinated by a regional board.	The specialized team will come from 1 public hospital involved in the regional "Taking Care" reform. GPs will be engaged on behalf of the local healthcare authority (ATS).
Italy-Toscana	Regional (PIanna di LUcaa and Lunigiana)	3000	The whole population of the north-west local health authority = 1.208.516 The whole population of Tuscany region = 3.496.478	Number of the GPS 65 Piana Di Lucca 39 Lunigiana Specialists TBD	-Functional Territorial Aggregation (FTA): Piana di lucca - 5 FTA Lunigiana = 2 FTA -public hospitals = -Piana di lucca = 1 Lunigiana = 2 Ambulatory care services =Piana di lucca = 61; Lunigiana = 53
Italy-Umbria	Regional -Health district "Media Valle del Tevere"	About 3.600 people (estimate: + 65 years old people of "TFA Marsciano" into Media Valle Tevere district with, at least, one chronic illness)	About 100.000 people (estimate: +65 years people of Umbria region with, at least, one chronic ill)	20 General practitioners 2 nurses case managers 1 primary care nurse 1 Medical doctor specialized in Public Health	1 FTA – Functional Territorial Aggregation composed by GPs who guarantee H24 assistance 7 days/7 1 "Casa della salute", a territorial services structure where are located GPs, Integrated home assistance service, a residential structure who guest old chronic patients and a specialized ambulatory care 1 COT – Territorial Operations Central which manages the discharges of frail/chronic patient from hospital to home

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Country	Geographical area of GP implementation	Population directly involved	Target population after JADECARE	Health professionals involved	Healthcare organizations involved
Italy-Marche	Regional and local	9.000	Total population of Marche region = 1.531.753	For the local area: a working group composed of about 50 professionals of different disciplines, such as GPs, nurses, physicians specialized in chronic diseases, informatics, clinical engineers, social workers, etc.	For the local area: about 25 healthcare organizations, such as primary care centers, community hospitals, ambulatories, nursing homes)
Latvia	National	TBD	359 000 children in Latvia;70 000 patients annually in Eblendncy department (Children's Hospital - CH). 17 000 patients are being treated in Inpatient units of CH;	700 physicians and 600 of nursing staff in CH	Children's Hospital, 3 regionals hospitals
Lithuania	Regional	600	628,748 at national level	60 (family physician, nurses, medical specialists, public health care specialist/life style medicine specialists, kinesitherapists /other health professionals).	6 (primary care centers, specialized ambulatory care, municipal public health buraus
Portugal	Local	TBD	1,2 million in the Area. 8,2 at national level	TBD around 10% of professionals	3 hospitals and 42 primary care centers
Serbia	Local – Belgrade	TBD	380,000 patients 75,000 over 65	Primary Healthcare centers: 2 with 20 ambulances 2 clinical centers	90 GPs in Primary Health Center- Novi Beograd 50 nurses - Primary Health Center- Novi Beograd 80 GPs in Primary Health Center-Zemun 50 nurses - Primary Health Center-Zemun 30 specialists Clinical Center Bezanijska Kosa 80 nurses Clinical Center Bezanijska Kosa 30 specialists Clinical Center Zemun 80 nurses Clinical Center Zemun
Slovenia	Regional	2.000 directly involved,	Whole population in the area 10.000. Between 100.000 and whole population (2 million)	10 GPs 15 specialists - doctors 15 nurses at GP 15 nurses at specialists 5 case managers at health care providers 10 other health care professions at health care centers (e.g. physiotherapist, kinesiologist, psychologist)	1 hospital 2 primary health care centers (primary care and specialized ambulatory care included) 2 private GPs included in public network

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Country	Geographical area of GP implementation	Population directly involved	Target population after JADECARE	Health professionals involved	Healthcare organizations involved
Spain-Andalusia	The region of Andalusia	500 patients	Of the total population, there are 3.106.921 chronic patients in Andalusia, (1.226.177 patients with 5 or more drugs and 381.952 are those with 10 or more drugs during at least 6 months).	75 Professionals in Primary Healthcare centers (Family physicians, pediatricians and nurses) and hospitals (specialists from different specialties).	Primary healthcare centers: 15 Hospitals: 5 Specialized ambulatory care: 5
Spain-Cantabria	Regional	1,000	550,000 potential targets	Approximately 250 health professionals will participate in the adoption of Good Practice with the role of primary care nurse, hospital nurse, physiotherapist, gp, and hospital specialist	Primary care centers: 5 Hospitals: 3
Spain-Castilla y Leon	Regional	TBD	Around 2% of total population, 2,319,857	TDB around 2% of Family doctor: 2,759 Primary Care Nurses : 2,613 Social health workers: 119	Around 2% of Health Centers: 247 Local Offices: 3,669 UCA (healthcare continuity units) in hospitals: 11
Spain-Murcia	Regional	TBD	Around 50,000 users out of total 1,400,000 users	8 GPs one per Health Center 8 Nurses one per Health Center 3 Physicians	Two of the nine Health Areas of the Murcia Region (including 8 primary care centers and 6 medical officers) Two Hospitals of reference one per Health Area.

JADECARE STRUCTURE

JADECARE consists of 8 work packages, the four core oGPs and other four focused on transversal activities (*WP1 Project coordination*, *WP2 Dissemination and communication*, *WP3 Evaluation* and *WP4 Sustainability*) (Figure 11).

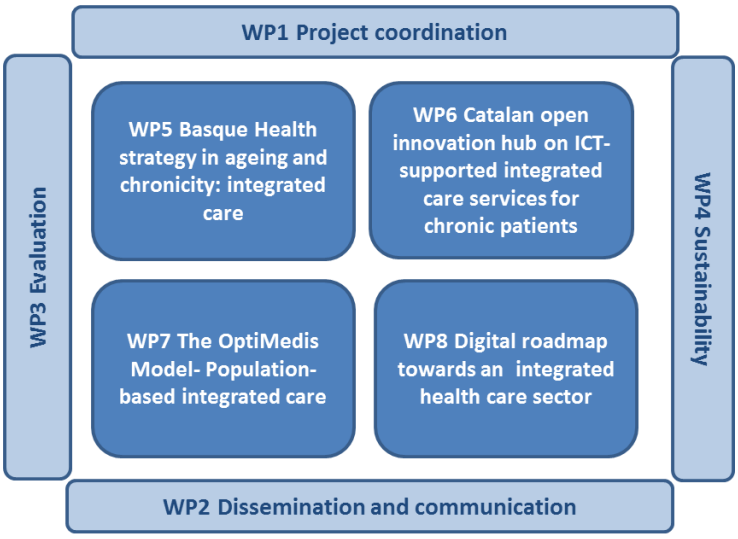

FIGURE 11 JADECARE PROJECT STRUCTURE

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JADECARE consortium consists of 17 CAs and 23 AEs. CAs call upon affiliated entities to implement action tasks described in the Joint Action, according to the Article 8 of the JADECARE Grant Agreement. AEs will implement actions and tasks according to the JADECARE Joint Action, as described in the Article 11.1 of the JADECARE Grant Agreement.

Coordination and implementation roles and activities in the Joint Action are performed by CAs (as Leading Beneficiaries (LB)), and AEs. AEs can act as Leading Executive Organisations (LEO) and Co-Leading Executive Organisations. CAs and AEs are responsible for Work Packages and/or Tasks and contribute to the Deliverables and Milestones as described in the JADECARE Joint Action.

JADECARE activities and outputs are consistent with the intended objectives, outputs and the overall impact of the Project. The structure of JADECARE supports the distinct transfer strategies, having next adopters only selecting features from one original GP or others being interested in more than one original GP. JADECARE devotes one work package for each oGP, from WP5 to WP8, which are named **transfer WPs** (tWP). If a given next adopter decides to choose features of distinct oGPs, they will participate in the corresponding tWPs. **The NAWGs are responsible for integrating the tasks performed in the different transfer WPs they are involved. They will have only one coherent Practice and implementation Action Plan**, **merging/consolidating the outputs of each of the transfer work Packages they are involved if they have a mixed match approach**. The coherent design and implementation of the final Practice and Action Plan will be supported, ensured and monitored. Transfer WPs are closely interconnected to tasks in *WP4 Sustainability*. It will facilitate, support and coordinate: (i) Knowledge exchange among early adopters and next adopters. (ii) Developing local Practices and Pilot Action Plans. In case of a mix-match approach, it will support putting together ("blending") the elements arisen from each of the Transfer work Packages involved. (iii) Synergies between transfer work packages and (iv) local good practice sustainability. Work Package 3, T3.2 will provide, support and monitor the implementation methodology.

Next adopters have an initial idea of the oGPs they are interested in (see section 5.1.5). However, it is at the beginning of the project (M1-M3) that the final selection of the core features of the oGPs to be implemented in each site will be made.

IMPLEMENTATION OF LOCAL GOOD PRACTICES

In JADECARE, a three-step implementation strategy (designed and tested in JA CHRODIS Plus) will be used by next adopters. It has been defined to be appropriate from the scientific point of view, applicable considering data availability and feasible according to project´s timeline and resources.
The three steps are:

- Pre-implementation phase: planning and preparation for the implementation (next adopters will deliver implementation action plans, that will include the vision of their future practice)
- Implementation phase: roll-out and operation (next adopters will provide inputs for regular monitoring and intermediary evaluation (for PDSA cycles) as well as the final evaluation)
- Post-implementation: impact assessment and learning (next adopters will deliver final implementation report, that will include sustainability strategy and action plan)

A set of methods and techniques will be used to enhance the adoption, implementation and sustainability of Practices. During the pre-implementation phase, three main activities will be carried out: (i) the scope definition, (ii) situation analysis and (iii) local Good Practice and Pilot Action Plan development. The scope definition implies next adopters to choose the final core features to implement, depending on their needs, expectations, strategic objectives, real possibilities and existing local interventions. Then, next adopters will analyze their context by performing a SWOT analysis related to the selected core feature(s) of the oGP. The SWOT analysis output will provide next adopters with a clear view of their improvement areas, priorities, scale, extent and strategic actions required for planning the implementation. Based on the situation analysis next adopters will describe their local Practice, which builds up on existing interventions plus the selected core features, and produce the Pilot Action Plans, the blueprint that outlines the implementation of the local GP. Core elements of sustainability will be addressed already in the pre-implementation phase and sustainability plans outlined.
As explained in the 5.2 section "JADECARE structure", if next adopters go for a "mix and match" approach, they will participate in more than one transfer WP. The activities performed within each transfer WP will be coordinated to avoid duplicities and overlapping. The next adopters will be in charge of ensuring that the work done in the different transfer WPs is aligned and tWP Leads and co-leaders will support them (Figure 7).

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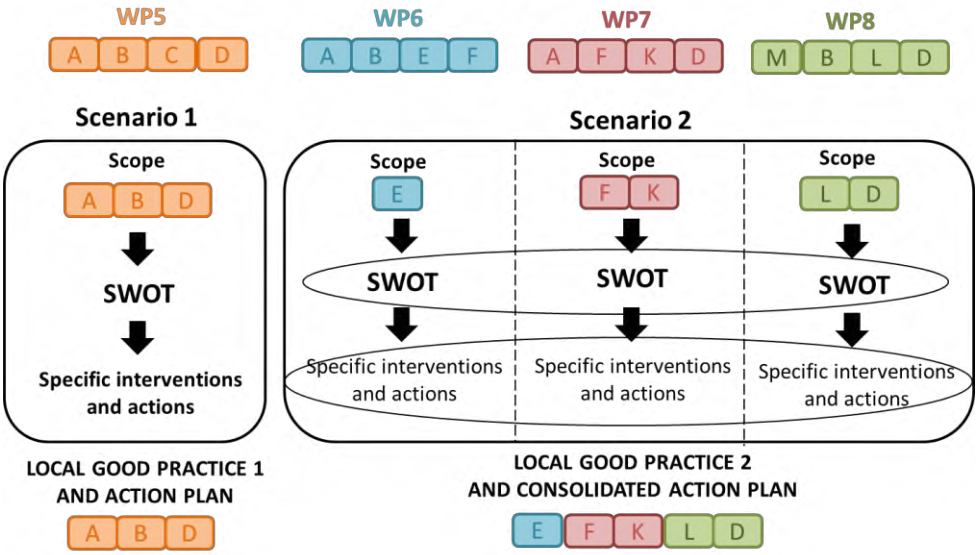

FIGURE 12 PRE-IMPLEMENTATION PHASE ACTIVITIES.

Implementation will start and specific interventions will roll out based on PDSA ("plan, do, study, act") cycle, structured collaborative procedures that intend to facilitate the implementation in real and system-level. PDSA cycles consist of:

- PLAN: Plan the actions defined in the Pilot Action Plan to test the changes. Detail actors (who), functions and roles (what), timeframe (when) and setting (where).
- DO: Test the action and once is finished, data are collected and any problem or unexpected observation is documented.
- STUDY: The data obtained during the DO phase are analyzed. The obtained results are compared to the predictions. Learning is summarized.
- ACT: Based on the lessons learned changes are refined. Modifications are determined. This improved change is then re-implemented in a new PDSA cycle.

The next adopters will complete at least one PDSA cycle and will commit to the promotion of the implementation beyond the Joint Action and in line with their sustainability plan. The outputs of the PDSA cycle(s) will include assets that facilitate, support and boost the adoption of original GPs and the capacity building for implementing digitally enabled integrated care. These assets can vary from regulatory or strategic documents to guidelines and tools for planning, implementation, management, evaluation and technology, among others.

Transfer and implementation of digitally supported integrated care solutions require 'simultaneous innovation' in both care service redesign (e.g. care pathway or case management) and the technology tools to enable it. The full process of their development, production, funding, implementation and evaluation requires careful consideration in this context.[84]

A special emphasis will be made on the different dimensions identified in previous implementation experiences such as the Carewell Project.[85] All key stakeholders have to be involved in user centered design activities to ensure their requirements are elicited, understood and documented. ICT-enabled integrated healthcare projects require the procurement of eHealth devices (e.g. telemonitoring devices, smartphones, tablets); ICT infrastructure components (e.g. servers) software; and interoperability middleware. Regulations and guidance, including timelines, in relation to procurement, will be considered. Education and training have to be considered and provided to the user (workforce, care recipients and family carers), through either online tutorials, individual or group-based learning sessions. Incentives have to be aligned to encourage collaboration within and across the care sectors and to address the key outcomes and key local priorities.

EVALUATION

Progress monitoring will provide a systematic assessment of the quality and compliance of the project to verify its planned implementation of the project and the achieving of the objectives. A comprehensive approach will be employed, using quantitative and qualitative methods, to provide key information to the partners, to overcome the detected limitations and strengthen the development of activities. It has to be taken into account, though, that for

[84] Assessing the Impact of Digital Transformation of Health Services Expert Panel on effective ways of investing in Health (EXPH) https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/022_digitaltransformation_en.pdf

[85] Lewis L, Goodwin N Guidelines for Implementing Integrated Care in Policy and Practice the Journey to Deploying Scalable Integrated Healthcare Services. February 2017 http://carewell-project.eu/fileadmin/carewell/deliverables/d8.6_v2.0_carewell_guidelines_for_deployment_printable_version.pdf

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some changes, it may not only take several years to see a clear impact at the health system level, but it may also be highly difficult to isolate the costs and effects of such changes in a developing health care environment.[86] The evaluation framework is based on previous published work by different authors that try to comprehend the difficulty of evaluation digital health solutions.[87,88,89,90]

The impact of the Project will be measured on two levels: a) the overall Joint Action (including impact on external stakeholders) and b) the next adopter sites. Impact will be described, analyzed and summarized in the deliverable 3.3 Final Evaluation Report.

The former is directly related to WP4, which deeply analyses the impact of the Joint Action at the policy level and focuses on solutions to ensure oGPs and local GP sustainability. The impact at the overall Joint Action mainly contributes to reinforce the capacity of care authorities to the transition of health systems to digitally enabled, integrated, person-centered care.

The latter is related to WP3 and transfer WPs (WP5-8) which provides methodologies and procedures to support the good practice transfer from early adopters to next adopters. At the Joint Action level, the specific Objectives and process, output and outcome indicators have been defined in section 2.2. A specific objective (number 6) addresses the degree of deployment of digitally enabled integrated person-centered care (DEIPCC) in 23 European Regions with different degrees of maturity. It sets different targets according to the baseline maturity of the regions. There are process indicators such as the number of oGPs´ features addressed in transfer process, the number of blended next adopters Good Practices and Action Plans implemented. Output indicators include increased capacity to implement DEIPCC (including topics such as use of technologies in care services, reorganization of care pathways and building capacity of individuals and communities) and small-scale and large-scale deployment and/or extended institutionalization of DEIPCC. The outcome/impact indicator(s) is the estimated involved population of JADECARE, 50,000 people.

The association between JADECARE expectations, specific objectives, process, output and outcome indicators and analysis approach have been depicted in the following evaluation framework:

JADECARE expectation	Objective	Process indicator	Output indicator	Outcome or impact indicator	Analysis approach
Reinforced capacity building of next adopters and health authorities	To create a community of stakeholders that includes caregivers, healthcare experts, policy makers and /or general public	Number of meetings with caregivers or healthcare experts Number of presentations at events (scientific, etc.)	Estimated audience of JADECARE dissemination channels	Level of perception that JADECARE guidelines and results have impact in policy setting, and scientific, industrial and general debates and fora	Quantitative
	To improve knowledge, capacity and use of JADECARE methodologies, tools and practices	Number of study visits Number of thematic workhops	Number of professionals participating in different knowledge exchange actions Satisfaction with knowledge exchange actions	% of professionals that improve in knowledge and skills	Quantitative and qualitative
	To perform a systematic appraisal of the quality of the transfer and	Scope definition, situation analysis and PDSA cycle performed on schedule	CFIR and SQUIRE 2.0 reports on adoption of good practices	Blueprint on learning from good practices	Quantitative and qualitative

[86] Assessing the Impact of Digital Transformation of Health Services Expert Panel on effective ways of investing in Health (EXPH) https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/022_digitaltransformation_en.pdf
[87] Kidholm K, Ekeland AG, Jensen LK, Rasmussen J, Pedersen CD, Bowes A, et al. A model for assessment of telemedicine applications: MAST. International journal of technology assessment in health care. 2012; 28(1):44-51.
[88] Jasehn. Report on A Minimum HTA Inspired Framework to Assess the Value of National eHealth Projects. Jasehn report, 2017.
[89] WHO. Monitoring and Evaluating Digital Health Interventions: A practical guide to conducting research and assessment. World Health Organization, 2016.
[90] Vis C, Kleiboer A, Prior R, Bønes E, Cavallo M, Clark SA, et al. Implementing and up-scaling evidence-based eMental health in Europe: The study protocol for the MasterMind project. Internet Interventions. 2015; 2(4):399-409

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JADECARE expectation	Objective	Process indicator	Output indicator	Outcome or Impact indicator	Analysis approach
	implementation process, understanding, evaluating and reporting the experience of adopting oGPs in heterogeneous next adopter sites.	Number of interviews and focus groups performed	Number of reports including the implementation experience from stakeholders´ perspective		
	To support next adopters in ensuring the sustainability of the practice with plans for actions at local/regional/national level	Elements of sustainability are addressed in Individual implementation action plans Establishment of local/regional/national networks among next adopters and stakeholders identified to be important to assure sustainability	Sustainability strategy and action plan of next adopters' practices	Perceived probability that the developed practice will be sustainable after end of JADECARE, as expressed by members of local/regional/national networks among next adopters and stakeholders identified to be important to assure sustainability	Quantitative and qualitative
	To present a potential use of results and deliverables of JADECARE for further building up the capacity of national and regional authorities to organize and deliver integrated person-centered care including integration in policies	Policy Board meetings including MoHs, national focal points for Health Programme at EC and other policy-oriented stakeholders	Reports including recommendations to next adopter's sustainability plans	Evidence-based policy making Report to assure further building up the capacity of national and regional authorities to organize and deliver Integrated person-centered care	Quantitative
Good practice transfer	To support and reinforce digitally enabled integrated person-centered care (DEIPCC) in 23 European settings with different degrees of maturity	Number of oGPs´ features addressed in transfer process	Number of next adopters with increased capacity to implement DEIPCC in the future	Estimated target population of JADECARE	Quantitative
		Number of blended next adopters Good Practices and Action Plans	Number of small-scale deployments (piloting) of DEIPCC.		
		Action plans implemented	Number of large-scale deployments (system level) of DEIPCC		
	To improve next adopters´ digital transformation	Analysis of digital situation is performed in next adopters' sites. Establishment of specific objectives regarding digital transformation are set in next adopters Action Plans	% Sites with Changes in digital services are confirmed (digital health system infrastructure; data analytics and use of technologies, citizen empowerment tools and patient reported data.	Perceived improvement of digital services by end users	Quantitative and qualitative
Successful Joint Action management	To provide technical, scientific, financial and administrative	Achievement of milestones	Avoidance of deviations	JADECARE overall deliverables accepted	Quantitative

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JADECARE expectation	Objective	Process indicator	Output indicator	Outcome or Impact indicator	Analysis approach
	management and support				
	Quality, compliance and usefulness a	% surveys completed (acceptance rate & perceived usefulness	Satisfaction with the project progress	% stakeholder consider Project useful	Quantitative

At next adopters level, evaluation will be customized in each site according to the SMART objectives and key performance indicators of the local Good Practice and Action Plans defined in the transfer Work Packages (WP 5-8). They will include general dimensions and digital transformation.
Regarding general dimensions, the KPIs will include:

- scope and degree of adoption of original Good Practices (oGPs),
- specific process, pathway reorganization and change management,
- the involvement and commitment of key stakeholders,
- the implementation experience and
- continuity and sustainability of the practice
- readiness of the organization to uptake digitalization

Regarding digital transformation, the KPIs will include:

- digital health system infrastructure,
- risk stratification and data analytics,
- use of technologies including Electronic Health Record, personal health folder and electronic prescription;
- citizen empowerment and use of patient reported data,
- innovation initiatives on integrated care reorganization of care pathways, workforce roles and skills and training and research programs,
- access to health services,
- management of change towards digitalization,
- ethical aspects of digitalization.

The impact assessment consists of:

- Assessment plan definition: the impact indicators (quantitative and qualitative), target levels for the impact indicators, the information to be collected and the collection methods or sources including a mix of qualitative and quantitative methods (questionnaires, surveys, semi-structured interviews or focus groups).
- Data collection: gathering information according to the assessment plan, data analysis (content analysis for qualitative data or statistical for quantitative data) and reporting.

The implementation process will be performed based on the Consolidated Framework for Implementation Research (CFIR), which facilitates and guides the analysis to elucidate the factors that have influenced (positively or negatively) the implementation process. The CFIR provides a menu of constructs that have been associated with effective implementation. The CFIR is easily customized to diverse settings and scenarios. Using CFIR will allow next-adopters' working group (NAWGs) not only to learn a specific methodology that helps identifying relevant factors affecting the implementation but also to increase success rate in future implementation experiences.
The whole implementation experience reporting will be done based on the SQUIRE 2.0 guideline. It will be used so the evidence base and transferability potential are enhanced.
The complexity of the JADECARE objectives and approach requires that the tasks of the four transfer WPs, the evaluation and the sustainability are closely interconnected (Figure 13). These WPs are interdependent in several ways, an output from one task can become the input for another task from the same or another WP. This which implies not only to apply clear and straightforward methodologies but also to establish effective communication and coordination between WP Leads and co-leaders.

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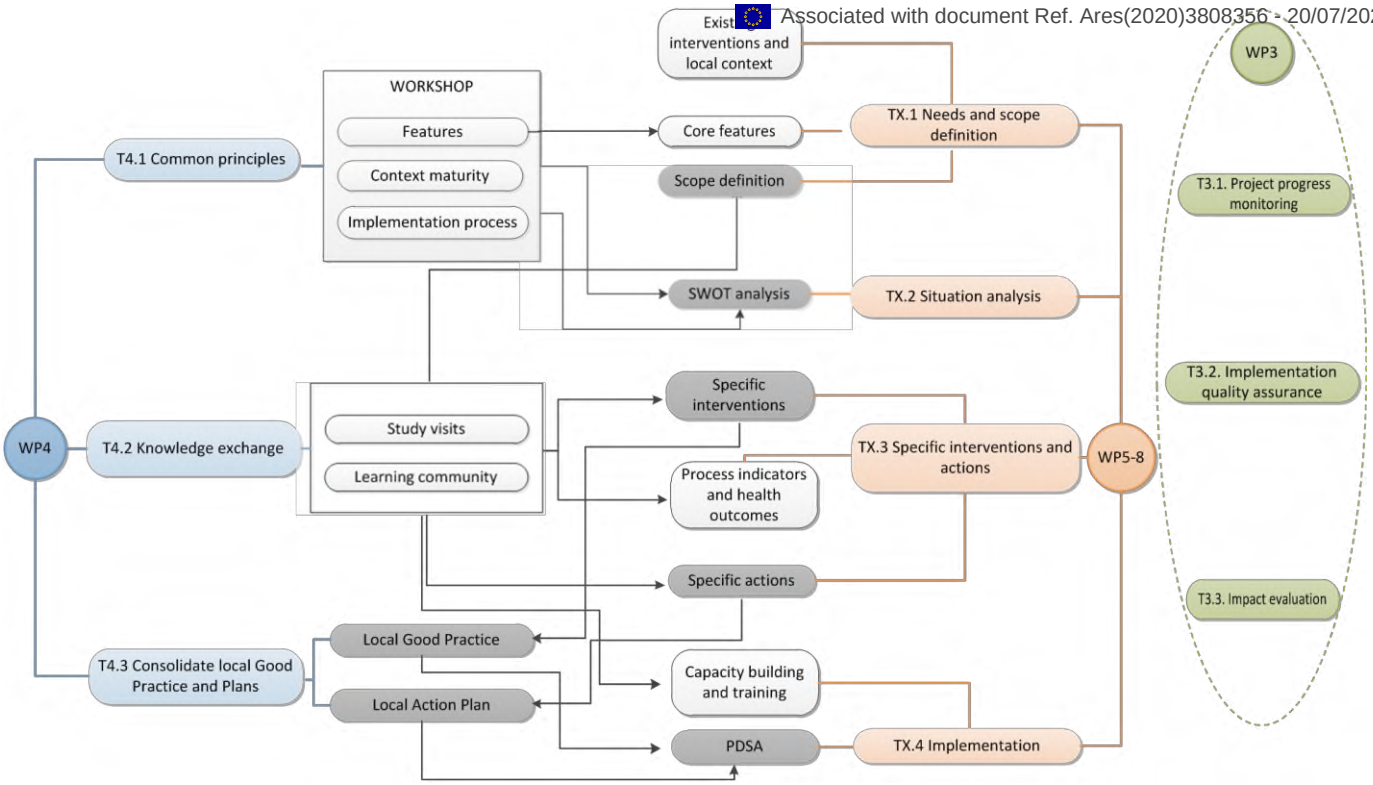


FIGURE 13. INTERDEPENCY OF TASKS OF WP3-WP8.

2.6 EXPECTED OUTCOMES AND BENEFITS OF THE PROJECT

JADECARE will contribute to innovative, efficient and sustainable digitally enabled integrated person-centered healthcare systems. It will encourage innovation and increase sustainability of health systems, enabling participating national authorities but also those beyond the Consortium, to benefit from the uptake of evidence-based interventions into practice and policy. These will improve their healthcare performance and outcomes. The results and outcomes of digital transformation of health services will depend on the quality of the process and the involved stakeholders. This includes end-users of digital health services (be it professionals, care users or citizens), developers of digital health services, producers of health services and governments.[91]

The expected results aim to influence:

- Increased use of evidence-based practices in Member States
- Increased sustainability of health systems

The scope, scale and extent of these outcomes will be different for each of the next adopters depending on their baseline maturity, their needs and their local strategies and resources. They will include regulatory or strategic norms, planning and implementation guidelines, management and delivery facilities and tools and digital technologies covering features such as:

- Change management and reorganized care models
- Embedded digital technologies and tools in care services
- Reorganized care pathways including new funding or payment methods
- Developed health workforce roles and skills
- Empowered citizens in for active participation in healthcare decision making
- Improved performance assessment methods

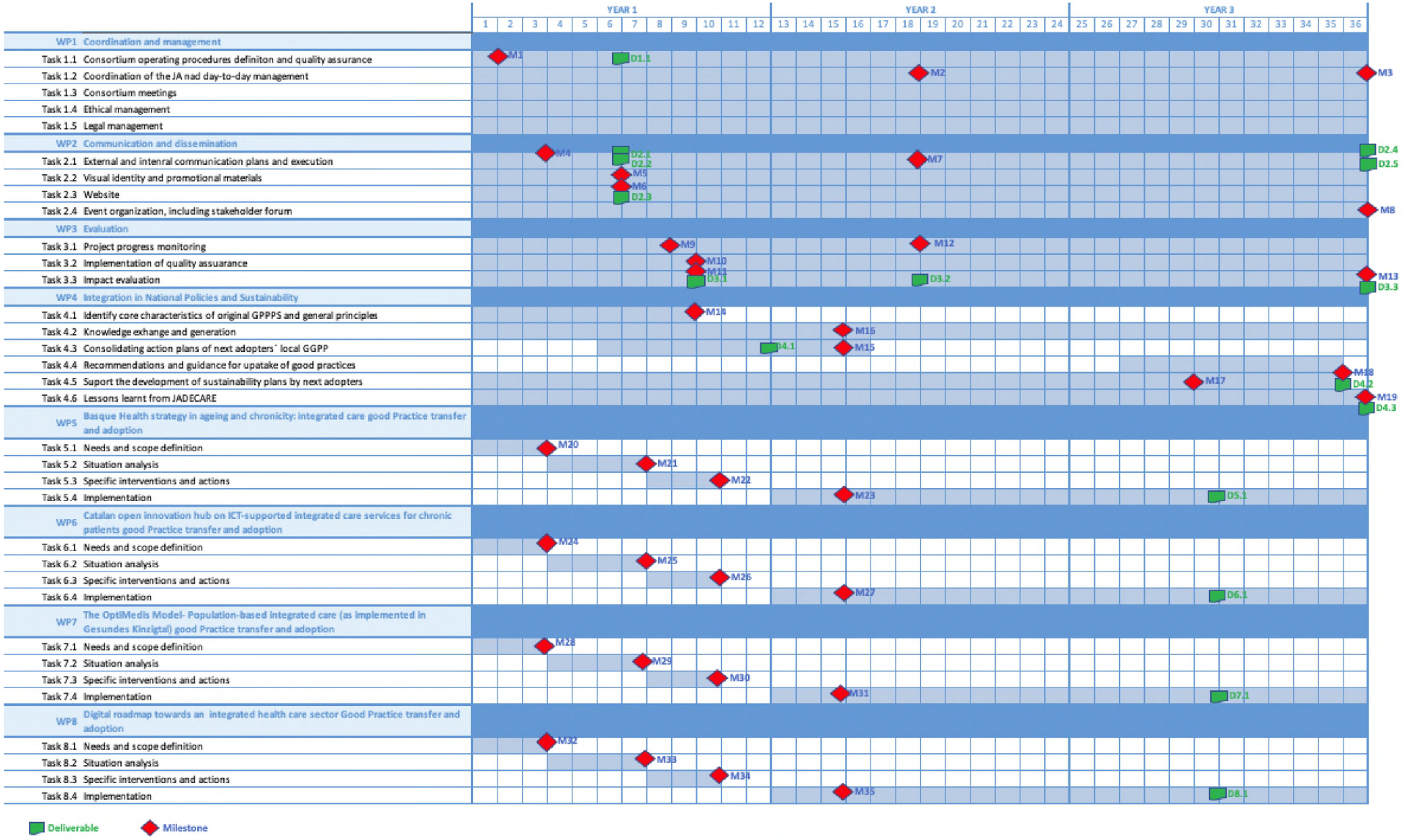
The evaluation will have a full description of the relevant digital technology, its use and aims, addressing elements like the intended use, costs and consequences.

JADECARE will enhance the collaboration and trust among stakeholders, support knowledge transfer and learning and generate further evidence on integrated care. This will yield benefits beyond the timeframe of the JA. JADECARE will share its main findings and will ensure the sustainability of policies at the local, regional and national levels.

[91] Assessing the Impact of Digital Transformation of Health Services Expert Panel on effective ways of investing in Health (EXPH) https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/022_digitaltransformation_en.pdf

2.7 GANTT CHART

The timetable includes the work packages and tasks as well as the different milestones (red) and deliverables (green).



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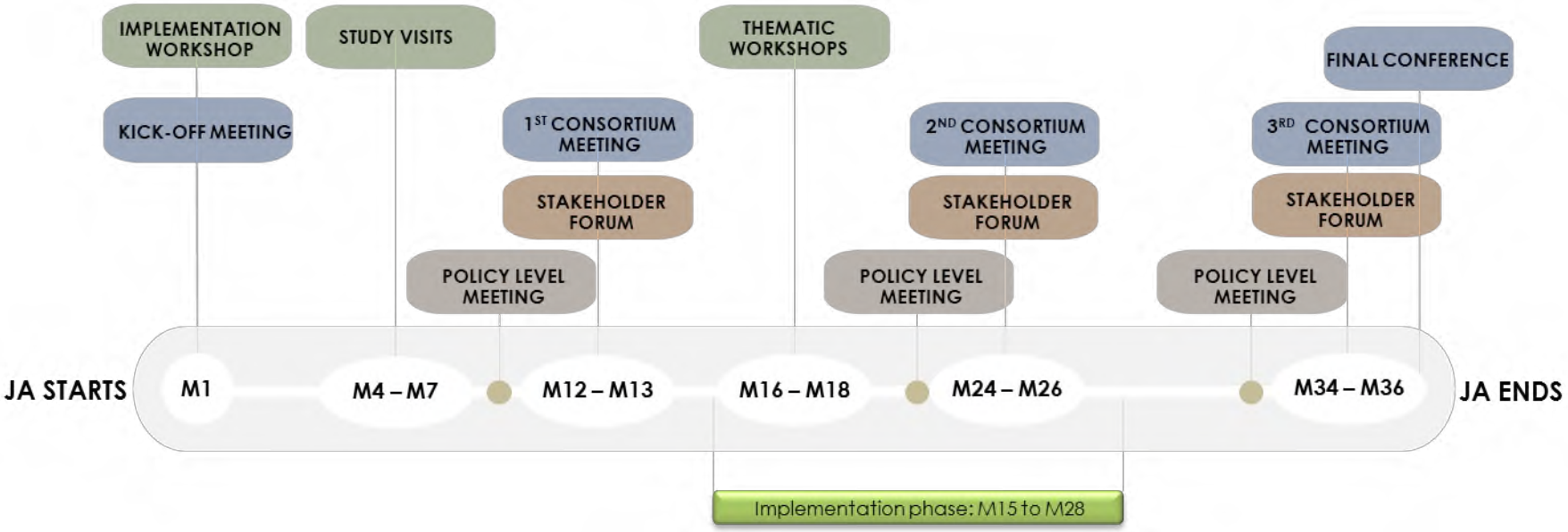

WORK PACKAGES

WP	WP TITLE	Leading Executive organization	Lead Beneficiary	WP DESCRIPTION
WP1	Coordination	KG	KG	The aim is to manage and coordinate the project adequately. To this purpose, the project coordinator team will provide technical, scientific, financial and administrative management and support. WP1 will monitor the progress to avoid deviations and will ensure ethical compliance. Moreover, this WP will guarantee smooth communication with CHAFEA and SANTE.
WP2	Communication and dissemination	**SU-HSMTC**	**AEEK**	WP2 will disseminate high quality information on JADECARE deliverables and progress. This will contribute to the development of a sustainable mechanism of advancing/providing high quality services of integrated care in Europe. The work starts with initial communication activities to position the JA on the EU landscape, generate recognition and understanding of the project goals and ambitions. Specific dissemination activities will follow to enhance and magnify the effect and impact of the common work and support the sustainability of best practice transfer and replication. WP2 will create and execute the external and internal communication plans as well as the visual identity and promotional materials. The website will be an essential element for WP2 as well as for the whole project. In addition, WP2 will have a task devoted to event organization including stakeholder forum.
WP3	Evaluation	AUTH	4THYPE	This WP will ensure proper functionality of JADECARE components in adopting countries. It will provide a methodological framework for assessing JADECARE system. It will cover the requirements and expectations for the different features adopted and will help to understand, evaluate and report in detail the experience of adopting the project. WP3 will assess the quality and compliance of the project processes and stakeholder views inclusion and satisfaction. It will also perform a systematic appraisal of the quality of the transfer and implementation process, evaluating and reporting the experience of adopting oGPs in in heterogeneous next adopter sites. Moreover, WP3 will assess the reinforcement of the capacity of health authorities to organize and deliver digitally-enabled, integrated, person-centered care. It will evaluate the transfer of the good practices (or their significant elements) from the “early adopters” to the “next adopters” by examining performance, acceptance, satisfaction and sustainability.
WP4	Integration in National Policies and Sustainability	NIJZ	NIJZ	This WP will share main findings, assure and cross fertilization and contribute to the sustainability at the national, local or regional level. It will set up a plan for future use of results and deliverables to be integrated into policies. To this purpose, WP4 will identify general principles and individual characteristics of successful implementation of good practices. This WP will support exchange of knowledge and experiences of implementation by next adopters including study visits and consolidation of their local GPs and Action Plans. It will generate recommendations and guidance for incorporation of good practices using new knowledge and understanding, based on the results of implementation by next adopters. Moreover, the WP will support next adopters in ensuring the sustainability of the practice with plans for actions at local/regional/national level. WP4 will provide results and deliverables to reinforce the capacity of national and regional health authorities in transforming health care systems and delivering integrated person-centered care including integration in policies
WP5	Basque Health strategy in	KG	KG	This WP will analyze and settle the bases and implement the GP from Basque Country in the next adopters. The next adopters will have the opportunity to learn about the oGP in a dedicated workshop during the Kick off

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WP	WP TITLE	Leading Executive organization	Lead Beneficiary	WP DESCRIPTION
	ageing and chronicity: integrated care good Practice transfer and adoption			meeting by month 1. They will select the core features of the oGP and work on them. The NAWGs will perform a situation analysis and define the strategic action, define the specific interventions and facilitate implementation. Kronikgune will provide a detailed description of the oGP in a dedicated workshop during the Kick off meeting. At next adopter´s site, NAWG, depending on their needs, expectations, strategic objectives, real possibilities and existing local interventions, will choose the final core features by month 3. Kronikgune will support next adopters during this process if required. In a second stage, study visits to the oGP site will be organized in order to provide next adopters with the possibility to acquire deep knowledge on specific aspects of the oGP. Then, development of future vision of the next adopters' practice, related to the selected features, implementation plan, monitoring and intermediary evaluation for PDSAs, final evaluation and elaboration of final implementation report, that will include sustainability strategy and action plan. specific interventions and actions will be taken in each next adopter site to allow the implementation.
WP6	Catalan open innovation hub on ICT-supported integrated care services for chronic patients good Practice transfer and adoption	IDIBAPS	KG	This WP will analyze and settle the bases and implement the GP from Catalonia in the next adopters. After knowing the oGP in the kick off meeting, next adopters could pre-select the initial core features in which are initially interested and the leader of WP6 will present the general outline of WP6 leadership and management plan at all phases of the implementation including final reporting. After the study visits to analyze the situation, a SWOT analysis will be developed to design and implement the specific intervention. In order to efficiently organize transferability to next adopters, WP6 has identified five well-defined blocks with high potential for implementation by next adopters, as well as specific actions within each of them: ▪ 1. Health risk assessment: population-based and enhanced clinical decision making (Block 1) ▪ 2. Promotion of healthy lifestyles (Block 2) ▪ 3. Vertical and Horizontal integration experiences adopted in Catalonia (Block 3) ▪ 4. Innovative assessment and regulatory aspects of digitally-supported integrated care services (Block 4) ▪ 5. Digital support of integrated care services (Block 5) IDIBAPS will support next adopters during this process if required. In a second stage, study visits to the oGP site will be organized in order to provide next adopters with the possibility to acquire deep knowledge on specific aspects of the oGP. Then, development of future vision of the next adopters' practice, related to the selected features, implementation plan, monitoring and intermediary evaluation for PDSAs, final evaluation and elaboration of final implementation report, that will include sustainability strategy and action plan. specific interventions and actions will be taken in each next adopter site to allow the implementation
WP7	The OptiMedis Model-Population-based integrated care good Practice transfer and adoption	OPTIMEDIS	EUSTRAS	WP7 will lead to the selection of the core features of the oGP that next adopter´s will work on and will perform the situation analysis and define the strategic actions of next adopters. In WP7 the specific interventions and actions that will be transferred to next adopters will be selected. This WP will facilitate and support the transfer of GP features to next adopters´ context. This WP will analyze, settle the bases and implement the GP from Optimedis in the next adopters. A dedicated workshop during kick off meeting will provide the opportunity to better now the oGP. After this first step, study visits will be organized at oGP site to deep into the knowledge of GP. Then, the situation of each next adopter will be analyzed, and the specific interventions and actions will be designed to implement the GP. OPTIMEDIS will support next adopters during this process if required. In a second

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WP	WP TITLE	Leading Executive organization	Lead Beneficiary	WP DESCRIPTION
				stage, study visits to the oGP site will be organized in order to provide next adopters with the possibility to acquire deep knowledge on specific aspects of the oGP. Then, development of future vision of the next adopters' practice, related to the selected features, implementation plan, monitoring and intermediary evaluation for PDSAs, final evaluation and elaboration of final implementation report, that will include sustainability strategy and action plan. specific interventions and actions will be taken in each next adopter site to allow the implementation
WP8	Digital roadmap towards an integrated health care sector Good Practice transfer and adoption	RSD	RND	This WP will analyze, settle the bases and implement the GP from South Denmark in the next adopters. After identifying the main features of the Danish GP in the dedicated workshop during the kick off meeting, next adopters NAWGs will have the opportunity to pay a visit to the oGP. As in the rest of transfer WPs, after the SWOT analysis the specific interventions and actions will be designed and piloted. Next adopters will have the opportunity to know better the oGP in a dedicated workshop during the Kick off meeting by month 1. First, Kronikgune will explain the methodology for the scope definition which is mainly delimited by selecting the features of the intervention that will be finally implemented. Then, following this methodology, the Region of Southern Denmark will describe in depth the core features of the oGP, Roadmap towards Integrated Care, implemented in the Region of Southern Denmark. The Roadmap towards Integrated Care consists of different elements that together make up the foundation for the digital and cross sectorial communication. Region of South Denmark will support next adopters during this process if required. In a second stage, study visits to the oGP site will be organized in order to provide next adopters with the possibility to acquire deep knowledge on specific aspects of the oGP. Then, development of future vision of the next adopters' practice, related to the selected features, implementation plan, monitoring and intermediary evaluation for PDSAs, final evaluation and elaboration of final implementation report, that will include sustainability strategy and action plan. specific interventions and actions will be taken in each next adopter site to allow the implementation

The interdependency between WPs and tasks responds to the complexity of the JADECARE objectives, approach and methodology. The four transfer WPs (WP5-8), the evaluation (WP3) and the sustainability (WP4) are closely interconnected and act in a synergistic manner. Findings and results of one task can feed other tasks of the same WP or another. To map this cross-fertilization, the main contents of deliverables, contributing tasks and partners are detailed in the table below.

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D.N	D. Name	Content	Input from	Leading Executive Organization	Main contributors
D3.1	Impact Assessment Plan	▪ Project progress monitoring plan ▪ Evaluation framework (objectives, process, output and outcomes indicators) for the 23 JADECARE next adopters ▪ Analysis plan (quantitative and qualitative) ▪ Data management procedures, templates, responsibilities and timeline ▪ Methodology for the implementation quality assurance	T3.1, T3.2 & T3.3	AUTH	AQuAS, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, next adopters, AGENAS
D3.2	Interim Evaluation Report	▪ Project progress measurement ▪ Intermediate evaluation of the KPIs (mainly process indicators) defined in the local Action Plans ▪ Monitoring of the next adopters' pilot implementation ▪ Identification of deviations in indicator achievement ▪ Definition of corrective actions	T3.1, T3.2, T3.3, T5.4, T6.4, T7.4, T8.4	AUTH	AQuAS, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, next adopters, AGENAS
D3.3	Final Evaluation Report	▪ Assessment of the quality and compliance of the project process and stakeholders' views on inclusion and satisfaction ▪ Analysis and reporting of the implementation process ▪ Impact at next adopters' level by analyzing process, output and outcome indicators included in the local Action Plans ▪ Lessons learned and recommendations for future good practice transfer and implementation	T3.1, T3.2, T3.3, T5.4, T6.4, T7.4, T8.4	AUTH	AQuAS, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, next adopters, AGENAS
D4.1	Local Good Practices and Action Plans	▪ Summary reports of the study visits ▪ Description of the local Good Practices (pilots) ▫ How the practice to transfer looks like ▫ Set up ▫ Locations ▫ Target groups ▫ Number of citizens/patients covered ▪ Documentation of the local Action Plans ▫ Concrete actions (what) needed for the implementation ▫ Responsible actor (who) ▫ Timeline (when) ▫ Settings (where).	T4.1, T4.2, T4.3, T4.5, T5.3, T6.3, T7.3 & T8.3	AGENAS	Next adopters, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ
D4.2	Blueprint on how to transfer the JADECARE good practices	▪ Guidelines and standard operation procedures for JADECARE good practice transfer: ▫ Methodology and recommendations to support the implementation or the adoption of an identified good practice ▫ Definition of core elements to assure scale up ▫ Process to ensure sustainability after the end of the project	T4.1, T4.2, T4.4, T3.3, T_.1, T_.2, T_.3 and T_.4. of	AGENAS	Next adopters, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, BAGSFI, AUTH, AQuAS

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D.N	D. Name	Content	Input from	Leading Executive Organization	Main contributors
			WPs 5.6.7 and 8)		
D4.3	Characteristics of JADECARE, leading to sustainability and integration into national policies.	▪ Description of the sustainability strategy, sustainability elements of local Good Practices, their integration into health policies and how JADECARE has helped Member States to support and reinforce their capacity for digitally enabled patient centered integrated care: ▫ identification of the holder of sustainability planning process ▫ what should be sustainable including expected results ▫ assessment of the context/situation ▫ planning for support of key stakeholders and community ▫ assessment of long-term stability and flexibility of the holder ▫ strategic partnerships ▫ strategic financial planning ▫ finding and conclusions from the Policy Dialogues	T4.1, T4.2, T4.5, T4.6, T3.3	NIJZ	Next adopters, KG, IDIBAPS, Eustras (Optimedis), RSD, AGENAS. BAGSFI, AUTH
D5.1	The Basque integrated care approach original Good Practice and transfer process	▪ Description of the "Basque integrated care approach" oGP, including main blocks and core features, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. ▪ Implementation process of the "Basque integrated care approach" in each next adopter´s site including how it started, who was involved, who was "coached", how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.	T4.1, T4.2, T4.3, T4.5, T5.1, T5.2, T5.3, T5.4	KG	Next adopters, AGENAS, NIJZ, BAGSFI
D6.1	The Catalan Innovation Hub original Good Practice and transfer process	▪ The description of the "Catalan Innovation Hub" oGP, including main blocks and core features, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. ▪ The implementation process of the "Catalan Innovation Hub" in each next adopter´s site will be described: how it started, who was involved, who was "coached", how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.	T4.1, T4.2, T4.3, T4.5, T6.1, T6.2, T6.3, T6.4	IDIBAPS	Next adopters, AGENAS, NIJZ, BAGSFI

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D.N	D. Name	Content	Input from	Leading Executive Organization	Main contributors
D7.1	The Optimedis Model original Good Practice and transfer process	▪ The description of the "Optimedis Model" oGP, including main blocks and core features, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. ▪ The implementation process of the "Optimedis Model" in each next adopter´s site will be described: how it started, who was involved, who was "coached", how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.	T4.1, T4.2, T4.3, T4.5, T7.1, T7.2, T7.3, T7.4	EUSTRAS (OPTIMEDIS)	Next adopters, AGENAS, NIJZ, BAGSFI
D8.1	The Danish roadmap towards Integrated Care original Good Practice and transfer process	▪ The description of the "Danish roadmap towards integrated care" oGP, including main blocks and core features, the implementation requirements and process step-by-step, barriers found and solutions identified, lessons learnt and recommendations and the present situation of the oGP. ▪ The implementation process of the "Danish roadmap towards integrated care" in each next adopter´s site will be described: how it started, who was involved, who was "coached", how the original practice was adapted, which of its elements were chosen, what other elements were added and from where, resources and capabilities needed, technology required, barriers and facilitators and how elements needed for local GP sustainability have been tackled.	T4.1, T4.2, T4.3, T4.5, T8.1, T8.2, T8.3, T8.4	RSD	Next adopters, AGENAS, NIJZ, BAGSFI

DELIVERABLES

DN.	Deliverable name	WP Nº	Lead beneficiary	Lead Executive organization	Contributing partners	Diss. Level	Delivery Month
D1.1	Project Handbook	WP1	KG	KG	All partners	PU	6
D2.1	Leaflet	WP2	AEEK	SU-HSMTC	All partners	PU	6
D2.2	Project website	WP2	BAGSFI	ZTG GMBH	All partners	PU	6
D2.3	Dissemination and communication strategy and plan	WP2	AEEK	SU-HSMTC	All partners	PU	6
D2.4	Final report on Dissemination	WP2	AEEK	SU-HSMTC	All partners	PU	36
D2.5	Layman report	WP2	AEEK	SU-HSMTC	All partners	PU	36
D3.1	Impact Assessment Plan	WP3	4THYPE	AUTH	AQuAS, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, next adopters, AGENAS	PU	9
D3.2	Interim Evaluation Report	WP3	4THYPE	AUTH	AQuAS, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, next adopters, AGENAS	PU	18
D3.3	Final Evaluation Report	WP3	4THYPE	AUTH	AQuAS, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, next adopters, AGENAS	PU	36
D4.1	Local Good Practices and Action Plans	WP4	AGENAS	AGENAS	Next adopters, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ	PU	15
D4.2	Blueprint on learning from good practices	WP4	AGENAS	AGENAS	Next adopters, KG, IDIBAPS, Eustras (Optimedis), RSD, NIJZ, BAGSFI	PU	35
D4.3	Characteristics of JADECARE, leading to sustainability and integration into national policies.	WP4	NIJZ	NIJZ	Next adopters, KG, IDIBAPS, Eustras (Optimedis), RSD, AGENAS, BAGSFI	PU	36
D5.1	The Basque integrated care approach original Good Practice and transfer process	WP5	KG	KG	Next adopters, AGENAS	PU	30
D6.1	The Catalan Innovation Hub original Good Practice and transfer process	WP6	KG	IDIBAPS	Next adopters, AGENAS	PU	30
D7.1	The Optimedis Model original Good Practice and transfer process	WP7	EUSTRAS	OPTIMEDIS	Next adopters, AGENAS	PU	30
D8.1	The “Danish roadmap towards Integrated Care original Good Practice and transfer process	WP8	RND	RSD	Next adopters, AGENAS	PU	30

2.8 PROJECT MANAGEMENT STRUCTURE

METHODS

The management approach of the JA is based on the PM^2 methodology of the European Commission, tailored to the context of JADECARE. It is also based on the broad experience of KRONIKGUNE in the coordination of cooperative project at international level in H2020 and previous Framework Programmes, but also in the area of Public Health.

The management structure of JA has been designed to respond to the needs of a large-scale consortium. It involves a broad range of stakeholders (CAs and AEs) at pan-European level in the implementation and sustainability of good practices. Specifically, it intends to reinforce the capacity of health authorities to successfully address the transition of health systems to digitally-enabled integrated person-centered care, as well as to support the best practice transfer, while respecting traditional and accepted project management standards and principles.

Coordination and implementation roles and activities in the Joint Action are performed by CAs (as Leading Beneficiaries (LB)), and AEs. AEs can act as Leading Executive Organisations (LEO) and Co-Leading Executive Organisations. CAs and AEs are responsible for Work Packages and/or Tasks and contribute to the Deliverables and Milestones as described in the JADECARE Joint Action.

Many tasks have a somewhat tight, though thoroughly evaluated, time schedule. This will require a close monitoring and emphasis on internal communication between consortium members, to allow close progress assessment and interaction between all the actors involved in the JA. The management structure aims to ensure efficiency and, at the same time, to avoid imposing an exaggerated overhead on the project that could hamper its real implementation and development.

The described management activities are focused on the executing phase of the JA, as well as on assuring that after the closing phase of the project, a real change has been achieved and the sustainability of the new models is guaranteed. The structure for the JA is based on a multi-level organization that ensures:

- The fulfilment of the project work plan.
- The management of trade-offs affecting scope, quality, time, and cost.
- The due attention needed on critical activities that aim to ensure the achievement of milestones and that contribute to strategic objectives.
- The relationships among partners, including conflict resolution.
- The quality and efficiency with which the project activities are carried out.
- The proper follow-up and fulfilment of the Grant Agreement with CHAFEA, including administrative and financial issues, the Consortium Agreement and any other legal arrangements with external parties.

GOVERNANCE, ROLES, RESPONSIBILITIES

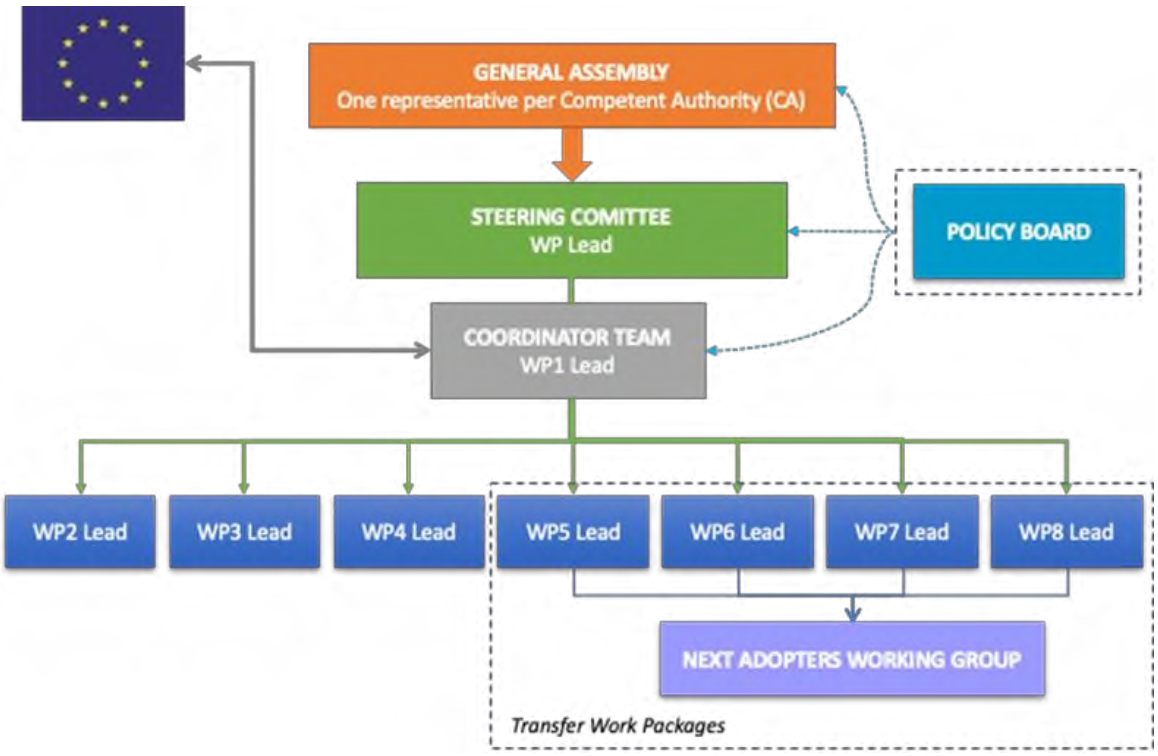

FIGURE 10 JADECARE MANAGEMENT STRUCTURE

The management structure in JADECARE is composed by the General Assembly (GA), the Steering Committee (SC), the Coordination Team (WP1 Leader), the Work Package Leads (WPL), the Next Adopters Working Groups (NAWG) and the Policy Board (PB). This management structure will promote smooth and dynamic collaboration between the project participants.

General Assembly (GA): A general assembly of all entities with decision-making responsibility in matters affecting the overall project strategy, major work plan updates, composition of the Consortium, effort and budget re-assignment.

The GA will be chaired by the Joint Action Coordinator and contain representatives from each of the Competent Authorities. This plenary assembly will be the ultimate decision-making body in JADECARE. It will deal with critical issues affecting the joint action as a whole, such as overall strategy and all other matters that the Steering Committee opts to refer to a higher level. GA members will be required to have the authority to take corrective actions and make decisions as necessary within their respective organizations or clarify the relevant line management. The GA will approve (via the Consortium Agreement) the management structure, and the decision-making principles and responsibilities of all management bodies as described in this section before the start of JADECARE. Typically, the GA will deal with major amendments to the work plan, changes in the composition of the Consortium, and changes in effort/budget allocation between work packages. The GA will also monitor and review progress, ensure that objectives are met and approve deliverables, supervise management and coordination and the performance in the different work packages, as periodically reported by the SC.

The GA will thus meet at least once a year face-to-face, so that the project evolution and governance are visible and transparent to all participants, and contributions are gathered and discussed in a timely fashion. GA members might be assisted by technical or managerial staff from their organizations for these meetings. For decision purposes, each member of the GA will be allocated one vote. Two thirds of the members attending a meeting of the GA will constitute a quorum. Simple majority of the attending members will be enough for decision adoption. In the event of a tied vote, the JA Coordinator (as Chair) will have an additional vote. DG SANTE and CHAFEA's representatives will participate as observers in the meetings.

Steering Committee (SC): A An operational body comprising the Coordination Team and the WP Leads (Lead Beneficiary, Leading and Co-Leading Executive Organisations) as a decision making on daily running of the project, with prerogatives regarding minor updates, and effort/budget re-assignment as well as conflict resolution.

SC will be an operational body in charge of daily coordination of the project work, following up progress in each of the critical areas and the planning of tasks and activities. The SC will be responsible of monitoring the technical quality of the work and coordination between WP Leads, and of conflict resolution as well as the establishment of mitigation plans to reduce impact of potential risks. These include in particular the resolution of disputes and matters relating to allocation of efforts, as well as situations in which the project efficiency might be endangered. At the initiative of any of its members, the SC will also be able to constitute committees for matters that require specific attention (such as security, new technological issues, gender equality, etc.), and to establish working procedures for such committees. The SC will meet at least once a month via tele- or web-conferencing, and at least once a year face-to-face. Consensus will be needed for decision adoption. DG SANTE and CHAFEA's representatives will participate as observers in the meetings.

Coordination Team (CT): KRONIKGUNE will assume the role of JA Coordinator, being the organization representing the JADECARE Consortium. It will be responsible for the achievement of the JA goals and the contractual obligations towards the European Commission, and will provide global scientific and technical leadership, quality assurance policy and overall coordination of the joint action. The Coordinator Team will be formed by the JA Coordinator supported by the Scientific Coordinator, the Project Manager and the Financial Manager

The JA Coordinator (JAC) will lead the Coordinator team, assuming the overall leadership of the JA; will provide strategic guidance, devise changes in scope and focus of the different tasks, coordinate all efforts of the SC and manage dependencies between tasks, linking components towards a successful completion of the JA. The JAC will be a central figure for conflict resolution, decision-making enabling and consensus building. The JAC will also deal with partnership management (accession of new partners, withdrawal, formal relationships with external collaborators), as well as supervise relationships with related external initiatives, managing the stakeholder expectations.

Scientific Coordination (SCO) will be responsible for the delivery of high-quality results within the identified objectives and constrains; will be in charge of establishing a common overall methodological approach, defining high quality standards and directing the efforts towards implementation, assessment and scientific publications. The Scientific coordinator will provide ethical oversight, guaranteeing that data collection and analysis are performed according to current legislation at European and national level.

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Project Management (PM) will be in charge of the day-to-day management of the JA; will support the coordinator's activities and monitor compliance with the work plan, planned resources, time schedule and liaison with CHAFEA. The PM will support WP Leads, promoting synergy and efficiency, facilitating communication among partners, ensuring timely submission of the project deliverables and tracking milestones. The PM will drive risk and issue management (identification, assessment of threats and opportunities, mitigation and contingency plans), manage quality control procedures, support meetings organization and production of minutes. The PM will also promote the application of the management methodology and the use of the PM2 methodology's artefacts, information systems, governance and logistics.

Financial Management (FM) will support the adequate use of resources of the project as well as to analyze/review/support issues that could arise in the participation of Affiliated Entities through their Competent Authorities. FM will be responsible for overall financial management (periodic reporting, budget management, payments control), supporting the SC and GA in budget arrangements, allocation of funds, coordinating and supporting partners in financial and administrative tasks. The FM will be also responsible of Grant Agreement and Consortium Agreement management (amendments) and other legal issues.

Other roles may be added to the Coordinator Team according to the needs of the project.

Work Package Lead (WPL) will be performed by the Lead Beneficiary (LB), the Leading Executive Organization (LEO) and the co-Leading Executive Organisation.

LEO and co-Leading Executive Organisation have the responsibility for day-to-day management and coordination of the activities included in their respective work packages as defined in the work plan, implement solutions for problems, supervise Task Leaders, produce the corresponding deliverables, identify risks as early as possible and follow them up, and report to the PM about the progress achieved against that planned. They will be able to raise proposals to the SC regarding effort and budget redistribution, and re-assignment of roles and responsibilities within their respective WPs. WP participants will meet at least once a month via tele- or web-conferencing.

Next Adopters Working Groups (NAWG) including local stakeholders in all the participating countries.

A Next Adopters Working Group (NAWG) will be created in each of the next adopter sites for the implementation of the Local Good Practices, led by the representative of the corresponding Competent Authority or Affiliated Entity. NAWGs will be supported by the responsible of the oGPs as described in the transfer WPs (WP5-8). The NAWG will include representative of health systems, healthcare professionals, community members, third sector. All members of each next adopter team will meet regularly in order to share their experiences and learn from them, suggest improvements, receive and provide support, plan different measures, review objectives, and collect and deliver good practices. During these meetings, the Competent Authority or affiliated Entity representative will inform the members of the team about the progress of the intervention in the other areas, highlighting any problematic situation or any issues raised.

Policy Board (PB) An external board composed by representatives of Ministries of Health (MoH) of all the participating countries.

The policy board will be formed by all Competent Authorities involved in JADECARE that are MoHs, national focal points for Health Programme at the European Commission (or other representatives of MSs identified by them) from other Member States from EU and EEA, and all other policy-oriented stakeholders that implementers will identify as important based on their sustainability-related analyses. The role of the Policy Board will be to give input to sustainability plans from the focus of policy, and the definition of core messages to support evidence-based policy making with respect to sustainability of JADECARE results. The PB will have a key role in guaranteeing the sustainability of the Joint Action and the impact after the end of the project. The Policy board will be stablished and coordinated by WP4 Leader and co-leader with support of the Coordination Team.

Regarding communication, a Consortium Communication Policy will be established by the Coordination Team, making extensive use of electronic resources and described in the project handbook. Regarding conflict resolution, the project organization is planned to support a bottom-up approach. Issues amongst participants in any given activity will be solved at the work package level with the help of the respective WPL, who, with assistance of the Coordination Team, will use mediation and expert and referent powers to objectively solve the issue. If still unresolved the issue will in turn be referred to the SC and ultimately to the GA, where voting mechanisms take place. DG SANTE and CHAFEA's representatives will participate as observers in the meetings.

PROCESSES & ARTEFACTS

The JADECARE consortium has put great care in defining the most appropriate management structure according to its complexity. The scale of the project requires putting great care in defining the most appropriate and efficient organizational structure and decision-making mechanisms:

- General Management Procedures: Entities are responsible for:
  - Effective economic management and conduct of operational work in accordance with the program guidelines and with ethical and legal standards.

- Complying with general terms and conditions governing the grant and any terms and conditions established by the CHAFEA.
- Managing and supervising operational personnel.
- Meeting reporting requirements specific to CHAFEA.
- Acknowledging, whenever possible, the financial support for the operational work.

- Quality assurance Management: a Project Handbook will be elaborated at the beginning of the project (M6) defining high quality criteria and deliverables acceptance procedures. The quality of the transfer and implementation process will be assessed through internal evaluation procedures and the project progress will be monitored to systematically assess the quality and compliance of the project process through an internal evaluation plan.
- Project change management: changes with a significant impact in any of the project dimensions (i.e. scope, time, cost, quality or risk) will be properly assessed, agreed on and approved by the appropriate level of authority. It will be will brought transparency, accountability and traceability to all project changes implemented after the initial scope and plan have been baselined.
- Communication management: JADECARE is a Joint Action involving **17 CA and 23 AE** that must interact. There will be at least *annual* meetings of the GA and monthly meetings of the SC. The Coordinator Team will carry out a *full supervision* and logistic support on these matters and on the synchronization of all tasks, defining control procedures to follow the evolution of work, solving potential conflicts between entities, defining communication and dissemination policies for results and planning the exploitation strategy (if any). In the annual GA meetings, technical progress will be transmitted through presentation of results and peer review, for a coherent coordination and project planning. Consensus in decision-making is highly desirable, both for quality assurance and to ensure that the goals and interests of the partners are respected. After each meeting, minutes will be compiled.

The primary forms of communication and exchange of documents among JADECARE partners will be teleconferences, email, FTP and web exchange.

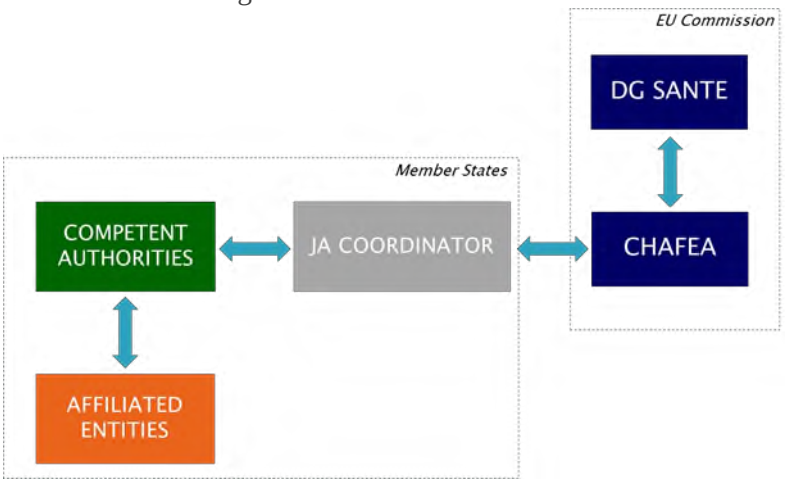

FIGURE 14 SHOWS THE COMMUNICATION WILL FLOW BETWEEN THE CAS, AES, THE JA COORDINATOR AND CHAFEA.

- Risk management process: will identify and monitor, during project implementation, internal and external risks as well as any other issues that might affect the project progress. A Risk Log will be used to document and communicate the risks and their response actions. Project risks have been identified at the preparation step and a risk assessment has been developed as detailed in the section 9.6. Risks will be updated and re-evaluated during the duration of the project. Each partner has the responsibility to report immediately to their respective WP Lead and to the Coordinator Team any situation that may arise and may affect the project objectives or their successful completion. Any change in time schedule of deliverables or in the allocated budget must be reported to the corresponding WP Lead and to the Coordinator Team. In case of problems or delays, the Steering Committee will be consulted, and it will establish mitigation plans to reduce the impact of risk occurring.
- Conflict Resolution: Conflicts will be solved at the lowest level possible, and preferably amicably. If an agreement cannot be reached at the task or WP level, then the JA Coordinator will mediate. If that is not satisfactory, then the GA will decide and, if necessary, will ask for the authorization of the EC for any envisaged changes.

The **main artefacts** that will be generated during project management will be:

- Project Handbook: will summarize the project objectives and document the selected approach for achieving the project goals. It will document the Critical Success Factors (CSFs), define the key controlling processes, the

conflict resolution and escalation procedure, policies and rules, and the project mindsets. The Project Handbook will document the project governance roles and their responsibilities and define the plans necessary for managing the project as well as any methodology-tailoring decisions. The project goals and scope (found in the Initiating Phase documents) are key inputs to this artefact. The Project Handbook is an important reference document for all project members and stakeholders, and along with the Project Work Plan, is the basis on which the project is managed and executed.

- Project work plan: will be used as the basis to monitor the progress and control the project. It will document all project activities needed to achieve the project goals along with their detailed effort/cost estimates, their schedule and resulting project duration and resource requirements. The project work plan will be developed and maintained by the Coordinator team.
- Project stakeholder matrix: The Project Stakeholder Matrix lists all (key) project stakeholders and their contact details and clearly states their role(s) in the project. It may also include a classification or categorization of each stakeholder.

QUALITY & CAPACITY OF THE PARTNERSHIP

As previously described the JADECARE consortium is composed by 17 competent authorities covering a representation of 17 of the actual 28 members of the European Union, one candidate country as Serbia and a potential candidate like Bosnia and Herzegovina. The **owners of the oGP** are involved in the project as applicants: Competent Authorities like KG or Affiliated Entities like IDIBAPS or RSD or as subcontractor like Optimedis (under Ville et Eurométropole de Strasbourg). The presence of the owners of the oGP is crucial to guarantee the real implementation of the four oGP that have been selected by the Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases (SGPP). Optimedis is a private company that has developed the oGP selected by the SGPP and included in WP7 and will participate as a subcontractor following H2020 rules for subcontracting activities, considering that cannot act as a partner in the Joint Action. As it has been described before table included in section 5.1.5 and the 23 **next adopters** have declared the interest in the implementation of oGP or mix-matches of the four selected GP by the SGPP. To guarantee a broad impact and future application of the oGP included in the Joint Action, observer regions have been included in JADECARE. United Kingdom will participate by the means of HSCB as an observer in JADECARE. HSCB doesn´t aim to be a next adopter during JADECARE duration but will actively participate to identify other potential barriers and solutions in their area of influence so the coverage of different health systems could even be broader. In addition, **experts in dissemination and communication activities** as AEEK and BAGSFI are going to lead WP2 where the organization of events including stakeholder forum will be a key element for the project involving all communication departments from the different regions participating in JADECARE. Without a large amount of robust data and indicators the future impact of JADECARE will be highly limited, so evaluation will be led by an **international expert in evaluation** as AUTH/4THYPE in close collaboration with other international experts like KG or AQUAS. Sustainability and integration in national policies is a must for JADECARE so apart from including a broad representation of health systems in Europe, the measures and pathways for this **sustainability** will be coordinate by NIJZ and AGENAS to generate the necessary plans for next adopters not only for the implementation but also for sustainability of the change. Both entities have a broad experience in the field and the work will be perfectly coordinated and aligned with activities included in WP 5-8.

KG is the designated CA for Spain and will be the coordinator of JADECARE. KG is experienced in the coordination and management of European projects and Joint Actions mainly related to research and implementation of innovative health care delivery integration systems. KG has coordinated Carewell (CIP)[92] , also ASSEHS (2HP) and is now coordinating UPRIGHT (H2020). In addition, has been recently awarded by H2020 program, to coordinate an Innovation action in the field of integrated care. Other European projects of interest are C3Cloud, Fi-STAR, Mastermind, SCIROCCO, ACT, ACT@Scale, Advantage, CHRODIS-Plus, EIP on AHA (B3 Action Group on Integrated Care) where they have collaborated with other participating entities like:

- **JA CHRODIS Plus** where CIPH (Croatia), AUTH (Greece), SU (Hungary); AGENAS, Ministry of Health Italy, NIJZ, AQUAS and CSJA have also been involved,
- **EIP on AHA** where all the participants in the project have selected regions in the map of Reference Sites and have included innovative practices in the repository of EIP-AHA. In addition, several partners are part of the Action Group B3 (Integrated care),
- **SCIROCCO** and **SCIROCCO Exchange** where KG has collaborated with the University Hospital Olomouc (Czech Republic), NIJZ, OPTIMEDIS, and Italian partners in the development of identified methodologies in collaboration developing at first time the concept of B3 Maturity model.

[92] https://ec.europa.eu/digital-single-market/en/news/top-25-influential-ict-active-and-healthy-ageing-projects

- Greece partners as well as region of Sothern Denmark, AQuAs and KG have been also working in **ACT Scale** whose aim was to identify, transfer and scale up existing and operational Care Coordination and Telehealth good practices with the target of reaching a total of 100,000 care recipients across regions and programmes in multiple European countries.
- In **CareWell** coordinator, Italian and Denmark partners have worked in the delivery of integrated healthcare to frail elderly patients through comprehensive multidisciplinary programmes. ICTs facilitate the coordination and communication of healthcare professionals and support patient centered delivery of care at home. The project supported the integration of care in six European Regions.

It is important to highlight that most of the partners as described in section 11 have been involved in **other JA** that are also linked to management of chronic diseases, frailty, e-health such as:

- **Joint Action to support the eHealth Network** [JAseHN]: AEEK, SE, NVD (Latvia) AEEK and CIPH
- **eHAction**: CHIF was responsible for preparing legal interoperability in cross-border context where NIZJZ and AEEK are also partners.
- **ADVANTAGE**: KG, CSJA, CIPH, AGENAS, ACSS, NIJZ and DOH have worked together in the JA related to frailty
- **infAct**: InfAct (Information for Action): MCA, NIJZ, MSAE, ACSS are participating in this JA.
- **iPAAC** JA: NIJZ coordinates this JA, where CIPH and ACSS participate.
- **JAHEE** - The Joint Action Health Equity Europe: MCA, CIPH, NIJZ and ACSS are working together in this JA.
- **SHARP**: MCA, NIJZ, CIPH, MSAE are collaborating in this JA.

In addition, several of the participants have worked in **the preparation of the Health system performance assessment – Integrated Care Assessment** (20157303 HSPA) document as participants in the co-design of the performance assessment framework and maturity assessment of health systems.

CAPACITY OF THE STAFF TO CARRY OUT THE PROJECT

COORDINATOR: KRONIKGUNE

Kronikgune (KG) is an Institute for Health Services Research that promotes and carries out management and organization research on health and socio-health services. Its scientific research programme is aligned with the policies of the Basque Department of Health, that pursue the continuous adaptation and transformation of the health system by keeping people at the centre of the system and addressing the challenges derived from aging, chronicity and dependency.

Kronikgune will advance in health policies and services evaluation, intervention models development, dissemination and the analysis of health services' change and implementation. Its expertise lies in the analyses for health promotion strategies; study of stratification models and their usefulness to predict patients' needs and adequacy of resources; design of personalized care; best models and management services for integrated care; strategies and advanced methods of decision making, organizational transformation and innovation, including research in developing new products and technologies for e-health (diagnosis, support, monitoring, coordination).

Kronikgune is experienced in the coordination and management of European projects and Joint Actions mainly related to research and implementation of innovative health care delivery integration systems.

Kronikgune's area of expertise comprises the development and implementation ICT enabled solutions for the management of chronic disease, evaluation of health services and identification of determinants in the management of chronicity, with a common framework that integrates both social and health aspects.

Overall, Kronikgune analyses strategies for health promotion, including individual and structural actions and action models in community health; studies stratification models and their usefulness to predict needs and adequacy of resources for chronic patients; the design of personalized care (care management for high-risk patients, chronic patient integrated, multidisciplinary collaborative care programs); best models and management services for chronicity, including funding, contracting services, integrated care systems, technologies or new professional roles; strategies and advanced methods of decision making, organizational transformation and innovation, including research

Since 2016, the Basque Country is considered a 4-star Reference Site, which is the highest rating awarded by the European Commission to demonstrate excellence in the development, implementation and scaling-up of innovative practices, in line with the strategic aims of EIP on AHA. This recognition is also due to the commitment undertaken regarding an integral approach to active and healthy ageing and including new policies which place the person at the centre of all actions.

The Basque Government Health Department, through Kronikgune, Osakidetza and other organizations and institutions, has been part of the European EIP on AHA Association since 2012.

Kronikgune participated in the 6th EIP on AHA Partner Conference hold under the slogan: "Digital transformation of health and care for Active and Healthy Ageing in Europe". The event has focused on reviewing the action plans

defined within the Action Groups which come under the framework of the EIP on AHA strategy. The alignment of the plans and commitments undertaken by the partners in relation to the European Commission policies have been analysed, and in particular, regarding the "Transformation of Health" and "Care in the context of the Digital Single Market". Kronikgune, representing the Basque Country, took part in.

KEY STAFF:

- [redacted] obtained MD University of Navarra holds a Master degree in Community Health, University of London (LSHTM) and a Specialist degree in Family Medicine, Autonomous University of Madrid. Has a career in management in health and scientific institutions. From 1983 to 2002 he was in Andalucía, first as Regional Director of Primary Health Care and Health Promotion and later, as Academic Director of the Andalusian School of Public Health. From 2003 to 2011 he has been CEO of the Institute of Health Sciences of Aragón, responsible for Health R&D and knowledge management in the Region of Aragon, in Northeast Spain. Since July 2011 he is in charge of the Institute for Health Services Research Kronikgune, set up by the Basque Government within the R&D strategy to confront ageing, chronic diseases and healthy living. He has been involved in national and international projects advising public health and health systems development. His main expertise is on strategic management, human resources development and knowledge management in health services and research.
- [redacted] obtained an MD in Biology at the Autonomous University of Madrid (2005) and PhD in Genetics and Molecular Biology at the University of the Basque Country (2009). Currently, she obtained a Masters in research methods and evaluation of health services health economics of the National Distance Education University (UNED). In 2015 she obtained the LEAD – The certificate of Specialization in Leadership and Transformation in Organizations and Health Systems from Deusto Business School. Since the end of 2012, she has been a researcher in Kronikgune and from November 2015 until now, she has been coordinator of research projects in Kronikgune.
- J[redacted] holds an Engineering in Industrial Organization at the University of Deusto (2010) and a Master degree in Health Management at Deusto Business School (2015). In 2017, he obtained the Expert Course in Health Services and Chronic Diseases Research. He has experience in the implementation of health services in national and European project context. Since 2016 he works as Project Manager at Kronikgune, where he has been involved in several EUfunded projects including Mastermind, [redacted], SCIROCCO, SCIROCCO Exchange and the JA CHRODIS Plus.
- [redacted]holds a bachelor in Business Administration at Deusto Business School (1990). In 2018, he obtained the Senior Management Programme for Research, Innovation and Technology Transfer Institutions at IESE Business School. He has experience working as Auditor and Chief Financial officer. Since 2012, he works as Financial and Administrative Manager at Kronikgune. He is responsible for the financial and administrative management of several European Projects in DG SANTE, H2020, CIP and FP7 programmes. He has been the financial coordinator of ASSEHS, CAREWELL and UPRIGHT project.

AFFILIATED ENTITIES

- **CSJA:** The Regional Ministry of Health of Andalusia (CSJA) is responsible for public health, health policy, planning and regulation, healthcare management and provision in Andalusia, as well as the leadership of the Andalusian Public Healthcare System (APHS). CSJA develops different initiatives in the field of frailty prevention following the IV Andalusian Health Plan, the general framework of health policies in Andalusia to improve the health of the population, through Health in All Policies strategy. Two other comprehensive plans tackle specifically this issue: the Andalusian Plan of integrated care for patients with chronic diseases, and the Andalusian Comprehensive Care Strategy. Andalusia is a 4-star Reference Site within the European Innovative Partnership on Active and Healthy Ageing. **SAS** Andalusian Health Service- Public agency depending on the Regional Ministry of Health of Andalusia which main aim is to provide healthcare services to the population in the region. It is a wide network based on a high-quality, patient-centered, accessible care, with two levels of care: primary healthcare, the backbone, with 1,500 primary centers and 30 public hospitals. SAS counts with key professionals and departments whose participation becomes essential for this Joint Action. **Fundación Pública Andaluza Progreso y Salud (FPS)** is a non-for-profit organization which belongs to the Andalusian Regional Ministry of Health. FPS provides services to the Andalusian Public Health System through three lines of activity.
- **SCS:** The Cantabrian Health Service (SCS) is an autonomous administrative body attached to the Ministry of Health of the Government of Cantabria. The SCS has implemented a strategy for the managmenet of the Chronicity of Cantabria, as a guide and the driving force for change, the instrument to improve knowledge and the network of social services in a position to face an enormous challenge of the population's health conditions and to place the health system in a better position. The principles of user participation, of their families, and of patient associations; of training and co-responsibility; of continuity of care and coordination between levels and systems permeate the entire Plan and give meaning to the concept of placing at the centre of the plan. IDIVAL

manages the RTD developed by the health system in the region. IDIVAL has a strong commitment to research and innovation, ingredients that have been key in its success story and have reverted to the high quality of care provided daily

- **SACYL:** The Chronic Patient Care Strategy in Castilla y León (SACYL) aims to adapt the functioning of the Castilla y León healthcare system to the new reality of the growing demand for care derived from patients with chronic diseases. It focuses on five fundamental aspects: Organize and adapt hospital resources to the conditions and needs of these patients; Strengthen the role of primary care and improve its conditions to facilitate effective care; To ensure coordination between the professionals of the different levels of care that intervene to guarantee the continuity of care; To advance towards healthcare integration through the effective coordination of the health and social systems; To promote the active participation of patients and caregivers in the maintenance of health.
- **SMS:** The Murcian Health Service (SMS) is the responsible for health care in the Region of Murcia, integrating a total of 11 hospitals, with 3,651 beds and 508 outpatient appointments of primary care, and providing healthcare to 1.47 million inhabitants (about 3.09% of the whole Spanish population). The SMS provide services and develop the following actions: Health Promotion, Prevention of the disease, Comprehensive Primary Care health, Specialized Healthcare. It is noteworthy that the Region of Murcia is considered by firms specialized in the implementation and evaluation of health-related technologies. The Foundation for Health Training and Research of the Region of Murcia (FFIS), is a foundation dependent on the Health of Regional Department of Murcia, and with the Health Service of Murcia (SMS) are the main actors in the development and promotion of the innovation in the Health Sector in The Region of Murcia. The main objective of the Foundation for Training and Health Research in the Region of Murcia (FFIS) is to organize, coordinate, promote and manage health research training and generating effective innovation and useful knowledge to the healthcare system of the Region of Murcia. The team will include: Pedro Perez Lopez as member of the Member of the Institutional Committee of the Chronic Attention Strategy: Luis G Contreras Deputy Director General of projects and Innovation among others.
- **IDIBAPS:** The Consorci Institut d'Investigacions Biomediques August Pi i Sunyer (IDIBAPS) is a public research centre dedicated to translational research in the field of biomedicine. IDIBAPS is formed by the Government of Catalonia, the University of Barcelona's Faculty of Medicine (UB), the Hospital Clínic de Barcelona (HCB) and the Institut d'Investigacions Biomèdiques de Barcelona of the Spanish Council for Scientific Research (IIBB-CSIC). Since 2006, IDIBAPS and HCB have pioneered a profound transformation of health services towards integrated care in the district of Barcelona-Esquerra (AISBE 540 k inhabitants) and are contributing to scale-up integrated care in the region of Catalonia (ES). Within the IDIBAPS-HCB frame, the Integrated Care and System's Medicine (InCaSyM) group, will collaborate in JADECARE under the leadership of Prof. Josep Roca MD, PhD. Key collaborators will be: Isaac Cano, PhD (computer scientist); Carme Hernandez, PhD (nurse coordinator of the home hospitalization program at HCB); Anael Barberan, PhD (physiotherapist coordinator of the healthy lifestyles program); and, Ines Mila (operations manager). IDIBAPS, WP6 leader, plays an umbrella role coordinating, jointly with AQuAS, all local stakeholders in Catalonia.
- **AQUA**S Agència de Qualitat i Avaluació Sanitàries de Catalunya has the mission of generating relevant knowledge to contribute to the improvement of the quality, safety and sustainability of the Catalan Health Care System and thus easing the decision-making process for citizens and health care managers and professionals. AQuAS combines different study methodologies in its assessments. Primary data, secondary data, and data synthesis may be included in the process. The activities of the AQuAS – at request and by own initiative – take place within the public Catalan healthcare system, industry, insurance companies, research units, and users in Catalonia, Spain, and abroad. AQuAS is also a collaborating center of the World Health Organization (WHO), developing various support tasks on HTA and promoting use of proper health technologies. AQuAS has also an active participation in making and coordinating groups for developing evidence-based clinical practice guidelines.

BOSNIA AND HERZEGOVINA

COMPETENT AUTHORITY

The Ministry of Civil Affairs of Bosnia and Herzegovina (MCA) is state-level institution responsible for carrying out tasks and discharging duties, which are within the competence of Bosnia and Herzegovina and relate to defining basic principles, coordinating activities and harmonizing plans of the Entity authorities and defining a strategy at the international level in the field of health care. Within the Ministry, there is the Department of Health with its two sections: Section for Statistical Analytical Work and Reporting and the Section for European Integration and International Cooperation.

Health system in Federation of Bosnia and Herzegovina is decentralised. There is one Federal ministry of health and 10 cantonal ministries of health. Federal ministry of health is roof institution for Federal health insurance fund, Public health institute and Institute for transfuziology. Each of cantonal ministries has its own cantonal health insurance

fund, and its own cantonal institute for public health. Every canton has clinical centres, cantonal hospitals, general hospitals, health centres and ambulates.

KEY STAFF:

- [redacted], Project Coordinator, holds an university degree in medicine, with over 25 years of professional experience in managing and coordination of the various international healthcare Projects which were/are implemented in Bosnia and Herzegovina and funded by World Bank, UN agencies, EU and bilateral donors.

AFFILIATED ENTITIES

The main duty of the **Ministry of Health and Social Welfare of the Republic of Srpska** is the creation of a modern, rational, efficient and effective health care and social welfare systems, dedicated to the policy of the improvement of the population health and conditions which affects the health and social welfare.

The Ministry of Health and Social Welfare of Republic of Srpska performs administrative and other professional tasks related to the promotion, improvement, control and protection of public health, public health, health care, health system, pharmacy, social, family and child care in Republic of Srpska, Bosnia and Herzegovina

KEY STAFF:

- [redacted] is experienced project manager and project coordinator with key expertise in development and deployment of information systems in health care. His previous engagements in last 15 years include preparation of project documentation (operational manuals, budget, procedures and results frameworks, terms of reference) within specific framework; coordination and oversight of development of various information systems for health system of Republic of Srpska and information management; development of study/research methodologies, survey design and implementation.

The Institute for Public Health of the Federation of Bosnia and Herzegovina operates in two organizational units, in Sarajevo and Mostar, which form a single functional unit. The Institute performs professional tasks within the legally defined activities, through its services / centers, which are structured into departments.

Through a diverse range of public health functions, the Institute seeks to fulfil its mission as a professional referral and scientific institution in the field of public health, which through monitoring, scientific research and education, as well as health promotion, actively influences the improvement of the health status of the population of Federation of BiH and a vision that emphasizes the role of the Public Health Institute of the Federation of BiH. With its function, the Institute significantly influences the improvement of the health status of the population and the creation of sound public policies in cooperation with all public health institutions, other sectors and with the full support of the community.

KEY STAFF:

- [redacted], Director of the Institute, is a primarius doctor, and has great experience in the field of primary health care. For many years, He has been working as a health care manager, and this brings great value to one such project. This experience can be of great help for prediction and planning of future moves in this field of what is needed in practice. He owns great knowledge on practical medicine and information flow which is crucial for the proper perceiving and solution of the problem.
- [redacted]worked on all projects regarding information systems in public health sector from 2013 and has a great knowledge of how things work and how to organise activities properly. She worked on survey design and data analysis, data mapping and data mining, statistical analysis, design of information system, user support and implementation of systems on the actual field.

CROATIA

COMPETENT AUTHORITY

CIPH is a central public health institute in the Republic of Croatia. CIPH deals with public health, health promotion and education, disease prevention, microbiology, environmental health, school medicine, mental health care and addiction prevention. CIPH's main tasks are to plan, promote and implement measures for the enhancement of population health and reduction of health problems. The Institute functions as a statistical authority which maintains national public health registries, supervises data storage and coordinates the work of other health registers. It coordinates the network of regional public health institutes, actively participates in the creation of health policy and public health regulations and engages in international co-operation for the purposes of improving public health and welfare.

CIPH's Division of Occupational Health has been recently incorporated to CIPH but their field of expertise includes integrated care for workers and their health and healthy aging at work not only in order to improve job satisfaction but also to provide our workers longer work ability and healthier aging and retirements as well as improving employability of persons with disabilities.

KEY STAFF:

CIPH's team will include key roles as the Assistant Director-General of Occupational Health and Head of Division of Occupational health and Head of Department of Work Ability Preservation and Heath at Work in Croatian Institute of Public Health (CIPH).

- [redacted] MD, PhD, is an occupational and sports medicine specialist, Assistant Director-General of Occupational Health and Head of Division of Occupational health and Head of Department of Work Ability Preservation and Heath at Work in Croatian Institute of Public Health (CIPH). Dr. Bubaš is also Chair of ICOH Scientific Committee Education and Training in Occupational Health and Board member of European Association of Schools of Occupational Medicine.
- [redacted] MD, PhD is an occupational medicine specialist, Head of Department of occupational diseases. Primarius Bogadi Šare has extend knowledge in occupational diseases and health and safety at work. In 2006 she has participated as a principal investigator in the project led by Croatia and the Netherlands, on implementing best practices in health coverage of worker and implementation of best practices in occupational health.

AFFILIATED ENTITIES

CIPH's affiliated entity, CHIF has a main role in implementation and deployment of eHealth in Croatia and together with Ministry of Health a significant role as policy maker concerning health in general. Croatian Health Insurance Fund is state institution financing health protection and covering mandatory health insurance in the country. Thus, CHIF manages prevention at all levels and also health protection. Meaning that CHIF is nationally responsible for managing all the primary health care, secondary and tertiary health care, organizing digitalization of health services and introducing good practices, upgrading the system for the better. CHIF collaborates with Croatian Institute of Public Health when introducing and delivering national prevention programs and best practices in prevention. Croatian Institute of Public Health is funded by the government in all areas of managing public health. Without the support of the Croatian Health Insurance Fund it will be much harder to introduce best practice examples into daily practice at national level as the CHIF has direct contact (through contract agreements) with healthcare workers and institutions at all three levels of health care. Meaning, the network that CHIF has will help introduce best practices into every day provision of healthcare.

KEY STAFF:

- [redacted], graduated in Faculty of Electrical Engineering and Computing (University of Zagreb), attended HKS Executive Education (Digitazing Public Services). She is an experienced software engineer, with an advanced knowledge of software methods and processes, and requirements engineering.
  She has been involved in development and implementation information strategy in national projects (CEZIH, ePrescriptions, National Prevention Program, etc) and she was team leader on JAseHN project. She is participating eHAction and she is coordinator for EESSI project.
- [redacted], prof. spec. ing. logist. graduated at the University of Applied Sciences Velika Gorica, professional study of Management of Logistic Systems and Processes. He has 15 years experince in IT sector in Croatian health insurance fund and actively planed and worked at several National eHealth projects such as the ePrescriptions, eRefferal and eResult , eOrdering and eWaiting lists. He is participating eHAction project.

CHIF's team will include a team with experienced software engineer, advanced knowledge of software methods and processes, and requirements engineering.

CZECH REPUBLIC

Ministry of Health of the Czech Republic (MZCR) is the central authority responsible for health care in the country. Due to existing health (and care) system development over long decades no consistent model of integrated care is implemented. Care integration term is usually used in two contexts in the CR: 1. Perspective integration of health and social care that should resolve accumulated issues on so called "health and social care border" with services provided to citizens and patients that typically require both health or social care but the conditions for such services provisioning are still not well aligned, and 2. Partial solutions of coordinated care established by either specific health service according to law (so called "dispensary care" used in specific diseases), or coordination managed on the bases of cooperation of medical professionals sometimes formalised in programs jointly agreed by pertinent national medical societies, and/or agreed institutional relations or agreements between various healthcare providers in the country. None or just marginally some of these cases sufficiently herald by attributes of integrated care as understood in the context of healthcare reforms by EIP on AHA, DG SANTE or WHO, particularly if it comes to relation with electronic sharing of health information and other eHealth services, though such services as such are being implemented in the last period in line with modern trends in EU countries. Endorsement of the Strategic Framework "Health 2030" by MoH in 2019 has opened new space for development and implementation of concepts of integrated care models and further digitalization of healthcare in the Czech Republic.

KEY STAFF:

[redacted], MD was appointed Deputy Minister of Health of the Czech Republic in December 2017. From 2003 to 2017 she has been as Director of the National Office of the World Health Organization (WHO) in the Czech Republic. In 1991-2003 she was invited to the Ministry of Health, where she held various positions, including an advisor to the Chief Hygienist of the Czech Republic, the head of the outpatient and primary care department and the director of the department for science and research. She is the author and co-author of a number of articles focused primarily on prevention, health promotion, public health, WHO policies and strategies and their implementation into the Czech Republic. As of 2019, Mrs. A. Steflova also coordinates implementation plans in the Strategic Framework "Health 2030".

[redacted], PhD has his expertise in healthcare innovations based on information and communication technologies. He focuses on new health and care models using digital technologies and assessment of innovative services and their impacts. He is particularly involved in deployment and scaling up of digitally-enabled care solutions for chronic diseases. He is an expert of the Ministry of Health of the Czech Republic for telemedicine, artificial intelligence and innovations supporting integrated and person centered care in its National eHealth Centre (NCEZ). He has a track of experience with international projects of the Czech National eHealth Center (NTMC) of the University Hospital Olomouc (UHO) and with coordination of membership in EIP on AHA and activities of AHA Reference Site.

[redacted]currently works at National eHealth Centre (NCEZ) as its director. NCEZ is the national e-Health authority under the Ministry of Health. He was formerly the Chief Information Officer (CIO) of the North Bohemia Regional Hospital Trust. He is a Chairman of the Czech Society of Medical Informatics and Scientific Information. [redacted] is responsible for nationwide strategy and implementation of the digital health services in the Czech Republic.

AFFILIATED ENTITIES

Systematic use of eHealth services in healthcare and development of integrated care models is one of the targets of Affiliated member – University Hospital Olomouc (UHO) with its Czech national eHealth Center (NTMC). UHO is one of the largest and oldest state-owned teaching hospitals in the CR, with 4,200 employees providing complex health care services, UHO reports to MoH and effectively acts as Regional Hospital in Olomouc Region with approx. 640 000 inhabitants. UHO is the driver of innovations in healthcare in the Region, develops and scales up eHealth infrastructure, services and applications. During COVID-19 crises in 2020, it launched several innovative digital solutions transferable also to other regions. UHO has been acting also as Competence Centre for Telemedicine of MZCR since 9.2019.

UHO is a member of EIP on AHA since 2012, actively working in AG B3 on Integrated care, with commitments and submitted own good practices. It is also an AHA Reference site nominated in 2013, 2016 and 2019. UHO has participated in several EU projects and Twinnings with scopes relevant to JADECARE; last Twinning focused on healthcare reforms and digital solutions in Catalonia, attended also by MZCR representatives, was concluded in January 2020.

KEY STAFF:

- [redacted] is Deputy director of ICT of UHO. He is responsible for the development and operation of ICT in UHO and for the concept and implementation of Regional e-Health platform, as well as digital security.
- [redacted], MBA is Deputy director of UHO responsible for the strategy and processes of purchasing medical devices and innovations.
- [redacted] belongs to the NTMC department of UHO and works as a project manager with expertise in the economics of innovation implementation. He is involved in the management of projects focused on the development of telemedicine, eHealth and assistive technologies, innovation of teaching using ICT tools, responsibility for the development of the Czech National eHealth Center.

[redacted]MD. Senior consultant. Professional orientation - pediatric medicine, psychology, eHealth, public health, health policy, health literacy, primary and community care, research management, education.

DENMARK

COMPETENT AUTHORITY

The Steno Diabetes Center North Denmark is an relative new organization. In December 2017, the Novo Nordisk Foundation approved a grant of DKK795 million to the North Denmark Region for establishing and operating Steno Diabetes Center North Denmark

The vision for Steno Diabetes Center North Denmark is that it will improve the longevity and quality of life of everyone with diabetes and create coherent treatment near people's homes and halt the growth of people developing diabetes.

The Hallmark of the "Steno Diabetes Center" is "Digital Health" and the center has recruited highly skill employees in the field, who have worked many years with digital transformation.

The Digital Health team is a team of one manager and two project managers. All with 15+ years expires in the field of digitalisation and with academic background. The Team is part of the Steno Diabetes Center Norddenmark, which have these other departments, which will be involve in the project:

- Department of Patient-centered and evidence-based treatment of diabetes: Doctors, nurse and other caregivers who are treating the patients
- Department of Clinical research: Diabetes research unit with Professor, senior researchers and Ph.D. students
- Department of Developing competencies and education: Educators and manager of user counsil
- Department of Intersectoral collaboration: Projectmanagers and health care professionals, who collaborate with GP and municipalities.

https://aalborguh.rn.dk/for-sundhedsfaglige/steno-diabetes-center

KEY STAFF:

- [redacted] holds a Master of Arts in Information Science and Cross-cultural Communication and a Master in Management and Organizational Psychology. As digitization manager, Tina Archard Heide is head of Digital Health and Diabetes in Steno Diabetes Center North Jutland. The Digital Health unit is working across SDCN's various areas with health professionals, researchers and private companies to develop new digital opportunities and healthcare for citizens with diabetes. Before Steno Tina Archard Heide comes from a position as head of TeleCare Nord, which on behalf of the Northern Jutland municipalities and the Region of Northern Jutland has been behind large-scale projects around home monitoring for COPD and heart failure patients.
- [redacted] has a Master of Science in Public Administration from Aalborg University and a later diploma of management from Technical University of Denmark. Ulrik is working in Steno with focus on diabetes technologies, data and networking. Prior to Steno, Ulrik Appel worked with welfare and innovation in a variety of public sectors. Primary as chief consultant for a municipal innovation unit in the country third largest municipality (Municipality of Aalborg)

AFFILIATED ENTITIES

The Region of Southern Denmark is one of five administrative public units in Denmark. The Region of Southern Denmark has a large focus on innovation in health and social care and is a four-star excellence reference site in the European Partnership on Active and Healthy Ageing (EIP on AHA). The health Innovation Centre is the central unit of innovation within the Region of Southern Denmark.

Through a strong focus on cross-disciplinary collaboration, user involvement and design-thinking the Health Innovation Centre of Southern Denmark develops innovative solutions that contribute to high quality healthcare for citizens and efficient services and procedures for healthcare professionals. The innovation field explores new ways of designing hospitals, improving telehealth and telecare solutions, and supporting daily operations in and around the Region's hospital units, e.g. using emerging technologies such as AI and robotics.

The centre employs coproduction and co-creation as a method to involve users as co-creators of solutions. Involving users – patients, citizens, and employees – is at the core of the Health Innovation Centre of Southern Denmark, e.g. through a specialisation in needs analyses, user qualification/testing of new technologies and services as well as implementation. At its core is close collaboration with public health and care organizations and private companies as well as knowledge- and educational institutes such as the University of Southern Denmark. The main aims are to bring integrated care to the citizens of the Region as well as being a meeting point and an accelerator for public and private innovation partnerships.

The Region of Southern Denmark is known as an international front-runner in health innovation, telemedicine, integrated care, and assisted living. This is partly due to the long tradition of participating in international activities relating to the core activities of the region. In the JADECARE project, the role of the Region of Southern Denmark, represented by the Health Innovation Centre, is as Best Practice case with the Digital Roadmap towards Integrated Care. This concept consists of our SAM:BO agreement connecting the sectors digitally supplemented by a number of projects in the area of digitally enabled integrated care.

KEY STAFF:

- [redacted] is the manager of the department for Telemedicine and Ambient-Assisted Living Technologies at the Health Innovation Centre of Southern Denmark. He has a Master's degree in IT and has been involved in a variety of IT-projects both within and beyond the Health Care sector. He has extended experience with EHR systems, where he has been the project manager of several projects in OUH and responsible for a team of project managers. He works specifically in the fields of Integrated Care, Digitalization of the Health Care sector and Implementation of national and regional IT-strategies.
- [redacted] has a Master's degree in political science with a special focus on combining New Public Management with ICT innovation. She has been politically active with four years as member of the Regional

Council. She also has experience as a consultant in the Health Innovation Centre of Southern Denmark, where she has been working within Public and Private Innovation and as a project manager for a wide range of IT projects including Nordic PPI. She is currently Team Coordinator for the Team of Telemedicine.

ESTONIA

COMPETENT AUTHORITY

Estonian Ministry of Social Affairs (MSAE) is responsible for the following areas of activity: health care, public health, e-health, labour, social security benefits, social services, children and families, gender equality and equal treatment. This means that most authorities responsible for integrated care, including digitally enabled integrated care, operate in the administrative field of MSAE. The key role of MSAE is to plan the policies in previously mentioned fields, including bringing together different stakeholders for achieving more integrated care. Improving integrated care has been one of the priorities for MSAE, being included in the Estonian eHealth Strategic Development Plan 2020[93], Welfare Development Plan 2016–2023[94] and other strategic documents. To achieve the strategic goals set, a variety of initiatives and projects have been launched.

MSAE is currently working towards building a broader integrated care strategy. The overall aim of this project is to contribute to a more integrated and person-centered provision of social, medical and vocational support services to people with disabilities and elderly with high support needs. One ambitious initiative is the enhanced care management programme carried out together with the World Bank, with implementation being coordinated and financed by the Health Insurance Fund. The focus of the programme is on high-risk patients and an algorithm has been developed to assist the family physician and the family nurse in identifying the patients who need more coordinated support. Coordination of the issues of social assistance is also encouraged, but not mandatory in the current phase of the programme. In the future, the algorithm could potentially be integrated in the wider coordination model, being developed in parallel, enabling a more systematic linkage between primary level healthcare and primary level social welfare. Also, preparatory work for creating an assessment instrument repository is ongoing. The aim is to create an assessment instrument repository that would enable sharing assessment (such as the interRAI assessments) between relevant stakeholders (such as patients, GPs, social workers, health and welfare service providers etc) and enabling carrying out joint assessments across disciplines and organizations. The goal is to enable more smooth service pathways, easier communication between different stakeholders and reduction of bureaucracy both for patients, service providers and funders.

To improve the integration of policies and services, MSAE is working closely together with variety of actors such as the Estonian Social Insurance Board, the Estonian Health Insurance Fund, the Estonian Unemployment Insurance Fund, unions representing patients and other interest groups, hospitals, GP-s, social service providers and other stakeholders.

KEY STAFF:

- [redacted] is an adviser for the Social Welfare Department in the Estonian Ministry of Social Affairs, focusing on the development person-centered services. She is currently responsible for several projects and initiatives aiming to improve integration between healthcare, social welfare and vocational services and policies. In addition to her work in the ministry, she is currently doing a PhD in innovation and governance, looking into new ways of public service delivery. New ways of service delivery, such as better use of data and co-creation between citizens, service providers and other stakeholders has been an important element of both her academic research and practical work in the ministry
- [redacted] serves as an adviser in the Smart Development Department at the Ministry of Social Affairs, where he is responsible for digital transformations in primary health care and supports innovative initiatives in social care. He has previously coordinated a task force on long term care at the Estonian Government Office, developed primary health care services at the Estonian Health Insurance Fund and conducted research at Tallinn University of Technology (TalTech). Rauno is also a PhD candidate at TalTech, focusing on policies for spurring innovation.
- [redacted] is a chief specialist in the Health System Development Department in the Ministry of Social Affairs, where she is responsible for the development of the primary health care system. She has also been involved in the development of the primary level care coordination system development and in other initiatives aiming to improve coordination and integration within healthcare system and across health and welfare systems. Her educational background is in sociology, social politics and public health.

AFFILIATED ENTITIES

Viljandi Hospital, that is the Affiliated entity in this project is currently running one of strategic integrated care projects that is aiming to develop and test a regional model for integrated care (together with digital tools to support

[93] https://www.sm.ee/sites/default/files/content-editors/sisekomm/e-tervise_strateegia_2020_15_en1.pdf
[94] https://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/welfare_development_plan_2016-2023.pdf

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the implementation of such model) in the region of Viljandi. The initial development of the model was funded by MSAE and the current work is funded by the innovation fund of the Estonian Health Insurance Board. While the work done in Viljandi mainly concentrates on improving the integrated care in the context of Viljandi region, the expectation is that the regional integration model could also be implemented in other regions of Estonia. Through this JA, some of the best practice elements could be transferred into the regional model of Viljandi and after successful pilot activities be scaled up into the national coordination and integration models.

FRANCE

The Eurométropole de Strasbourg has recently won a national call for proposals on local innovation with great ambition; its project includes developing an initiative of integrated care locally. The Eurometropole coordinates a consortium including the key local actors (hospital, physicians, health agency, health insurance, local authorities…). Eurometropole of Strasbourg covers the City of Strasbourg and 32 surrounding municipalities. The population grows moderately (+5% by 2040) and ages significantly, therefore increasing the needs for chronic diseases and elderly care.

The Eurométropole of Strasbourg is part of a bigger administrative medical territory of circa 1 million inhabitants with one main university hospital in Strasbourg, some private ones and more than a 1000 mostly private general practitioners. The population of the practitioners is ageing, mainly in the most rural areas of the territory.

KEY STAFF:

- [redacted] Project manager senior- Fanny has started in march 2019 to work on a project aiming at accelerating innovation in the health sector in the area of Strasbourg. Her missions entail reinforcing collaborations between health actors for the benefit of the local population. Her involvement in JADECARE is complimentary with her current core missions. She has extensive experience of managing European funding (ERDF) and has participated in some European projects (URBACT). She has a master in European studies (College of Europe of Natolin, Poland) (
- [redacted] Project director. Rémy has worked as Director for Economic development for 4 years and his missions entail fostering innovation in the health sector, encouraging local and international cooperation between healthcare actors, universities, clusters and entrepreneurs. He has successfully directed an application for a national call for projects on local innovation « with great ambition » (total budget for Strasbourg = 115 M €); the project includes developing an initiative of integrated care locally. In coordination with a consortium of key local actors (hospital, physicians, health agency, health insurance, local authorities…). Remy has graduated at a Business School (ESCP Europe, Paris, France).

SUBCONTRACTOR: OPTIMEDIS

The OptiMedis AG is a management company that designs, implements and evaluates accountable care systems in order to improve health, care experience, and lower costs. It manages a group of regional Integrated Care Delivery Systems that are located in different parts of Germany and serves as a research and performance management institute to these regional delivery systems. OptiMedis is well connected in Germany with health insurances, ministries, medical associations and public services in the regions it is operating in. OptiMedis AG has an internal department for research projects and data analytics, analysing complex social health insurance data for the regions it serves.

KEY STAFF

[redacted] is Vice Chairman of the Board at OptiMedis AG, where he oversees the programmes for research, health data analytics and development of population health management programs. Previous positions include Senior Lecturer in Health Services Research at London School of Hygiene and Tropical Medicine and Manager of the Quality of Health Systems Programme at the World Health Organization Regional Office for Europe. He holds an MSc and PhD in Public Health and an MA in medical sociology and organizational sciences. Oliver Groene served as principle investigator (PI) or co-PI on various large scale grants, with total research funding over 9 million EUROs. He publishes widely in leading clinical, quality-of-care and health policy journals (H-Index=36) and served as Deputy Editor of the International Journal for Quality in Health Care (impact factor 2.6) from 2015 - 2019.

[redacted] is Manager Health Services Research at OptiMedis. She obtained her PhD at the Medical Faculty at the University Clinic Hamburg, and has a background in Health Science and Physiotherapy. He worked centers on the assessment of quality of life outcomes and the implementation of new models of care.

GERMANY

COMPETENT AUTHORITY

BAGSFI

Hamburg is a country in the German federal system, with limited legislative power in the health sector. Germany with it's classically Bismarckian social system, has a quite fragmented health system. The big frame in the German

health policy is set on the federal level, and the definition of the concrete services – to be financed by statutory health insurance based on federal law - is set by a committee of the umbrella organizations of self-government institutions (statutory health insurances, physician associations, German Hospital Federation). The BAGSFI is since 2013 member of the EIP-AHA and hosted the D4 meeting in 2017.
The cooperation of the BAGSFI with the LGL and the ZTG was build up, after the initiative of the German federal health ministry, in the working group for telematics in the health sector (federal and all country ministries). Bavaria is the leading country of this working group. The cooperation between Bavaria, Hamburg and North-Rhine Westphalia ensure the dissemination of the JA results and increase the cooperation of active players in the field of integrated care in Germany.
Germany is currently in the role out phase of the telematics infrastructure, which will connect the health care providers, which is the basis for the use of electronic health records. In this phase it is very interesting to learn in the JA, and to elaborate which elements of the good practice can be implement in the German system.

KEY STAFF:

[redacted] works for the Ministry of Health and Consumer Protection of the Free and Hanseatic City of Hamburg, as member of the Division of Health Care Industry, International Affairs and Shareholdings. Since 2012, he is in charge of project development and management, and he is supervising projects' legal, administrative and financial framework. He is specialized in the promotion of innovation and digitalization in the health sector. As graduated nurse and with a degree in Health Science, he has a solid background around health systems; in addition, he has a Master degree in European Public Administration.

AFFILIATED ENTITIES

LGL: The Bavarian Health and Food Safety Authority (LGL) is the central authority of the Free State of Bavaria for food safety, health, veterinary affairs and occupational safety/product safety. The JA is attended by the subdivision GE6, which has extensive experience in the handling of funding programmes. This includes, for example, the “GesundheitsregionenPlus” (Health Regions Plus). The primary objective of Health Regions Plus is to improve the state of health of the population, particularly with regard to equal health opportunities, through sectoral networking and to improve the health-related quality of life. As an interdisciplinary and competent network of regional actors in the health care sector, the Health Regions Plus take care of the optimization of regional health care in Bavaria. Consisting of a health forum with management and steering tasks, topic-related working groups and a coordinating office, the Health Regions Plus focus primarily on the fields of health promotion and prevention via an interdisciplinary approach.
The funding agency "Innovative Medizinische Versorgungskonzepte" (Innovative Medical Care Concepts, IMV) in the subdivision GE6 promotes the implementation of innovative concepts for the preservation and improvement of medical care and/or for the promotion of cross-sector care. An evaluation process also accompanies these concepts. The funding focuses in particular on projects to maintain and improve care in rural areas, on interdisciplinary/sectoral cooperation between doctors, hospitals and other medical professionals and on high-quality patient care using digital media. The funding agency promotes, evaluates and supports these projects, which aim to be integrated into standard care.

KEY STAFF:

[redacted] Bavarian Health and Food Safety Authority – Team leader Bavarian Health Agency, health services. From 2002 to 2012, Head of Rehabilitation Sciences and Rehabilitation Economics at the university hospital of Munich. Theses subject “Validation of the Stroke Specific Quality of Life Scale -Validity of the SS-QOL in Germany and in Survivors of Hemorrhagic or Ischemic Stroke and Validity of the Stroke-Specific Quality of Life Scale for patients following traumatic brain injury”. Since 2012 team leader at the Bavarian Health and Food Safety Authority.

[redacted] Bavarian Health and Food Safety Authority – Coordination Office eHealth.Julia Eichelsdörfer is a graduate in business administration and a law assessor, with professional experience in both fields. Having worked in the private sector (including Consorsbank, Siemens and as an independent management consultant), she moved to the Bavarian Health and Food Safety Authority at the beginning of 2019, contributing her legal expertise to the Coordination Office

ZTG GmbH: Centre for Telematics and Telemedicine (ZTG GmbH) is a public-private partnership bringing together all stakeholders (also in the role of shareholders of the GmbH capital and hence as advisory board) in healthcare of the Federal State North Rhine Westphalia (NRW). Roughly stakeholders can be characterised as health provider, health professionals and statutory insurance organizations; third sector and patient’s representatives and industry. It has been founded with the support of the State Government in 1999 to implement the digital health elements of the state’s agreed high-level strategy for healthcare. ZTG GmbH receives meanwhile institutional funding from the State government and generates as well income from project activities. The objective of ZTG-GmbH is to introduce and

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to spread modern information and communication technologies into the healthcare system. The main goal is to strengthen the quality of care along the increasing demands. A consequent orientation to the interests of patients and health care providers based on the dialogue with all involved are central building blocks of our work. Besides consulting services, expert opinions and projects ZTG-GmbH focuses on creating networks between market players. Kay virtues are independence and highly specialized expertise. In order to secure long-term investment, interoperable interfaces are just as natural for us as viable privacy concepts and fair financing models. Given it's long standing advisory role to the Ministry for Labour, Health and Social Affairs of North Rhine-Westphalia ZTG is and has been involved in establishing policies and policies for digital health in the state NRW and also in national level activities like supporting a joint federal and states working group on eHealth reporting to the conference of German state health ministers and being representing in nation-wide activities like the advisory board of Gematik (German eHealth Agency) and various working groups supporting collaboration within Europe.

KEY STAFF:

[redacted] MA works as a Project Consultant at ZTG GmbH since 2018. She is involved in a variety of telemedicine related projects. She started to work at ZTG-GmbH as a student assistant in 2015. Master of Arts degree in Social Sciences with a minor in Health Economy and Health Systems from the Ruhr-University in Bochum. In addition, she is a 2014 European Public Administration (Bachelor of Arts) graduate from the University of Twente.

GREECE

COMPETENT AUTHORITY

4th THYPE (the 4th Health District of Macedonia and Thrace) is one of the two main health administration and policy organisations if Nothern Greece. It offers web applications such as employee management, store management, appointment management, External medicine secretariat, H/W & S/W support, VPN communication through Cisco Meraki equipment between Central Offices and 56 Health Centers. 4th RHA possesses the infrastructure and technique equipment:

Dell R620 servers holding virtual infrastructure, Netapp Storage (approximately 10Tb of Data), various virtual servers, such as Primary & Secondary AD server, Antivirus server, mail server, DB Server, Web Application Servers etc., Fortinet firewalls in HA mode for internal use and Cisco Meraki Firewalls located in 21 Health Centers and Central Offices.

KEY STAFF:

- [redacted] University Degree on Business Administration and two Master Degrees on Bussiness administation with expertise field IT systems she is currently working in the 4th Health District of Macedonia and Thrace, Ministry of Health as Head of the Programming and Development Department. She is project manager in EC Interreg projects where 4th DYPE is lead partner.
- [redacted] University Degree on Department of Statistics and Actuarial Science of the University of Piraeus she is currently working in the 4th Health District of Macedonia and Thrace, Ministry of Health as Head of the Research and Development Department. She has a long experience in the implementation of EC Interreg projects where 4th DYPE is lead partner
- [redacted] Chief Information Officer: Theodosios holds a BSc in Computer Science from Rutgers the State University of New Jersey (USA) and a Msc in Health Management from HOU (ΕΑΠ). He worked for more than 10 years in various companies such as Logismos S.A., Hellenic Steel S.A., and Intrasoft S.A. Since 1997 is in the Public Health Sector. Currently is in the 4th YPE of Makedonia & Thrace (4th Regional Health Authority of Makedonia and Thrace.) in the Dept. of Information System, managing and developing the information services. The main task is the implementation of the strategy for the utilization of the information technology in the health sector in the region (15 Hospitals, 51 Health Centers, 232 Peripheral Infirmary etc). Since 2001 he was engaged in several European Programs such as Prohealth, BeHealth, RESHEN (IST 2000/5th framework), Υγείας Πρότυπον (ΓΓΕΤ-ΕΠΑΝ), pEHR (eTEN),), IMPRESS Project (http://fp7-impress.eu/, Information Society SA, ΠΕΠ etc

AFFILIATED ENTITIES

The **Aristotle University of Thessaloniki (AUTH**) is the largest University in Greece. The School of Medicine accommodates >340 academic staff and >3500 active students. The Lab of Medical Physics is a major research and development centre in assistive technologies, applied neurosciences, medical education, affective computing, semantic web, medical robotics and brain computer interfaces, radiodiagnosis and non-ionizing radiation. It is composed of 10 research groups, leaders in their respective specialties, which pursue innovative research projects. They have been recognized internationally for their research excellence and have been funded by a wide spectrum of sources.

The Lab of Medical Physics is a major research and development centre in assistive technologies, applied neurosciences, medical education, affective computing, semantic web, medical robotics and brain computer interfaces, radiodiagnosis and non-ionizing radiation. It is composed of >10 research groups, leaders in their

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respective specialties, which pursue innovative research projects. They have been recognized internationally for their research excellence and have been funded by a wide spectrum of sources. Several groups and cliniques from the School are involved under the leadership of the Lab of Medical Physics (MedPhys).

KEY STAFF

- [redacted] is aProf. of Medical Physics, Medical Informatics and Medical Education in MedPhys, School of Medicine the Aristotle University of Thessaloniki, Greece. He has founded and has been leading four research groups, namely, in Medical Education Informatics, in Assistive Technologies and Silver Science, in Applied and Affective Neuroscience, and in Health Services Research. In the last 10 years, he has been the co-ordinator of seven large European projects (Lifechamos.eu, captain-eu.org, SmokeFreeBrain.org; www.meducator.net; www.longlastingmemories.eu, www.epblnet.eu, www.childrenhealth.eu) as well as the principal investigator for a number of national and international funded projects. His publication record consists of more than 120 international refereed journal papers, and over 530 international peer reviewed conference papers, as well as several book chapters / edited conference proceedings volumes and over some 4200 citations (h-index>28
- [redacted] graduated from the Physics department of Aristotle University of Thessaloniki in 2015. She has a master's in medical informatics. Since January 2018 she is a research associate in the Lab of Medical Physics in Aristotle University of Thessaloniki in "Smoke free Brain", "Anapneo", "INADVANCE" and "CoviRR" project. Also, she participates in a research that aims to examine the effect of microgravity in the quality of sleep, held in Medical Physics.

HUNGARY

COMPETENT AUTHORITY

AEEK is an umbrella agency of several authorities and the leading organization for health provision. "Its tasks range from hospital planning, care coordination, licensing of medical professionals and management of external funding to implementation of national strategies and communication with international research organizations" [OECD]. The mission of AEEK is to ensure the implementation of the strategy for the healthcare sector "Healthy Hungary 2014-2020". In addition, AEEK acts on behalf of the controlled entities in centralized public procurement processes, and/or assists them preparing and implementing procurement themselves.

AEEK owns, operates and controls public 100 hospitals (local, regional and national level) and provides public procurement activities and methodological support for them, as well as operates and develops the Electronic Health Cooperation Service Space (EESZT) nation-wide Health Informatics / eHealth system supporting care coordination between different providers and offering services to citizens (e.g. ePrescription). AEEK coordinates the work of the professional branches of the advisory body to the health minister to define clear care protocols and guidelines, as well as to streamline the pathway for patients with complex needs, both the quality of care and efficiency of care delivery may be improved.

Since 2011 AEEK has taken part in preparing and monitoring more than 120 ESIF and Swiss Contribution Fund (SCF) projects of health sector (exceeding 1 billion EURO total) and as lead partner implementing 30 ones (exceeding 140 million EURO total). These ESIF projects aim to execute development in prevention, primary care, outpatient and inpatient services. Development activities covered methodology, HR, ICT (complex national eHealth system), infrastructure (building and equipment) and national patient pathway reorganization.

In November 2017 AEEK launched the Electronic Health Cooperation Service Space (EESZT) transforming paper-based or locally working national healthcare system to a modern, service-focused nation-wide Health Informatics / eHealth system ("National EHR System") which meets all the latest demands and requirements related to data security, information technologies and healthcare

KEY STAFF:

AEEK is responsible for national data management and analysis, supports the dissemination of professional results, manages, and coordinates EU and other international projects related to the health sector. The personnel of the organization are highly-qualified experts, with professional knowledge, who also have skills and competences, and relevant experience in managing and participating in international projects. The organization may perform economic activity on the market e.g.: IT and health professional services.

- [redacted] leads international programmes and projects at National Healthcare Service Centre (AEEK), Hungary. He has extensive (29 years') experience in a) Preparing, planning and managing EU funded programmes, b) Strategic planning, c) Preparing and submitting applications for EU grant, d) Implementing and coordinating EU projects, e) Evaluating applications and monitoring projects, f) Generating and providing support to innovation, cluster, logistic, transport, energy, environment and health programmes and projects, g) Working with international organizations e.g. EU COM, EU Council, UN organizations, h) Preparing and implementing bilateral and multilateral

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international agreements. Since June 2018 he has been the Work Package leader of WP5 'Innovative use of health data' in the Joint Action supporting the eHealth Network (eHAction).

- [redacted] Senior advisor and consultant at National Healthcare Service Centre (AEEK), Hungary. He has extensive experience a.) in strategic and financial planning, b.) product and solution development in digital and online services, c.) e-learning solutions, d.) preparing and submitting applications for EU grants in Healthcare, e.) implementing EU projects. Robert worked as founder and top level executive at several market oriented ICT firms and has deep entrepreneurial background with international scope.
- [redacted] Béla is Director for Management, Data Analysis and Data Supply at National Healthcare Service Center (AEEK), Hungary. He has extensive 16 years' experience in a) Primary care, occupational medicine and occupational rehabilitation, b) Healthcare quality management and audit, c) Patient safety, d) Training and education e) Providing support to formal and informal care providers, f) Strategic planning, g) Preparing and submitting applications for EU grant, h) Implementing EU projects and coordinating work packages, i) System performance assessment.

AFFILIATED ENTITIES

Semmelweis University (SU): SU will be involved to provide capacities, knowledge and experiences in leading communication and dissemination, as well as to contribute to developing the plan for future use of results and deliverables to be integrated in policies. The Health Services Management Training Centre (HSMTC) at Semmelweis University was established 25 years ago with the aim to become a leading health policy and management education, research and knowledge centre for Hungary and in the broader region. The Centre has three main profiles: education, research and participation in organizational and system level development activities. It plays active role both in Hungarian and in international health policy and management affairs.

KEY STAFF:

- [redacted] joined the team of HSMTC in the fall of 2014 as financial economist. He is participating in finding of, application for and execution of different national and international projects. As the member of the Dissemination Knowledge Centre he is coordinating a number of Hungarian and international projects (JAseHN, EIT Health Innostars, HTA Joint Action, CHRODIS+ JA, IMI2 CSA, Helium, Erasmus+, Ecoquip), and active member of the eHealth team of HSMTC. Márton graduated in 1996 as financial economist, and in the last 25 years he has been working in all ranks of a bank, from a clerk till management positions.
- [redacted] obtained her degree in Sociology in 2009. She studied health care policy, planning, financing and health economics at Eötvös Loránt University. She studied psychology at St. Andrew's University, UK. She worked at the National Health Care Services Centre between 2012 and 2015, when she joined Health Services Management Training Centre as a junior expert.
- [redacted] obtained her degree in Artist Designer (MA) in 2009 at Moholy- Nagy University of Art and Design, and than as Design Manager in 2010. From 2008 to 2018 she worked as graphic designer and layout editor at local government of Perbál, when she joined Health Services Management Training Centre as graphic designer.

Jahn Ferenc Dél-pesti Kórház és Rendelőintézet (JFDPK)

JFDPK is a public hospital. It runs one of the health promotion offices (HPO) throughout Hungary. The HPO will be one of the key pillars to implement the knowledge transfer in Hungary. The HPO performs integrated healthcare and prevention functions of JFDPK. The HPO lacks digital characteristics, however, offers friendly conditions to make use of the learnings from the good practices of the JA. Therefore, the main idea of involving the hospital is to ensure expertise and capacities for preparing and executing the pilot through its HPO. The other key pillar to implement the knowledge transfer will be the Centre for Psychiatry and Addiction Medicine in JFDPK (CPAM).

KEY STAFF:

- [redacted] is the Strategic Director of Jahn Ferenc Kórház és Rendelőintézet. He has masters degree in law and state and in healthcare management, and bachelore degree in public administration. He is managing projects and development programs since 2001. As a strategic director, he is responsible for the EU and other funded projects of the hospital, and for the Pesterzsébet Health Promotion Office.
- [redacted] He is Doctor of Medicine (MD), Master in Science in Biomedical Engineering, Doctor in Philosophy (PhD) in Clinical Psychiatry and Master of Business Administration (MBA). He has professional qualifications as a Specialist in psychiatry, psychotherapy, in addiction medicine, in geriatrics, in health insurance and in psychiatric rehabilitation. He is the head of the Centre for Psychiatry and Addiction Medicine in JFDPK.
- [redacted] is a Health Promotion Office Manager and Mental Health Specialist at Pesterzsébet Health Promotion Office. She has previous work experience in the fields of health- and social care, and while working she acquired several degrees – Geriatric Nurse, Health Teacher, Mental Hygiene Specialist, Social Worker and Competence Developer Trainer. She is currently studying in a Grief Counselling programme.

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In her current position the main focus is to help the Health Promotion Office become an essential part of the district and spread professional network between agents of local health- and social care. While not at meetings or organising screenings for the people, she also helps our clients directly in various trainings to overcome struggles and in their life.

ITALY

COMPETENT AUTHORITY-AGENAS

The institutional role of AGENAS (national agency for regional healthcare services, public sector entity under the supervision of the ministry of health) can be illustrated by the different tasks it has been assigned with regard to integrated care:

- • the national chronicity plan (NCP), approved in 2016, aims at improving the quality of life of people suffering from chronic diseases, making assistance more effective and efficient and ensuring equity in access to citizens.
- • the pact for health 2014-2016 focusses on humanization of healthcare and the centrality of the patient including not only the physical aspects of the disease, but also the psychological, relational and social aspects that affect health status. The pact aims at implementing a multi-professional and interdisciplinary model of territorial assistance, characterized by the integration between specialized medicine and general medicine.
- • AGENAS coordinates a technical task-force to define/update guidelines and recommendations on integrated care networks. 6 organizational guidelines have been approved on cardiology, neonatology, stroke, severe trauma, oncology, community services and hospital-community integration. Other 6 networks are currently being developed.
- • since September 2017, Agenas is partner of the CHRODIS-plus joint action (ja), whose goal is to support member states in identifying efficient means to foster an effective management of chronic diseases and multimorbidity.
- • AGENAS supports the Ministry of health in the implementation of the national operating programme “chronicity” financed by EU structural funds, particularly for the implementation of line no. 1 “promoting the eblendnce, the collection and the knowledge of good practices”.

KEY STAFF:

[redacted] in Hematology General Clinic and Laboratory at the University of Rome and Master in Infective Disease at La Sapienza, Italy, is the Director of the Revision and monitoring of clinical networks and organizational development office. Before his AGENAS appointment, was a Medical Director of the Quality of activities and services Department within the Directorate of the Health Care Planning of the Italian Ministry of Health. From 2001 until 2003, during his work at the General Directorate for International Relations of the MoH, he was the Governmen representative to OECD and Council of Europe. Paolo Michelutti. Project manager in EU projects on health care management and health workforce planning. 20 years of experience in health care sector as expert and consultant in health workforce management and planning and health care organization improvement for local health care providers, regional competent authorities and national public institutions. Senior Lecturer at University in Organization Theory and Design. Lecturer in management training courses.

[redacted]Project officer in EU projects on health care management, with several years of experience in international cooperation, organizational and financial management of national and international research activity. Experienced in public health administration with a Master in European Projects planning and management, and in European public management and economic policy.

AFFILIATED ENTITIES

ASL NA2:

Local Health Agency Naples 2 (ASL NA2) is part of Campania regional health system, coordinated by the Health Directorate. In this proposal, ASL NA 2 will ensure the interaction with the Regional Health Directorate, as well as the engagement of the other stakeholders of the Regional Health System through Campania ProMIS network. With 13 Districts and 5 Hospitals, this ASL is one of Campania largest service providers, and include the large island of Ischia.

KEY STAFF: [redacted] ProMIS referent for ASL NA2.

[redacted]Analyst Manager - ASL Napoli 2 Nord at the UOC Information Technology and Clinical Engineering since October 2016. Degree in Electronic Engineering with a Computer Science address. 2nd level University Master in "Management of Companies and Health Organizations (DAOSan). From 2 May 2005 to 15 October 2019 "Director of Computer Integration Specialist Instructor" at Campania Region Directorate General 10 for University, Research and Innovation. Excellent technical skills and competences.

LOMBARDIA: The Lombardy Region DG Welfare regional authority has been recently awarded as a 4-stars Reference Site of EIP-AHA. Started with the approval of the regional law n. 23 of 2015 "Evolution of the Healthcare System", the Lombardy welfare reform has designed a new way of “Taking care” of the chronic and fragile patient based on the development of innovative technical-organizational models that act in an integrated way for all the

professional skills involved - hospital and territorial - through networks of care and health care support, also through telemedicine networks. The key concepts around which the new model is based is that of innovation and the definition of an individual assistance plan document for each enrolled citizen. Within the regional "Taking Care" program, Lombardy Region recognized the importance of continuous improvement and incremental local model adaptation as a mean to tackle the complexity of a changing healthcare environment. Lombardy Region is interested in deepening knowledge and skills on how to support hospitals in communication & education activities towards complex chronic patients, integrating patient empowerment & patient perceived quality of life in current care management programs.
KEY STAFF: [redacted]Medical Doctor and PhD, specialised in Hygiene and Prevention Medicine (University of Milan and London School of Hygiene). Manager, Head of the Unit "Clinical Network and Research", under the General Directorate "Welfare", Regione Lombardia, with mandate on the definition and assessment Health & Social Support Plans, the promotion of the creation of Network of Pathologies (chronicity, frailty, rare diseases, transplant networks), to guarantee homogeneity over the territory and the compliance with National / International Guidelines in particular for high complexity pathologies, the management of International projects on Health.
[redacted]Reviewer of several EC projects on eHealth and Semantic Interoperability. epSOS skills: WP manager for Implementation and Testing, semantic interoperability, sustainability, testing and piloting, system architecture. epSOS responsible for Implementation, testing, Semantic Services and National Pilot. Italian e-SENS eHealth pilot responsible. Trillium Bridge: WP Specification leader. EXPAND responsible for epSOS asset maintenance and relation with Institutions. H2020 PHC 34 eStandards, openMedicine, ASSESS-CT, VALUeHEALTH WP leader and contributor. He is the appointed Italian member of the eHMSEG – Semantic Task Force and WP Organization Leader within that Task Force. He is leading tasks in the CEF eHealth Italy Preparation and Implementation.
ARS TOSCANA: The Tuscany Regional Health Agency (ARS) is a public scientific entity of the Tuscany Region. ARS supports the Regional Government and the Council in their activities regarding health and healthcare policies, providing evidence-based knowledge. The staff is formed by medical scientists, epidemiologists, public health researchers, statisticians, data scientists, economists, sociologists, computer technicians and project managers. Among other activities, the entity assesses the quality of the implemented healthcare policies, the outcomes of clinical interventions and the quality of care in community health services, hospitals and nursing homes. We monitor whether the healthcare services organization and performance correspond to the real needs of citizens and if there are health inequalities. The scientific and technical support to the regional health system covers the entire course of policy development, up to the verification and assessment of results.
KEY STAFF: [redacted] MD, medical director, Faculty of Medicine and Surgery, Specialized inHygiene and Preventive Medicine. Expert in organizational management and clinical governance. Chief medical officer at
Svaldo Sensi. Nurses. Master Degree in Nursing and Obsterical Sciences. Specialized in coordination of nursery activities. Responsible for the territorial nursing care in North-west Tuscany Health Authority (Lucca district).
USL UMBRIA 1: Azienda USL Umbria 1 is a public Local Health Authority assisting the largest and most populous area of the Umbria region, the green heart of Italy. The high quality of services certified each year by the Ministry of Health, the ageing population index higher than the national average, the rural and dispersed population and the presence of innovative organizational forms of primary care such as TFA make Umbria an optimal territory for implementing innovative projects of management of chronic diseases using eHealth.
The Usl Umbria 1 Company in the last two years, thanks to the regional programming that has established the Territorial Functional Aggregations and territorial operations centers, has implemented an important innovation of territorial assistance that has improved the quality of services and integration between hospital and territory. In this context, the patient's domicile, residential and closeness of care play an increasingly privileged role, and for this reason the need for digital health, thanks to which it is possible to share data, carry out and install telemonitoring devices to improve care for the chronically ill.
KEY STAFF: [redacted]Head of Quality development and communication USL Umbria 1. She has activated the Territorial Operations Centre - COT, unique in Umbria, for the management of assisted discharge. She followed the computerization project of the Electronic Clinical Folder and assisted discharges in all 6 hospitals and 6 business districts. She was the Health Director of the University Hospital of Perugia, committing to a strong innovation in the organization of services to achieve high standards of appropriateness and safety of care such as the widespread institutional accreditation in 52 complex structures; activation of beds of Short Observation of First Aid, Surgical, Urological, Pediatric and Internalistic; the Rooms of Lucina for the management of physiological childbirth by midwives; 12 Nursing Hospital PL, among the first national experiences.
MARCHE: The regional authority Marche Region, through its Health Service, has been recently awarded as a 3-stars Reference Site of EIP-AHA. The Marche Region and the Regional Agency for Health (ARS), its operative arm, are highly committed to the organization and delivery of integrated person-centered care, with particular care for older people, and to incentivizing health reforms and digital transformation of healthcare. The Region, besides other

strategic, economic and monitoring roles, is involved in strategic actions, such as the definition and implementation of the Social-Health Regional Plan, the development of a strategy to support and valorize marginal or disadvantaged territories, and the execution of the Regional law on active ageing. One of the current focus is to make sure that the existing care models are re-shaped to better address and respond effectively to the current needs of the health systems, at a time where major economic and demographic change is taking place. Therefore, Marche Region-ARS is very interested in learning and transferring innovative practices in the field of integrated care, which could produce impact in the management of chronic diseases and quality and continuity of care. Marche Region-ARS has a wide network of collaborations with local, national and international institutions and is part of ProMis, an institutionalized Italian Network led by Aulss4-Veneto Region including all regions, aimed to the collaboration and internationalization of the research in the public health field.
KEY STAFF: [redacted] has over 15 years' experience as clinical engineer in different healthcare authorities. Since 2017 he is Responsible for the Center of HTA and biomedical technologies of ARS, that is in charge of developing and implementing technology innovations on information systems, digital solutions, and telemedicine systems in the region. Managers (Regional Health manager)
[redacted] has over 15 years' experience in research and has worked in various centres in Italy. She has been the Italian Scientific Manager in various EU projects aiming at improving knowledge around active and healthy ageing. Since 2013 Dr Di Furia has been a Medical Manager at ARS, responsible for Hospital Care, eblendncy and urgency in acute settings, research and training. Since 2016 she is the Director of Health Department of Marche Region. Moreover, she is the representative of ProMis for Marche Region.
MhH Italy: The MhH has been institutionally performing activities concerning the monitoring of the National health service delivery for people with complex needs either frail, with chronic conditions, disable and dependent.
In cooperation with the Regions and in line with the international recommendations, the Moh adopts regulations on the project topics and issues and tries to reduce gap between the Regions in their implementation. In this project Mho will participate in the international comparison to enhance awareness, experience and managerial efficiency of its integrated health care bodies. The Moh will support the integration of different policies regulations and resolutions from a European/international perspective into Italian ones where they resulted effective. The Mho will be proactive in the dissemination of the results of the work packages in which is involved (and the overall project results itselves) and will promote the transfer of the results into national policies, Guidelines and Agreements with the Regions.
KEY STAFF: [redacted] She has been working in the Public Health Care sector since 1987, with main charges in healthcare regulation, organization and planning. Since 2016 she is the Director of Office II "National Health Plan and Sector Plans" of the Directorate General for Health Planning in the MoH. She was the Chief of Healthcare Organization Department at Agenas from 2002 to 2016. She is member of several Round tables and Scientific Committees hold by the Ministry of Health concerning community care services, accreditation system and cross-boarder care. Her main field of research is Primary Health Care management, monitoring and regulation; She is author of many scientific publications both national and international and of several national dossier on specific health topics such as dependency, palliative care, primary care, dependency, prevention.
Modesta Visca, Since 2016 she is in charge of healthcare regulation, organization and planning in the office II DG health planning MoH and in the past in the Healthcare Organization Department at Agenas. Since 2006, she has been working in project management of research activities of national projects and her main field of research is Primary Health Care and Long Term Care services management, monitoring and planning and recently cross-boarder care. She has been involved in several European projects and Joint Action (managed by DGSANCO as project manager assistant and health economist and by DGEMP as health policy expert). She participates also spreading health research results in international networks and associations such European Public Health Association EUPHA, European health Management Association EHMA, European Forum for Primary Care EFPC.
[redacted]eceived the Laura Degree in Law from University "La Sapienza" in Rome, a second level Master of science in Labor, Trade Union and social security disciplines, University of Tor Vergata, in Rome and Specialization Diploma in "Law and Economics of the European Communities", University "La Sapienza". She has up to 20 years of experience in administration and financial issues. She is the Director of General Affairs and National System for the Verification and Control of Healthcare - Office I , Directorate General for Healthcare Planning of the MoH. She directed in the past years the Human Resources Office of the Italian Medicines Agency-AIFA.

LATVIA

COMPETENT AUTHORITY
The National Health Service of the Republic of Latvia is the operating direct administrative institution subordinate to Ministry of Health. The aim of the National Health Service is to: implement State policy for availability of health care services; administrate the State budgetary funds prescribed for health care; implement State policy in the

planning of health care services; ensure rational and the most effective use of State budget; implement the e-Health programme according to the policy decided by the State.
The Ministry of Health supports the participation in Joint Action on implementation of digitally enabled integrated person-centered care, by nominating National Health Service as Competent authority and Children's Clinical University Hospital as Affiliated entity.
There are and/or has been implemented several projects in Latvia with National Health Service:

- Development of e-health integrated information system (NVD, The National Health Service)
- Development of Electronic Health Card and Integration Platform Information System (NVD, The National Health Service) - to create an environment in which information could be exchanged between different health information systems;
- Electronic booking of visits (e-booking), electronification of healthcare workflows
- Development of electronic prescription information system (NVD, The National Health Service)
- Cross-Border Healthcare Contact point - an information centre, providing information regarding our Latvian national health care system and procedure for obtaining cross-border health care services (The National Health Service)

KEY STAFF:

- [redacted] is the Director of National Health Service (NHS). He had a broad experience in Medical Technology and IT/Electronics with a demonstrated history of working in the hospital & health care industry, as well as consumer electronics and telecom retail networks. Skilled in Sales & Marketing Management, Negotiation & Customer Relations, People Management. Holding Master degree in Health Management and developing in area of healthcare management, public health and related business areas. Best performing in dynamic international environments.

AFFILIATED ENTITIES

State owned company "Children's Clinical University Hospital" is the largest specialised multi-profile medical institution for children in Latvia. Every year more than 30,000 patients are treated on an in-patient basis and more than 160,000 receive out-patient medical care services. The hospital's vision is to ensure high quality and safe health care services for children, developing multi-profile and eblendncy as well as child-friendly medical care, medical education and research implementing 6 Sigma (LEAN) principles for patient flow and better human resources planning.

KEY STAFF

- [redacted] for 20 years, has held national and international senior positions in the pharmaceutical company GSK as a board member and director of external relations. He has also served as a member of the board of directors of the Foreign Investors Council and chaired the Health Task Force, and was a lecturer in health management at Riga Stradins University. Having excellent skills of healthcare management, team management, strategical planning and management of business processes. He is the Head of Children´s Hospital since 2016.
- [redacted] is the National Coordinator of Latvia at HOPE (the European Hospital and Healthcare Federation); International Medical Training Manager at Riga Stradins University (RSU); Managing Director at Children's Hospital Foundation. She is an Experienced Manager with a demonstrated history of working in the management consulting industry. Specialized in healthcare sector for last 5 years. Having good skills in Project Management, Strategic Planning, Development Programs, Business Process, Process Improvement, Strategy, Quality Management, and Internal Audit. Have participated in one month-long experience, skills and knowledge-sharing programme for healthcare professionals in Spain. Currently national coordinator of European Hospital and Healthcare Federation for Latvia

LITHUANIA

Lithuania is focusing on quality, affordability and efficiency in primary health care system. Integrated care service development also is one of the key points of county health care development prioritiesThe integrated services in outpatient primary health care is supported by a team of personal and public health care specialists and social workers. Presently outpatient primary health care services consist of: Family Physician (FP) services, Primary mental health care services and Primary dental health care (PDHC) services, public health bureaus of municipalities. In 2019 FP team has been supplemented by: life style medicine specialist, nurse assistant, social worker, kinesitherapist. PDHC team supplemented by oral hygienist.
One of the main priorities in our country is to strengthen public health services at local level, including disease prevention and healthy lifestyle promotion, raising of health literacy in general population, implementing integrated health services. In order to achieve threes objectives, we strongly believe, that establishment of public health bureaus at municipalities is a makes a significant impact to the results. First municipality public health bureaus were established in 2006 and up to now we have a network of 47 bureaus out of 60 municipalities. Municipalities without

local established public health bureaus have to ensure the provision of public health services through collaboration agreements between bureaus in other municipalities.
This organizational structure ensures better provision and development of integrated services.
Year 2018 remote primary health care services started to take place. Primary outpatient healthcare institutions have been empowered to provide remote services by using information and communication technologies. Presently the family doctor has possibility to: remotely issue referrals for diagnostic procedures, remotely prescribe medicine and medicinal products. However, the development of remote consultations between FP and Medical specialists are planned as well as further development and enhancement of services are required in areas such as rehabilitation and kinesitherapy.
Integrated health care services, digitalisation and remote services possibilities are making big impact to better organization of treatment of multimorbid patients.

KEY STAFF:

- [redacted] - Ministry of Health of the Republic of Lithuania, Personal Health care Department, Primary health care and nursing Division. Adviser. Responsible for restructuring and further development of primary health care.
- [redacted] – Ministry of Health of the Republic of Lithuania, Personal Health care Department, Primary health care and nursing Division. Chef specialist, working in further development and digitalization of Primary health care and nursing area.
- [redacted] - Ministry of Health of the Republic of Lithuania, Personal Health care Department, Primary health care and nursing Division. Chef specialist, working in medical rehabilitation- kinesitherapy, geriatrics and internists area.
- [redacted] – Ministry of Health of the Republic of Lithuania, EU fund support division. Head of the Division. Responsible for the planning, development and implementation of the specific measures (projects) aimed at improving quality, accessibility, effectiveness and performance of health care services.

PORTUGAL

COMPETENT AUTHORITY

The **Central Administration of the Health System (ACSS)** coordinates Networks of the Primary Health Care, hospital care and long term care at a national level, sets funding models for contracting health care and monitors the implementation of those contracts. It is also in charge of providing NHS with appropriate information and communication systems in coordination with the Shared Services of the Ministry of Health (SPMS). In this context ACSS has been working on models of care that promote integration and people centered care. The main challenges for ACSS are contribution to the efficiency and sustainability of the NHS; improvement of the governance of the health system; ensuring equitable and consistent funding policies in line with the health policy; development of human capital and improve the performance of healthcare professional and increasing the transparency in the NHS.

KEY STAFF:

[redacted] is a medical doctor, with a specialist degree in internal medicine, by the Faculty of Medicine, Lisbon (1984). She has a career both as a MD and as a Manager of healthcare organizations. Since 2013, she is the coordinator of the “Consulta a tempo e horas” - Access Management Unit at the Administration of the Health System. Since 2017 she coordinates a case management project in a Local Health Unit (Unidade Local de Saúde do Litoral Alentejano) and she is also the president of the Portuguese Association for Integrated Care (2018).
Fátima Fonseca is a medical doctor, specialist in family medicine, by ICBAS (University of Porto), since 2002. She has also experience in management of health units, namely a Local Health Unit (Unidade Local de Saúde do Alto Minho). In her career she has been in charge of several projects related to integration of care such as patient pathways, patient centered care and health governance. She is also the vice-president of a patients association for respiratory diseases.
[redacted] is graduated in nursing, by the Lisbon School of Nursing. She holds a Master degree in Health Management and a PhD in Public Health, both by the NOVA University of Lisbon – National School of Public Health. She as experience as a nurse from 2004 to 2011 and after that working with the Directorate-General of Health and the Administration of the Portuguese Health System, namely with projects related to integration of care.

AFFILIATED ENTITIES

The **NOVA National School of Public Health (ENSP/NOVA**), a pioneer institution in public health teaching in Europe, as well as the research centre it hosted, the Public Health Research Centre (CISP/NOVA), is a producer of nationally and internationally recognized research oriented to the resolution of problems in the fields of health and health care. ENSP/NOVA counts with renowned experts in diverse fields, including health promotion, management and economics, and belongs to the NOVAhealth Integrated Care which is committed to innovation and research in care integration. Since its foundation, in 1966, the ENSP/NOVA is a reference university institution in the design, development and evaluation of the Portuguese health system that has closely collaborated with the Portuguese

Ministry of Health and its institutions, including ACSS. The role of ENSP/NOVA in the Joint Action will be to support ACSS in the three phases of JADECARE (pre-implementation, implementation and post-implementation phases).

KEY STAFF:

[redacted] is Professor at the Department of Health Systems Policies' and Management and Deputy Director of NOVA National School of Public Health and. He holds a Phd in Public Health, a Post-Graduation in Hospital Administration and he is graduated in Corporate Management. Research interest includes the study of Integrated Care, Ambulatory Care Sensitive Conditions, Healthcare Financing and Cost Methods in Health Organizations. He was member of several Technical Groups of the Ministry of Health and consultant of the World Bank for Public Expenditure Reviews and Public Expenditure Tracking Surveys. He is Associate Editor of the Portuguese Journal of Public Health and reviewer of scientific journals.

SHARED SERVICES OF THE MINISTRY OF HEALTH (SPMS)

Shared Services of the Ministry of Health (SPMS) is the Portuguese Health Ministry Central Purchasing entity, the National Authority for information communication and technology (ICT) and for international cooperation matters on eHealth. Conceived in 2010 as a State-Owned Enterprise (SOE) by the Ministries of Health and Finance, SPMS purpose is to provide shared services, in the areas of purchasing and logistics, financial services, human resources and ICT to entities who operate specifically on health and care, in order to "centralise, optimise and rationalise" the procurement of goods and services within the Portuguese National Health System (NHS).

With regard to the provision of shared services for the transition to digital-enabled systems from "early" to "next adopter", the following two information systems design by SPMS represent the latest contributions for enhancing the Portuguese NHS:

- SClínico Hospitalar - Conceived to standardize electronic clinical records, SClínico aims to normalize the clinical information collected throughout health institutions in order to allow access and systematization of patients' clinical information. This system is common to all NHS caregivers and incorporates in itself - screening, discharge letters, e-Bulletin for vaccination, Health Data Platform, Electronic Medical Prescription, Home Respiratory Care Prescription, Patient Tracking Information System with HIV / AIDS (SI-LIFE) and VCI. VCI is a module in SCLINICO that allow Healthcare Professional from a hospital to see in an integrated view all the health data from hospital and primary care units about a patient.
- S3 - Developed to promote interoperability among healthcare information systems, S3 represents a SONHO's (Integrated Hospital Information System) upgrade by incorporating within itself: a 360-vision component, cross-sectional scheduling, document management, multi-channel communication with citizens and different partners involved in the administrative and clinical processes.
- Thus, by cooperating nationally and internationally for the advancement and development of state-of-the-art healthcare services, SPMS strives to achieve a public, integrate, inclusive, efficient and citizen-centered NHS where information effectively interoperates whilst promoting preventive and self-care actions by being instantly accessible to both citizens and healthcare providers.

KEY STAFF

[redacted] – President of SPMS' Board of Directors, MD, PhD. He studied Medicine and is an Internal Medicine Specialist. Prof. Henrique obtained his PhD degree in Management from the Judge Business School, University of Cambridge, and has several publications in the area of management and informatics in healthcare. He was formerly the Chief Medical Information Officer (CMIO) of the Hospital Prof. Dr Fernando Fonseca and later Adjunct for Health IT to the Health Secretary of State. Moreover, he is responsible for nationwide efforts on complete electronic prescription and new Health Information Platform Sharing for Electronic Health Records. At EU level, [redacted] Co-chairs the eHealth Network and steers the 3rd Joint Action supporting the eHealth Network.

[redacted] – Head of the National Telehealth Centre and SPMS' Director for Information System, , PMP® graduated in Mathematics (Computing and Operations Research) and Mathematics (Teaching) with post-graduations in Project Management and Evaluation from Universidade Católica Portuguesa and in Advanced Management for Healthcare Organizations from AESE Business School. Since 2011 she works in SPMS, and at the present is an IT director, responsible for several areas, including Mobile and Citizens Services, Hospital Systems and ePrescription.

SERBIA

Serbia health system has been facing up a profound change during the last twenty years because of the previous political context. Serbia received multiple international support, mainly earmarked for capacity building (improvement of buildings, medical equipment and education) and to reform the way of health system functioning. For instance, European Union supported health care in Serbia since the year 2000. As Serbia continues its negotiations with the EU over accession by 2020, modernising the country's healthcare system will become increasingly important. Healthcare will be covered under Chapter 28 (consumer and health protection) in the

accession negotiations. Serbia recently joined the Third EU Health Programme 2014-20, highlighting the country's commitment to improving its healthcare system in line with EU standards. Integrated care is a key element in the policy of health for the country in fact palliative care has been introduced in Serbia, the Ministry of Health established the Palliative Care Task Force and adopted the National Strategy for Palliative Care to guide the development of palliative care across Serbia as a first step of this strategy.

KEY STAFF:

[redacted] received BS, MS and PhD degrees in computer engineering and computer science from University of Belgrade in 1993, 1998 and 2001, where he is currently the deputy director of the University of Belgrade Computer Centre. He also worked at the UCLA Radiology Science Department. His current areas of work and interests include health informatics, IT and research infrastructures, software governance and architecture and management and improvement of IT services. [redacted] participated in several FP and H2020 projects, often as activity or task leader, and was a project manager of the EU funded IPA project EU-IHIS (2012-2015) that implemented hospital information systems in 19 hospitals throughout Serbia and developed a cross-institutional EHR platform. He is also teaching in postgraduate courses on medical informatics and virtual reality at the University of Belgrade School of Electrical Engineering.

[redacted], BS degrees in economics and MS degree in computer science, Belgrade Univesity.I work as an IT Consultant Second Serbian Health Project for Ministry of Health Republic of Serbia since august 2017. It is a World Bank Project. I am responsible for the implementation of all eHealth projects for Ministry of Health. Now we are in the implementation of eRadiology on a national level and implementation of electronic health record (EHR). Before that I was in National Health insurance fund, person in charge for information about drugs. He will be the project manager.

SLOVENIA

COMPETENT AUTHORITY

NIJZ as National Institute of Public Health hold the authority and leadership position in development, implementation and research in all aspects of public health. It is one of the core institutions in the healthcare system to develop and implement national strategic documents, such as National Health Resolution, National resolution on healthy food and physical activity, National cancer plan, National diabetes plan etc. NIJZ is leading and supporting the implementation of nationwide project to integrate health promotion and disease prevention/early diagnosis activities at primary care that is based on community approach. In JA CHRODIS PLUS, NIJZ is developing a model for integration of care across primary and secondary levels of care, as an implementation of the National Health Resolution.

NIJZ has also taken on the role of coordinator in four prominent EU-funded Joint Actions: EPAAC – European Partnership for Action Against Cancer, PARENT – Cross-border Patients' Registries Initiative, CANCON – Development of a European Guide on Quality Improvement in Comprehensive Cancer Control and iPAAC – Roadmap on Implementation and Sustainability of Cancer Control Actions.

KEY STAFF:

- [redacted] research associate, senior diabetes and policy expert, co-leader of work package on diabetes in JA-CHRODIS, co-leader of work package on quality of care in prevention and care of chronic diseases in JA CHRODIS PLUS, co-chair of National diabetes programme coordination group at Ministry of Health Slovenia, senior expert in several WHO-MoH Slovenia national projects and a member of working group on Optimizing service delivery, leading the Task on Diabetes – a case study as a part of the project Analysis of the health system in Slovenia at MoH, and expert in several other national and EU projects.
- [redacted] in cultural anthropology, with experience in JA CHRODIS PLUS as the coordinator of Slovenian pilot action, leading and/or working in several diabetes-related national projects, and in national projects addressing health inequalities and vulnerable groups by developing community approach involving social research and interventions.
- [redacted] project officer with a university degree in economics. She has over 25 years of professional experience, having a high command in English. For the last 10 years she has been working as financial and administrative officer for European projects at the Research and Project Management Centre at NIJZ. Involved in more than 50 European funded projects including JA-CHRODIS and JA CHRODIS PLUS.

AFFILIATED ENTITY

The affiliated entity, Health Insurance Institute of Slovenia (ZZZS), represents the national payer in our single-payer healthcare system, and the development/refining of payment models to support integration of care is one of their priorities according to their strategic plan.

The Health Insurance Institute of Slovenia (HIIS; i.e. Zavod za zdravstveno zavarovanje Slovenije, http://www.zzzs.si) conducts its business as a public institute, bound by statute to provide compulsory health insurance. HIIS is the sole mandatory health insurance provider in Slovenia.

It's principal task is to provide effective collection and distribution of public funds, in order to ensure the insured persons quality rights arising from the said funds. The benefits basket arising from compulsory health insurance, comprise the rights to health care services and rights to several financial benefits.
Regarding the law, HIIS is responsible for payment models, which are the basis for payment of health services, provided by the public health care providers. Therefore, HIIS has a lot of experiences in this field. Additionally, HIIS is constantly searching for new ideas and new methods of payment to achieve better treatment outcomes and more efficient use of limited resources – generally to achieve triple aim: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. The upgrade of current payment models is included in the HIIS strategic program for the period 2020 – 2025, including the piloting of a new model, which could be the model of integrated care.

KEY STAFF

- [redacted] manager of analytics and development department at ZZZS. She has many years of experiences in various areas of HIIS activities: she cooperated or led many internal projects (i.e. introduction of health insurance card, digitalisation of data exchange with health care providers), as well as national and international projects (i.e. SUSTAINS, DRG cost analysis).
- [redacted], medical doctor, specialization in internal medicine. Karmen has many years of experiences in clinical work with diabetic patients. She works partially at the ZZZS at the analysis and development department and partially at the Jesenice General Hospital. Her favourite areas are quality management, patient's empowerment and new forms and possibilities of integration between the different levels of health care. She has participated in the preparation and implementation of various projects.
- [redacted] is a consultant at ZZZSwith more than 20 years of experiences in negotiations and contracting health care providers, system of healthcare financing, payment models (healthcare services reimbursement), data analysis about health service performance, digitalisation and introduction of new methods. She is an expert in development of new models of healthcare services payment, especially on primary health care and hospital care.

UNITED KINGDOM (NORTHERN IRELAND)

The Health & Social Care Board (HSCB) is an executive body s of the DoH In Northern Ireland
The DoH leads a major programme of cross-government action to improve the health and well-being of the population and reduce health inequalities through an Integrated Care approach. Northern Ireland is recognised for its work in developing innovative solutions for medicines management and adherence - this was one of the areas of "good practice" for which we were awarded 4* Reference Site status. A number of networks have been developed focusing on this area and spanning several European countries. This includes a Medicines Optimisation Working Group which has members from 9 countries. A key objective is the WHO global challenge on medicines safety.
A strategy for NI health and social care was launched in 2016 - Health and Wellbeing 2026: Delivering Together. It aims to reform the way services are delivered, focusing on integrated person-centered care. As part of this, a programme of hospital services reform is in progress which is targeted at reducing waiting lists and redesigning services in areas such as pathology and stroke. 17 Integrated Care Partnerships (ICPs), each covering a population cohort of approximately 100,000 have been in place n NI since 2013.
The work of ICPs is also helping inform work on a prototype for an Integrated Care System in NI. A new way of working in the planning and delivery of integrated health and social care services.
Within primary care implementation has begun of a multi-disciplinary team (MDT) approach. These programmes are underpinned by digital transformation as set out in the eHealth and Care Strategy, and in particular by the implementation of the Encompass electronic health and care record which will support further integration and connectivity across NI's care model.

KEY STAFF:

- [redacted] the Director of Integrated Care at the Regional Health and Social Care Board. A qualified and experienced General Practitioner with extensive experience in primary care management within the Northern Health Board; and Deputy Chief Medical Officer at the Department of Health, Social Services and Public Safety. The Director currently leads on the delivery of GP, Community Pharmacy, Dental and Ophthalmic Services for HSC Board as well as initiatives to improve integrated working across health and social care, and is Chair of the International Foundation for Integrated Care (Ireland).
- The Director is supported by the Programme Director for Integrated Care at the Regional Health and Social Care Board. With 29 years' experience in Health and Social Care management. The Programme Director currently leads on a number of integrated programmes including ICPs and Project ECHO©.

FINANCIAL MANAGEMENT

Financial management will be key for the adequate progress of JADECARE. As previously described a financial manager will be included in the coordinator team. This manager will support the adequate use of resources of the

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project as well as to analyse/review/support issues that could arise in the participation of Affiliated Entities through their Competent Authorities. Financial responsible have been identified in each of the participating CA and a specific communication group will be created with all the financial responsible to share the documents, review the process and analyse any potential issue that could arise. In the handbook the general rules and quality norms for keeping and reporting the financial data will be provided and webinars, teleconferences or other necessary means will be used to keep all the participating entities updated.

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2.9 BUDGET

CONTENT DESCRIPTION AND JUSTIFICATION

JADECARE budget distribution favours the success of the selected oGPs transfer devoting a large part of the budget to prepare the local environment for implementation, including twinning actions, such as study visits, thematic workshops, webinars and mentoring from experts. All next adopters have been provided with a specific budget for study visits (framed into WP4) allowing deeper understanding of the oGPs and thematic workshops (within the transfer WPs) to share learning and experience during the implementation. In particular, more than 380.45 (47.11%) person months have been allocated to the transfer WPs which aims to ensure that next adopters have the required resources to adopt the features of selected oGPs. WP4 (20.11%) includes a considerable effort from Competent Authorities and next adopters as well so the sustainability of digitally enabled integrated care becomes a key issue in policy level debates.

The direct costs, in addition to travel costs (attendance to Kick off meeting, Consortium Meetings, Policy level meetings, final conference, study visits, thematic workshops and invitation of collaborating partners to JADECARE meetings) include dissemination material (15.000€ for US), website (25.000€ for ZTG-GmbH), scientific publications (7.000€ for US), translation (2.000€ for each CA) and audit (8.000€ for KG, 8.000€ for AGENAS, 4,000 for NIJZ and 4,000 for EUSTRAS). The material to be translated includes: newsletters, leaflets, evaluation protocols and outputs (for example guidelines for qualitative analysis and summaries of interviews and focus groups), guidelines for sustainability targeting policy makers etc.

SUMMARY OF EFFORT

Participant short name	WP1	WP2	WP3	WP4	WP5	WP6	WP7	WP8	Total Person-Months Per Participant
1. KG	**67,00**	7,00	32,75	15,25	**19,00**	19,00	0,00	35,25	**195,25**
2. MCA	2,00	3,00	4,00	7,00	7,00	0,00	21,00	0,00	**44,00**
3. CIPH	2,00	1,00	2,00	1,40	4,80	0,00	0,00	6,40	**17,60**
4. MZCR	2,00	2,00	2,00	6,00	5,34	5,33	0,00	5,33	**28,00**
5. RND	2,00	2,00	2,00	7,00	7,50	0,00	**7,50**	**13,00**	**41,00**
6. MSAE	2,00	2,00	2,00	5,00	4,60	4,70	4,70	0,00	**25,00**
7. EUSTRAS	2,00	1,00	2,00	3,00	0,00	0,00	6,00	0,00	**14,00**
8. BAGSFI	2,00	11,00	2,00	10,25	0,00	0,00	0,00	0,00	**25,25**
9. 4THYPE	2,00	2,00	**20,00**	4,00	18,00	0,00	0,00	0,00	**46,00**
10. AEEK	2,00	**21,00**	2,00	7,00	0,00	**25,00**	0,00	0,00	**57,00**
11. AGENAS	2,00	8,00	10,00	**31,25**	31,00	31,00	3,00	17,00	**133,25**
12. NVD	2,00	2,00	2,00	4,00	0,00	0,00	0,00	21,00	**31,00**
13. LR SAM	2,00	1,00	2,00	4,00	7,50	0,00	0,00	7,50	**24,00**
14. ACSS	2,00	2,00	5,00	5,50	18,00	0,00	0,00	0,00	**32,50**
15. MoHRS	2,00	1,00	2,00	4,00	15,00	0,00	0,00	0,00	**24,00**
16. NIJZ	2,00	2,00	2,00	45,00	0,00	0,00	10,00	0,00	**61,00**
17. HSCB	2,00	1,00	0,00	3,00	0,00	0,00	0,00	0,00	**6,00**
Total Person Months	**99,00**	**69,00**	**93,75**	**162,65**	**137,74**	**85,03**	**52,20**	**105,48**	**804,85**

Country	Organization	WP1	WP2	WP3	WP4	WP5	WP6	WP7	WP8	Total
Spain	KRONIKGUNE	67	1	10	3	13	0	0	0	94
Spain	CSFJA	0	0,25	0,75	1	1	1	0	0	4
Spain	FPS	0	0,75	2	2	5	5			14,75
Spain	SCS	0	0,25	1	1	0	0	0	4	6,25
Spain	IDIVAL	0	0,75	2	2,25	0	0	0	7	12
Spain	SACYL	0	1	2	2	0	0	0	14	19
Spain	SMS	0	0,75	1	1	0	0	0	7	9,75
Spain	FFIS	0	0,25	1	1	0	0	0	3,25	5,5
Spain	AQUAS	0	1	13	0	0	0	0	0	14
Spain	IDIBAPS	0	1	0	2	0	13	0	0	16
Bosnia and Herzegovina	MCA	2	1	0	3	0	0	0	0	6
Bosnia and Herzegovina	MHSwRS	0	1	2	2	0	0	14	0	19
Bosnia and Herzegovina	ZZJZFBIH	0	1	2	2	7	0	7	0	19
Croatia	CIPH	2	1	2	1,4	2,8	0	0	3	12,2
Croatia	CHIF	0	0	0	0	2	0	0	3,4	5,4
Czech Republic	MZCR	2	1	0	4	0	0	0	0	7
Czech Republic	UHO	0	1	2	2	5,34	5,33	0	5,33	21
Denmark	RND	2	1	2	4	7,5	0	7,5	0	24
Denmark	RSD	0	1	0	3	0	0	0	13	17
Estonia	MSAE	2	1	0	3	0	0	0	0	6
Estonia	VH	0	1	2	2	4,6	4,7	4,7	0	19
France	EUSTRAS	2	1	2	3	0	0	6	0	14
Germany	BAGSFI	2	1	2	5,25	0	0	0	0	10,25
Germany	LGL	0	5	0	2,25	0	0	0	0	7,25
Germany	ZTG	0	5	0	2,75	0	0	0	0	7,75
Greece	4THYPE	2	1	0	4	15	0	0	0	22
Greece	AUTH	0	1	20	0	3	0	0	0	24
Hungary	AEEK	2	1	0	5	0	9	0	0	17
Hungary	SUHSMTC	0	19	0	0	0	0	0	0	19
Hungary	JFDPK	0	1	2	2	0	16	0	0	21
Italy	AGENAS	2	1	0	18,25	3	3	3	3	33,25
Italy	MhH	0	1	0	3	0	0	0	0	4
Italy	ASL NA2	0	1	2	2	0	14	0	0	19
Italy	LOMBARDIA	0	1	2	2	0	0	0	14	19
Italy	ARSTOSCANA	0	1	2	2	14	0	0	0	19
Italy	MARCHE	0	1	2	2	0	14	0	0	19
Italy	USL UMBRIA	0	1	2	2	14	0	0	0	19
Italy	PROMIS	0	1	0	0	0	0	0	0	1
Latvia	NVD	0	1	0	0	0	0	0	6	7
Latvia	CCUH	2	1	2	4	0	0	0	15	24
Lithuania	LR SAM	2	1	2	4	7,5	0	0	7,5	24
Portugal	ACSS	2	1	2	2,75	8	0	0	0	15,75
Portugal	ENSP/NOVA	0	1	2	1,75	6	0	0	0	10,75
Portugal	SPMS			1	1	4	0	0	0	6
Serbia	MoHRS	2	1	2	4	15	0	0	0	24
Slovenia	NIJZ	2	1	0	43	0	0	0	0	46
Slovenia	ZZZS	0	1	2	2	0	0	10	0	15
United Kingdom	HSCB	2	1	0	3	0	0	0	0	6
	Total Person Months	99	69	93,75	162,6	137,7	85,03	52,2	105,48	804,85

FIGURE 15 SUMMARY OF EFFORT PER CA AND AE

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DETAILED BUDGET

a

Applicant No. & Short Name	**1.KG**		
(If affiliated entity: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Director	7.000,00	12,00	84.000,00
R+D Coordinator	6.000,00	18,00	108.000,00
Project Manager Senior	4.000,00	36,00	144.000,00
Project Manager	3.500,00	28,00	98.000,00
		Total person month	**Total Costs (€) for (A)**
		94,00	434000,00
	Justification		
	Coordination of the JA, owners of oGP leader of WP5, support to all applicants		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	0 16200 5400 8857,46	Kick off meeting will be held in Bilbao 3 Consortium Meetings (5 persons) Coordinator Final Conference (5 persons) Coordinator 3 Policy level meetings (1 person per MS)	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	20000 2000 8000 4000 4000	KoM Organization (room Rental, Wifi, Catering,) Translation Audit WP4 study visits organizers Thematic workshops: oGP	
Total Costs (€) of (C)	**68.457,46**		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**35.172,02**		
Total estimated eligible costs	**537.629,48**		

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Applicant No. & Short Name	1.1 CSFJA		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Coordinator_Project Leader	6.000,00	2,25	13.500,00
Project Manager	4.000,00	1,75	7.000,00
		Total person month	**Total Costs (€) for (A)**
		4,00	20.500,00
	Justification		
	Personnel involved implementation of GP as next adopters.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	NA		
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)			
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**1.435,00**		
Total estimated eligible costs	**21.935,00**		

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Applicant No. & Short Name	1.2 SCS		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Coordinator_Project Leader	6.000,00	1,50	9.000,00
Implementation expert	3.500,00	4,75	16.625,00
		Total person month	Total Costs (€) for (A)
		6,25	25.625,00
	Justification		
	Personnel involved implementation of GP as next adopters.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	NA		
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)			
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	1.793,75		
Total estimated eligible costs	27.418,75		

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Applicant No. & Short Name	1.3 SACYL		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	7.000,00	1,00	7.000,00
Coordinator_Project Leader	6.000,00	2,00	12.000,00
Project Manager	4.000,00	12,00	48.000,00
Implementation expert	3.500,00	4,00	14.000,00
		Total person month	**Total Costs (€) for (A)**
		19,00	81.000,00
	Justification		
	Personnel involved implementation of GP as next adopters.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 6480 6480	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
Total Costs (€) of (C)	23.760,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**7.333,20**		
Total estimated eligible costs	**112.093,20**		

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Applicant No. & Short Name	1.4SMS		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Coordinator of implementation in Murcia	7.136,00	3,25	23.192,00
Responsible of innovation in SMS	8.665,00	0,50	4.332,50
Researchers	7.033,00	3,50	24.615,50
Implementation expert	5.580,00	2,50	13.950,00
		Total person month	**Total Costs (€) for (A)**
		9,75	66.090,00
	Justification		
	Personnel involved implementation of GP as next adopters. Participation of the responsible of innovation is critical to guarantee the real implementation of the innovative GP proposed in JADECARE. And also the coordinator of implementation, who is the responsible of Strategy for chronic patients management in Murcia.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080 3240	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) WP4: Study Visit Implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
Total Costs (€) of (C)	8.640,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**5.231,10**		
Total estimated eligible costs	**79.961,10**		

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Applicant No. & Short Name	1.5 AQUAS		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	7.000,00	2,00	14.000,00
Coordinator_Project Leader	6.000,00	2,00	12.000,00
Project Manager	4.500,00	10,00	45.000,00
		Total person month	**Total Costs (€) for (A)**
		14	71000
	Justification		
	Personnel involved in evaluation, sustainability. Co-leader WP3.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	10.800,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**5.726,00**		
Total estimated eligible costs	**87.526,00**		

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Applicant No. & Short Name	1.6 IDIBAPS		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researchers	8.500,00	4,00	34,000
Project Manager	6.500,00	12,00	78,000
		Total person month	Total Costs (€) for (A)
		16,00	112.000,00
	Justification		
	Leading WP6 as oGP owner, support to transfer to next adopters		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000 4000	WP4 study visits organizers Thematic workshops: original oGP	
Total Costs (€) of (C)	18.800,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	9.156,00		
Total estimated eligible costs	139.956,00		

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Applicant No. & Short Name	1.7 FPS		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Coordinator_Project Leader	6.000,00	1,00	6.000,00
Project Manager	4.000,00	9,75	39.000,00
Implementation expert	3.500,00	4,00	14.000,00
		Total person month	**Total Costs (€) for (A)**
		14,75	59.000,00
	Justification		
	Personnel involved implementation of GP as next adopters		
(B) Direct costs of sub-contracting		Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 6480 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000	Thematic workshops: original oGP	
Total Costs (€) of (C)	24.520,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**5.846,40**		
Total estimated eligible costs	**89.366,40**		

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Applicant No. & Short Name	**1.8 IDIVAL**		
(If AE: Affiliated to which Applicant number/Short name)	**1.KG**		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Project Manager	4.000,00	12,00	48.000,00
		Total person month	**Total Costs (€) for (A)**
		12,00	48.000,00
	Justification		
	Personnel involved implementation of GP as next adopters		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	2160 6480 2160 6480 6480	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	NA		
Total Costs (€) of (C)	23.760,00		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**5.023,20**		
Total estimated eligible costs	**76.783,20**		

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Applicant No. & Short Name	1.9 FFIS		
(If AE: Affiliated to which Applicant number/Short name)	1.KG		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Responsible of JADECARE in FFIS	4.663,50	3,50	16.322,25
Project manager technician	3.208,50	2,00	6.417,00
		Total person month	Total Costs (€) for (A)
		5,50	22.739,25
	Justification		
	Personnel involved implementation of GP as next adopters		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080 3240 3240	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000	Thematic workshops: organizers	
Total Costs (€) of (C)	15.880,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	2.703,35		
Total estimated eligible costs	41.322,60		

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Applicant No. & Short Name	**2 MCA**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Project Coordinator	2.900,00	3,00	8.700,00
Senior experts	3.900,00	3,00	11.700,00
		Total person month	**Total Costs (€) for (A)**
		6,00	20.400,00
	Justification		
	Team will be involved in WP1-4 and supporting the implementation of GP.		

(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	**Costs (€)**	**Justification**
	1080	Kick off Meeting (1 person)
	3240	3 Consortium Meetings (1 person)
	1080	Final Conference (1 person)
	3240	Policy level meetings (1 person)
(C.2) Equipment	**Costs (€)**	**Justification**
	NA	
(C.3) Other goods and services	**Costs (€)**	**Justification**
	2000	Translation of oGP and dissemination materials
Total Costs (€) of (C)	**10.640,00**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**2.172,80**	
Total estimated eligible costs	**33.212,80**	

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Applicant No. & Short Name	2.1 MHSw-RS		
(If AE: Affiliated to which Applicant number/Short name)	2.MCA		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project Coordinator	2.500,00	6,00	15.000,00
Implementation expert (service manager)	2.500,00	12,00	30.000,00
Implementation expert (quality and measures)	2.750,00	1,00	2.750,00
		Total person month	**Total Costs (€) for (A)**
		19,00	47.750,00
	Justification		
	Team will be involved in WP1-4 as appropriate and in the implementation of GP.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 6480 6480	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	23.760,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**5.005,70**		
Total estimated eligible costs	**76.515,70**		

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Applicant No. & Short Name	2.2 ZZJZFBIH		
(If AE: Affiliated to which Applicant number/Short name)	2.MCA		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project Coordinator	2.500,00	6,00	15.000,00
Implementation expert (service manager)	2.500,00	12,00	30.000,00
Implementation expert (quality and measures)	2.750,00	1,00	2.750,00
		Total person month	**Total Costs (€) for (A)**
		19,00	47.750,00
	Justification		
	Team will be involved in WP1-4 as appropriate and in the implementation of GP.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 6480 6480	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	23.760,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**5.005,70**		
Total estimated eligible costs	**76.515,70**		

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Applicant No. & Short Name	3. CIPH		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project manager/financial officer	1.487,87	1,10	1.636,66
Project Coordinator	3.992,92	1,80	7.187,25
Senior experts	2.444,29	9,30	22.731,90
		Total person month	**Total Costs (€) for (A)**
		12,20	31.555,80
	Justification		
	Team will be involved in WP1-4 as appropriate and in the implementation of GP.		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160 6480 2160 3240 6480 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) Policy level meetings (1 person) WP4: Study Visit Implementation sites Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000 4000	Translation JADECARE materials Thematic workshops organizers
Total Costs (€) of (C)	29760	

(D) Indirect Costs	Total Costs (€)
(Max. 7% on A, B and C)	**4.292,11**
Total estimated eligible costs	**65.607,91**

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Applicant No. & Short Name	**3.1 CHIF**		
(If AE: Affiliated to which Applicant number/Short name)	**3. CIPH**		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Implementation expert (service manager)	2.291,85	2,70	6.188,00
Implementation expert (quality and measures)	1.804,69	2,70	4.872,66
		Total person month	**Total Costs (€) for (A)**
		5,40	11.060,66
	Justification		
	Team will be involved in WP1-4 as appropriate and supporting the implementation of GP.		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	1080 3240 1080	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person)	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	NA		
Total Costs (€) of (C)	5.400,00		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**1.152,25**		
Total estimated eligible costs	**17.612,90**		

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Applicant No. & Short Name	**4 MZCR**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Managers	5.050,00	2,00	10.100,00
Researchers	5.050,00	4,00	20.200,00
Administrator	2.867,00	1,00	2.867,00
		Total person month	**Total Costs (€) for (A)**
		7,00	33.167,00
	Justification		
	Team will be involved in WP1-4 as appropriate and supporting the implementation of GP.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080 3240 4320	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) Policy level meetings (1 person) WP4 Study visit implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	2000	Translation of JADECARE materials.	
Total Costs (€) of (C)	14.960,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**3.368,89**		
Total estimated eligible costs	**51.495,89**		

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Applicant No. & Short Name	4.1 UHO		
(If AE: Affiliated to which Applicant number/Short name)	4 MZCR		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Clinician	5.050,00	2,00	10.100,00
Nurses	2.867,00	1,00	2.867,00
Managers	5.050,00	4,00	20.200,00
Researchers	5.050,00	6,50	32.825,00
Administrator	2.867,00	7,50	21.502,50
		Total person month	**Total Costs (€) for (A)**
		21,00	87.494,50
	Justification		
	Team will be involved in WP1-4 as appropriate and in the implementation of GP. Co-leader WP8.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 4320 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000	Thematic workshops organizers	
Total Costs (€) of (C)	22.360,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**7.689,82**		
Total estimated eligible costs	**117.544,32**		

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Applicant No. & Short Name	5. RND		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Clinician	12.000,00	6,00	72.000,00
Nurses	5.500,00	6,75	37.125,00
Managers	7.000,00	11,25	78.750,00
		Total person month	**Total Costs (€) for (A)**
		24,00	187.875,00
	Justification		
	Team will be involved in WP1-4 as appropriate. Leader of WP8 owner of oGP.		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	3240	Policy level meetings (1 people)
	6480	WP4: Study Visit Implementation sites
	3240	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation of JADECARE materials
	4000	Thematic workshops organizers
Total Costs (€) of (C)	29.760,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**15.234,45**	
Total estimated eligible costs	**232.869,45**	

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Applicant No. & Short Name	5.1 RSD		
(If AE: Affiliated to which Applicant number/Short name)	5. RND		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project leader	7.830,00	12,75	99.832,50
Project assistant	2.685,00	4,25	11.411,25
		Total person month	Total Costs (€) for (A)
		17,00	111.243,75
	Justification		
	Team will be involved in WP1-4 as appropriate and in the implementation of GP. Owner of oGP		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) Policy level meetings (1 person)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000 4000	WP4 Study visits: organizers Thematic workshops: oGP	
Total Costs (€) of (C)	22.040,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	9.329,86		
Total estimated eligible costs	142.613,61		

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Applicant No. & Short Name	**6. MSAE**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project Coordinator (MSAE) and policy expert (social welfare and integrated care)	3.300,00	4,00	13.200,00
Policy expert (health)	3.300,00	1,00	3.300,00
Policy expert (digital development)	3.300,00	1,00	3.300,00
		Total person month	**Total Costs (€) for (A)**
		6,00	19.800,00
	Justification		
	Team will be involved in WP1-4 as appropriate.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) Policy level meetings (1 person)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	2000	Translation JADECARE materials	
Total Costs (€) of (C)	10.640,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**2.130,80**		
Total estimated eligible costs	**32.570,80**		

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Applicant No. & Short Name	6.1 VH		
(If AE: Affiliated to which Applicant number/Short name)	6. MSAE		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project Coordinator (Viljandi Hospital)	2.500,00	4,00	5.000,00
Implementation expert (service manager)	2.500,00	3,00	5.000,00
Implementation expert (quality and measures)	2.750,00	3,00	5.500,00
Implementation expert (IT)	2.300,00	3,00	8.250,00
Implementation expert (specialist doctor)	6.200,00	3,00	18.600,00
Implementation expert (management)	6.800,00	3,00	20.400,00
		Total person month	**Total Costs (€) for (A)**
		19,00	62.750,00
	Justification		
	Team will be involved in WP1-4 as appropriate and implementation of GP.		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 6480 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000	Thematic workshops organizers	
Total Costs (€) of (C)	24.520,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**6.108,90**		
Total estimated eligible costs	**93.378,90**		

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Applicant No. & Short Name	7. EUSTRAS		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Director	7.000,00	3,00	21.000,00
Project Manager Senior	4.000,00	11,00	44.000,00
		Total person month	Total Costs (€) for (A)
		14,00	65.000,00
	Justification		
	Team will be involved in WP1-4 as appropriate and in WP 7 with Optimedis		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
Optimedis: subcontracting oGP Optimedis	179000	The owners of the oGP OptiMedis Model-Population-Based Integrated Care, will be subcontracted by Eurométropole de Strasbourg (France), leader of WP7. It is necessary to subcontract Optimedis to guarantee the presence of the all the owners of oGPs selected by the SGPP.
Total Costs (€) of (B)	**179000**	

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	3240	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	3240	Policy level meetings (1 person)
	3240	WP4: Study Visit Implementation sites
	3240	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation of JADECARE materials
	3240	Thematic workshops: organizers
	4000	Audit
Total Costs (€) of (C)	26.520,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**18.936,40**	
Total estimated eligible costs	**289.456,40**	

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Applicant No. & Short Name	**8. BAGSFI**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Managers (Project management, communication, first level controlling)	7.611,52	5,25	39.960,48
Researchers (Preparation and execution of tasks 4.1 and 4.2)	7.611,52	5,00	38.057,60
		Total person month	**Total Costs (€) for (A)**
		10,25	78.018,08
	Justification		
	Team will be involved in WP1-4 as appropriate and in implementation of GP, next adopters		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160 6480 2160 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) Policy level meetings (1 person)
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation of JADECARE materials
Total Costs (€) of (C)	16.040,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**6.584,07**	
Total estimated eligible costs	**100.642,15**	

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Applicant No. & Short Name	8.1 LGL		
(If AE: Affiliated to which Applicant number/Short name)	8. BAGSFI		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Researchers (Preparation and execution of tasks 2.4.)	7.004,92	4,25	29.770,91
Researchers (Preparation and execution of tasks 4.2.)	7.004,92	3,00	21.014,76
		Total person month	**Total Costs (€) for (A)**
		7,25	50.785,67
	Justification		
	Team will be involved in WP1-4 as appropriate and implementation of GP.		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	1080 3240 1080 12000	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) External speakers - SH forum (CM)
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	NA	
Total Costs (€) of (C)	17.400,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**4.773,00**	
Total estimated eligible costs	**72.958,67**	

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Applicant No. & Short Name	**8.2 ZTG- GmbH**		
(If AE: Affiliated to which Applicant number/Short name)	**8. BAGSFI**		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Managers (Project Management Liaison; Contributions to Task 4.1 (core characteristics of oGPs and general principles) and Task 4.2 (Knowledge exchange and generation)	7.291,68	3,75	27.343,80
Researchers (Liaison to WP2 Dissemination; Support for Task 2.3 (Website))	7.291,68	4,00	29.166,72
		Total person month	**Total Costs (€) for (A)**
		7,75	56.510,52
	Justification		
	Team will be involved in WP1-3 as appropriate, key role in WP4 in WP2		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	1080 3240 1080	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person)	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	25000	Website development and maintenance	
Total Costs (€) of (C)	30.400,00		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**6.083,74**		
Total estimated eligible costs	**92.994,26**		

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Applicant No. & Short Name	9. 4THYPE		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	4.500,00	1,00	4.500,00
Coordinator_Project Leader	4.000,00	6,00	24.000,00
Project Manager	3.500,00	12,00	42.000,00
Junior Researcher	3.000,00	3,00	9.000,00
		Total person month	**Total Costs (€) for (A)**
		22,00	79.500,00
	Justification		
	Team will be involved in WP1-4 as appropriate, and in implementation of GP, next adopters.		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	3240	Policy level meetings (1 person)
	6480	WP4: Study Visit Implementation sites
	6480	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation of JADECARE materials
Total Costs (€) of (C)	29.000,00	

(D) Indirect Costs	Total Costs (€)
(Max. 7% on A, B and C)	**7.595,00**
Total estimated eligible costs	**116.095,00**

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Applicant No. & Short Name	**9.1 AUTH**		
(If AE: Affiliated to which Applicant number/Short name)	**9. 4THYPE**		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Senior Researcher	*5.000,00*	*3,00*	*15.000,00*
Coordinator_Project Leader	5.000,00	4,00	20.000,00
Project Manager	3.500,00	14,00	49.000,00
Junior Researcher	3.000,00	3,00	9.000,00
		Total person month	**Total Costs (€) for (A)**
		24,00	93.000,00
	Justification		
	Team will be involved in WP1-4 as appropriate and implementation of GP. Leader WP3		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	2360 6480 2360	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people)	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	NA		
Total Costs (€) of (C)	11.200,00		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**7.294,00**		
Total estimated eligible costs	**111.494,00**		

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Applicant No. & Short Name	**10. AEEK**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	3.950,00	1,00	3.950,00
Coordinator_Project Leader	3.500,00	4,00	14.000,00
Project Manager	3.150,00	10,00	31.500,00
Junior Researcher	2.800,00	2,00	5.600,00
		Total person month	**Total Costs (€) for (A)**
		17,00	55.050,00
	Justification		
	Team will be involved in WP1-4 as appropriate and in implementation of GP, next adopters		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160 6480 2160 3240 2160	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) Policy level meetings (1 person) WP4: Study Visit Implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation of JADECARE materials
Total Costs (€) of (C)	18.200,00	

(D) Indirect Costs	Total Costs (€)
(Max. 7% on A, B and C)	**5.127,50**
Total estimated eligible costs	**78.377,50**

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Applicant No. & Short Name	10.1 SU-HSMTC		
(If AE: Affiliated to which Applicant number/Short name)	10. AEEK		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	4.500,00	1,00	4.500,00
Coordinator_Project Leader	4.000,00	3,00	12.000,00
Project Manager	3.500,00	12,00	42.000,00
Junior Researcher	3.000,00	3,00	9.000,00
		Total person month	**Total Costs (€) for (A)**
		19,00	67.500,00
	Justification		
	Team will be involved in WP1-4 as appropriate and lead WP2.		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160 6480 2160	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people)
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	20000 15000 7000	Final conference organization Dissemination material: Audio-visual material (3-5 videos) 4,000.00; Communication package (visual ID, templates, leaflet (i.e. 3000), flyer (i.e 3000 – 5000); Layman report (3000-5000) and poster template, roll-ups, infographics)11,000.00 Scientific publications
Total Costs (€) of (C)	52.800,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**8.421,00**	
Total estimated eligible costs	**128.721,00**	

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Applicant No. & Short Name	10.2 JFDPK		
(If AE: Affiliated to which Applicant number/Short name)	10. AEEK		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	4.500,00	1,00	4.500,00
Coordinator_Project Leader	4.000,00	4,00	16.000,00
Project Manager	3.500,00	6,00	21.000,00
Junior Researcher	3.000,00	2,00	6.000,00
Implementation expert	3.000,00	8,00	24.000,00
		Total person month	**Total Costs (€) for (A)**
		21,00	71.500,00
	Justification		
	Team will be involved in WP1-4 as appropriate, next adopters		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 4320 3240	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000	Thematic workshops: organizers	
Total Costs (€) of (C)	22.360,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**6.570,20**		
Total estimated eligible costs	**100.430,20**		

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Applicant No. & Short Name	**11 AGENAS**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Clinician (Scientific legal responsible)	11.869,24	1,00	11.869,24
Project Manager senior	5.194,33	25,00	129.858,25
Project Manager Junior	2.645,72	3,25	8.598,59
Researchers (expert epidemiologist)	8.532,00	3,00	25.596,00
Researchers (expert statistician)	4.274,23	1,00	4.274,23
		Total person month	**Total Costs (€) for (A)**
		33,25	180.196.31
	Justification		
	Team will be involved in WP1-4 as appropriate and in implementation of GP, next adopters. Co-lead WP4		

(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	**Costs (€)**	**Justification**
	2160 6480 2160	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people)
(C.2) Equipment	**Costs (€)**	**Justification**
	NA	
(C.3) Other goods and services	**Costs (€)**	**Justification**
	2000 8000	Translation JADECARE materials Audit
Total Costs (€) of (C)	20800	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**14.069,74**	
Total estimated eligible costs	**215.066,05**	

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Applicant No. & Short Name	11.1 ASL NA2		
(If AE: Affiliated to which Applicant number/Short name)	11 AGENAS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Clinician (Medical director)	9.000,00	1,00	9.000,00
Managers (Administrative)	2.500,00	2,00	5.000,00
Managers (Reference contact)	6.500,00	12,00	78.000,00
Researchers (Technical staff)	2.700,00	4,00	10.800,00
		Total person month	**Total Costs (€) for (A)**
		19,00	102.800,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	6480	WP4: Study Visit Implementation sites
	6480	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	NA	
Total Costs (€) of (C)	23.760,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**8.859,20**	
Total estimated eligible costs	**135.419,20**	

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Applicant No. & Short Name	**11.2 LOMBARDIA**		
(If AE: Affiliated to which Applicant number/Short name)	**11 AGENAS**		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Senior Researcher	7.000,00	1,50	10.500,00
Coordinator_Project Leader	5.500,00	3,00	16.500,00
Project Manager	4.375,00	13,00	56.875,00
Junior Researcher	4.500,00	1,50	6.750,00
		Total person month	**Total Costs (€) for (A)**
		19,00	*90.625,00*
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		

(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	**Costs (€)**	**Justification**
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	6480	WP4: Study Visit Implementation sites
	6480	Thematic workshops: implementation sites
(C.2) Equipment	**Costs (€)**	**Justification**
	NA	
(C.3) Other goods and services	**Costs (€)**	**Justification**
	NA	
Total Costs (€) of (C)	23760	

(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**8.006,95**	
Total estimated eligible costs	**122.391,95**	

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Applicant No. & Short Name	11.3 ARS TOSCANA		
(If AE: Affiliated to which Applicant number/Short name)	11 AGENAS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Clinician (Medical director)	8.643,00	1,00	8.643,00
Nurses (Qualified healthcare professional)	3.984,00	2,00	7.968,00
Managers (Adminsitrative)	2.163,00	1,00	2.163,00
Managers (Reference cotnact)	6.545,00	12,00	78.540,00
Researchers (Technical staff)	3.121,00	3,00	9.363,00
		Total person month	**Total Costs (€) for (A)**
		19,00	106.677,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	6480	WP4: Study Visit Implementation sites
	3240	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	4000	Thematic workshops organizers
Total Costs (€) of (C)	24.520,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**9.183,79**	
Total estimated eligible costs	**140.380,79**	

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Applicant No. & Short Name	11.4 USL UMBRIA		
(If AE: Affiliated to which Applicant number/Short name)	11 AGENAS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Clinician (Medical director)	6.500,00	1,00	6.500,00
Nurses (Qualified healthcare professional)	3.583,00	3,00	10.749,00
Managers (IT Staff)	3.500,00	8,00	28.000,00
Managers (Adminsitrative)	3.583,00	7,00	25.081,00
		Total person month	**Total Costs (€) for (A)**
		19,00	70.330,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	6480	WP4: Study Visit Implementation sites
	6480	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	NA	
Total Costs (€) of (C)	**23760**	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**6.586,30**	
Total estimated eligible costs	**100.676,30**	

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Applicant No. & Short Name	11.5 MARCHE		
(If AE: Affiliated to which Applicant number/Short name)	11 AGENAS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Physician (Qualified professional leading integrated care team)	7.100,00	12,00	85.200,00
Nurses (Qualified healthcare professional)	3.200,00	2,00	6.400,00
Managers (Administrative)	3.980,00	1,00	3.980,00
Managers (Director)	13.200,00	1,00	13.200,00
Managers (Regional Health manager)	10.020,00	3,00	30.060,00
		Total person month	**Total Costs (€) for (A)**
		19,00	138.840,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	2160 6480 2160 6480 6480	Kick off Meeting (2 people) 3 Consortium Meetings (2 people) Final Conference (2 people) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	23.760,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**11.382,00**		
Total estimated eligible costs	**173.982,00**		

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Applicant No. & Short Name	11.6 PROMIS		
(If AE: Affiliated to which Applicant number/Short name)	11 AGENAS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project Manager	4.677,00	0,50	2.338,50
Managers (Administrative contact)	3.121,00	0,50	1.560,50
		Total person month	**Total Costs (€) for (A)**
		1,00	3.899,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	9363	Activities of dissemination and communication	
Total Costs (€) of (B)	**9363**		
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person)	
(C.2) Equipment	Costs (€)	Justification	
(C.3) Other goods and services	Costs (€)	Justification	
Total Costs (€) of (C)	5.400,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**1.306,34**		
Total estimated eligible costs	**19.968,34**		

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Applicant No. & Short Name	**11.7 MhH**		
(If AE: Affiliated to which Applicant number/Short name)	**11 AGENAS**		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Managers (Reference contact)	12.703,00	1,00	12.703,00
Researchers (Technical staff)	4.861,00	3,00	14.583,00
		Total person month	**Total Costs (€) for (A)**
		4,00	27.286,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation GP, next adopter		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	1080	Kick off Meeting (1 person)
	3240	3 Consortium Meetings (1 person)
	1080	Final Conference (1 person)
	3240	3 Policy level meetings (1 person)
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	NA	
Total Costs (€) of (C)	8640	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	2.514,82	
Total estimated eligible costs	38.440,82	

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Applicant No. & Short Name	**12. NVD**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Managers	1.190,00	7,00	8.330,00
		Total person month	**Total Costs (€) for (A)**
		7,00	8.330,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	1080 3240 1080	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person)	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	NA		
Total Costs (€) of (C)	5400		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**961,10**		
Total estimated eligible costs	**14.691,10**		

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Applicant No. & Short Name	12.1 CCUH		
(If AE: Affiliated to which Applicant number/Short name)	12. NVD		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Managers	2.742,00	14,00	38.388,00
Clinician	1.350,00	10,00	13.500,00
		Total person month	**Total Costs (€) for (A)**
		24,00	51.888,00
	Justification		
	Team will be involved in WP1-4 as appropriate, and in implementation of GP, next adopters		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	3240	Policy level meetings (1 person)
	6480	WP4: Study Visit Implementation sites
	6480	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation JADECARE materials
Total Costs (€) of (C)	29.000,00	

(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**5.662,16**	
Total estimated eligible costs	**86.550,16**	

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Applicant No. & Short Name	13 LR SAM		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Site Administrator	2.530,00	6,00	15.180,00
Assistant responsible Primary Health care	1.516,00	6,00	9.096,00
Assistant, rehabilitation, Sanatorium (anti-relapse) treatment implementation	1.605,00	6,00	9.630,00
Assistant, planning, development and implementation	2.383,00	6,00	14.298,00
		Total person month	**Total Costs (€) for (A)**
		24,00	48.204,00
	Justification		
	Team will be involved in WP1-4 as appropriate, and in implementation of GP, next adopters		

(B) Direct costs of sub-contracting	Costs (€)	justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	3240	Policy level meetings (1 person)
	6480	WP4: Study Visit Implementation sites
	3240	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation
	4000	Thematic workshops: organizers
Total Costs (€) of (C)	29760	

(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**5.457,48**	
Total estimated eligible costs	**83.421,48**	

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Applicant No. & Short Name	**14. ACSS**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Manager	1.624,00	8,00	12.992,00
Clinician	8.772,00	3,00	26.316,00
Nurse	1.908,00	4,75	9.063,00
		Total person month	**Total Costs (€) for (A)**
		15,75	48.371,00
	Justification		
	Team will be involved in WP1-4 as appropriate, and in implementation of GP, next adopters		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	1080 **3240** **1080** **3240** **6480** 6480	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) Policy level meetings (1 person) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	**Costs (€)**	**Justification**	
	NA		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	2000	Translation JADECARE materials	
Total Costs (€) of (C)	23600		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**5.037,97**		
Total estimated eligible costs	**77.008,97**		

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Applicant No. & Short Name	14.1 NOVA		
(If AE: Affiliated to which Applicant number/Short name)	14. ACSS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Researchers (two people)	1.800,00	10,75	19.350,00
		Total person month	**Total Costs (€) for (A)**
		10,75	19.350,00
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	5400		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**1.732,50**		
Total estimated eligible costs	**26.482,50**		

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Applicant No. & Short Name	14.2 SPMS		
(If AE: Affiliated to which Applicant number/Short name)	14. ACSS		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
ICT and Communication Director	5.519,00	2,00	11.038,00
Chief of Unit/Office or Coordinator	4.552,21	2,00	9.104,42
Technical experts	2.474,28	2,00	4.948,56
		Total person month	**Total Costs (€) for (A)**
		6,00	25.090,98
	Justification		
	Team will be involved in WP1-4 as appropriate, implementation		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 **3240** 1080	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	5400		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**2.134,37**		
Total estimated eligible costs	**32.625,35**		

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Applicant No. & Short Name	**15. MoHRS**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior Researcher	750,00	1,00	750,00
Project Manager	1.440,00	11,00	15.840,00
Junior Researcher	1.000,00	1,00	1.000,00
Implementation expert	2.250,00	11,00	24.750,00
		Total person month	**Total Costs (€) for (A)**
		24,00	42.340,00
	Justification		
	Team will be involved in WP1-4 as appropriate, and in implementation of GP, next adopters		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	2160	Kick off Meeting (2 people)
	6480	3 Consortium Meetings (2 people)
	2160	Final Conference (2 people)
	3240	Policy level meetings (1 person)
	6480	WP4: Study Visit Implementation sites
	6480	Thematic workshops: implementation sites
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	2000	Translation JADECARE materials
Total Costs (€) of (C)	29.000,00	

(D) Indirect Costs	Total Costs (€)
(Max. 7% on A, B and C)	**4.993,80**
Total estimated eligible costs	**76.333,80**

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Applicant No. & Short Name	**16. NIJZ**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Senior experts	4.750,00	6,00	28.500,00
Manager	5.000,00	28,00	140.000,00
Financial Manager & admin.support	3.750,00	4,00	15.000,00
Junior Researchers	2.500,00	8,00	20.000,00
		Total person month	**Total Costs (€) for (A)**
		46,00	203.500,00
	Justification		
	Team will be involved in WP1-4 as appropriate, leader of WP4		

(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification
	NA	
Total Costs (€) of (B)		

(C) Other direct costs		
(C.1) Travel	Costs (€)	Justification
	3240 9720 3240 3240 16000	Kick off Meeting (3 people) 3 Consortium Meetings (3 people) Final Conference (3 people) Policy level meetings (1 person) Collaborating SH travel
(C.2) Equipment	Costs (€)	Justification
	NA	
(C.3) Other goods and services	Costs (€)	Justification
	18000 2000 4000	3 policy level meetings organization Translation JADECARE materials Audit
Total Costs (€) of (C)	59.440,00	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**18.405,80**	
Total estimated eligible costs	**281.345,80**	

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Applicant No. & Short Name	16.1 ZZZS		
(If AE: Affiliated to which Applicant number/Short name)	16. NIJZ		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Clinician	3.300,00	4,00	13.200,00
Managers	5.375,00	9,00	48.375,00
Senior researchers	4.700,00	1,00	4.700,00
Junior researchers	2.665,00	1,00	2.665,00
		Total person month	**Total Costs (€) for (A)**
		15,00	68.940,00
	Justification		
	Team will be involved in WP1-4 as appropriate, and in implementation of GP, next adopters		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080 6480 3240	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) WP4: Study Visit Implementation sites Thematic workshops: implementation sites	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	4000	Thematic workshops organizers	
Total Costs (€) of (C)	19.120,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**6.164,20**		
Total estimated eligible costs	**94.224,20**		

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Applicant No. & Short Name	**17. HSCB**		
(If AE: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Project manager	4000	6	24000
		Total person month	**Total Costs (€) for (A)**
		6	24000
	Justification		
	Observer for future implementation		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
	NA		
Total Costs (€) of (B)			
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	1080 3240 1080 3240	Kick off Meeting (1 person) 3 Consortium Meetings (1 person) Final Conference (1 person) Policy level meetings (1 person)	
(C.2) Equipment	Costs (€)	Justification	
	NA		
(C.3) Other goods and services	Costs (€)	Justification	
	NA		
Total Costs (€) of (C)	8.640,00		
(D) Indirect Costs	Total Costs (€)		
(Max. 7% on A, B and C)	**2.284,80**		
Total estimated eligible costs	**34.924,80**		

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PREVIOUS AND CURRENT GRANTS RELEVANT TO THE PROGRAMME

CALLS	Current and previous grants
JOINT ACTIONS (CHAFEA)	**CHRODIS PLUS**: KG, AQUAS, CSJA, NIJZ, MoH-Italy, SU, AUTH, AGENAS, and CIPH are participating in the JA that will contribute to the reduction of this burden by promoting the implementation of policies and practices that have been demonstrated to be successful **Joint Action to support the eHealth Network [JAseHN]:** AEEK, SE, MoH it, NVD (Latvia) AEEK and CIPH have been working develop political recommendations and instruments for cooperation in the four specific priority areas that are specified in the eHN's Multi annual Work Programme (MWP) and that were adopted by the eHN in May 2014: (1) interoperability and standardisation, (2) monitoring and assessment of implementation, (3) exchange of knowledge and (4) global cooperation and positioning. **eHAction:** CHIF was responsible for preparing legal interoperability in cross-border context as a base for Legal Agreement for eHeath projects and implementation of eHealth guidelines as work package leader where NIZJZ and AEEK are also partners. **ADVANTAGE**: KG, CSJA, CIPH, AGENAS, ACSS, NIJZ and DOH have worked together in the JA related to frailty that has summarised the current state of the art of the different components of frailty and its management, both at a personal and population level **infAct:** InfAct (Information for Action) is a JA on health information (HI): MCA, NIJZ, MSAE, ACSS are participating in this JA. **iPAAC JA** the general objective of the Joint Action – Innovative Partnership for Action Against Cancer is to develop innovative approaches to advances in cancer control. NIJZ coordinates this JA, where CIPH and ACSS participate. **JAHEE** - The Joint Action Health Equity Europe will represent an important opportunity for MS to work jointly to address health inequalities and underlying social determinants of health. MCA, CIPH, NIJZ and ACSS are working together in this JA. **SHARP:** The SHARP Joint Action will strengthen implementation of Decision 1082/2013/EU, supporting the EU level preparedness and responses to health threats and the implementation of the International Health Regulations. MCA, NIJZ, CIPH, MSAE are collaborating in this JA.
PROJECTS OF THE EU HELTH PROGRAMME	**SCIROCCO** and SCIROCCO Exchange projects build upon the preliminary achievements of the B3 Action Group on Integrated Care of the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) that first developed the concept of the B3 Maturity Model. KG, OPTIMEDIS, ITALY, MoH (Czech Republic) and NIZJZ among other partners of this project that have been involved in SCIROCCO or SCIROCCO Exchange. **VIGOUR**: will effectively support care authorities in progressing the transformation of their health and care systems to provide sustainable models for integrated care which will facilitate identification of good practice and scaling-up. PROMIS, CSJA and DOH participate in this project.
EUROPEAN COLLABOR. PROJECTS (H2020/ INTERREG)	All applicants are highly active in the development of collaborative projects: **KG**: C3-CLOUD: aims to develop personalised care plans for complex multimorbid patients, supported by ICT tools and managed by a coordinated multidisciplinary team, that promotes integrated care and the involvement of the patient and/or caregiver; UPRIGHT general objective is to promote mental wellbeing and prevent mental disorders by enhancing resilience capacities in youths, through a holistic approach addressing early adolescents, families and education professionals. **CIPH/CHIF**: INCA Inclusive Introduction of Integrated Care (INCA) – the aim is to coordinate the socio-sanitary services of the different administrations, aiming to reduce costs, improve patient experience and achieve greater efficiency and value from health delivery systems. EXPAND - Expanding Health Data Interoperability Services (EXPAND). To convey the results of EXPAND, creating critical mass among the different Stakeholders in preparation of deployment of CEF cross-border eHealth services. **MoH (Czech Republic):** Interreg CE project NiceLife (aiming among others to scale up relevant good practice from Italy) and SHAPES (innovation action –IA - that aims to develop and deploy a pan-European Integrated Care Platform).

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CALLS	Current and previous grants
	4THYPE/AUTH:: «SMiLe, Strenghtening primary Medical care in IsoLated and deprived cross-border arEas>>. INTERREG V-A Partnership Program "Greece - Bulgaria 2014-2020" The Lab co-ordinates the H2020 SmokeFreeBrain (www.smokefreebrain.eu) project in line with a call from the Global Alliance of Chronic Diseases (GACD). The Lab co-ordinates the H2020 project CAPTAIN (https://www.captain-eu.org/), which develops coaching technologies for the elderly. The lab participates in H2020 INADVANCE (http://medphys.med.auth.gr/project/inadvance) project, focused on palliative care. The lab participates with the role of partner in many European projects promoting active and healthy ageing through new technologies, like H2020 project UNCAP (Ubiquitous iNteroperable Care for Ageing People; http://www.uncap.eu/) and H2020 iPrognosis (Intelligent Parkinson early detection guiding novel supportive interventions; http://www.i-prognosis.eu/) which aims at the early diagnosis of the Parkinson's disease. **AEEK**: HELIUM -Health Innovation Experimental Landscape through Policy Improvement, INTERREG EUROPE, The aim of the project is to support experience exchange as well as sharing good practices concerning health innovation in order to promote the effective execution of projects especially funded by the Structural Fund. ECHO - Establishing and operating a pilot for a Cybersecurity Competence Network to develop and implement a common Cybersecurity Research & Innovation Roadmap. ECHO delivers an organized and coordinated approach to strengthen proactive cyber defense of the European Union, through effective and efficient multi-sector collaboration. InterReg Europe - Delivery of Innovative solutions for Home Care by strengthening quadruple-helix cooperation in regional innovation chains (HoCare). Objective of HoCare project is to boost delivery of home care innovative solutions in regional innovation chains by strengthening of cooperation of actors in regional innovation system using Quadruple-helix approach. **AGENAS:** In September 2017 AGENAS signed a joint tender Contract with the Semmelweis University, the University of Leuven (Katholieke Universiteit Leuven), the Italian Ministry of Health (Ministero della Salute), and the Standing Committee of European Doctors (CPME), for the action titled "Support for the health workforce planning and forecasting expert network" in the field of European health workforce planning. **NVD-CCUH:** Children's Clinical University Hospital Riga is full member in 2 ERNs and affiliated partner in several European Reference Networks (ERNs) approved by the ERN Board of Member States. The ERNs are co-funded by the European Commission (EUCERD Joint Action). ERNs will develop new innovative care models, eHealth tools, medical solutions and devices; "Integrated hospital units for patient and staff-centered oriented deep renovation IN-PATIENT"(within H2020); **DOH**: Through Structural Funds such as the INTERREG VA programme, there has been significant investment to underpin cooperation between the health and social care sector in NI and the border counties of the Republic of Ireland (RoI). The health theme of the INTERREG VA Programme 2014-20 is delivering cross-border projects across a range of areas including older people's services and health research. Projects are encouraged to incorporate integrated and innovative approaches, eHealth applications and interoperable solutions - an example is mPower which is enabling older people to live independently in their own homes, supported by a modernised infrastructure for healthy ageing. The Programme is expected to demonstrate the workability of a range of innovative transnational service delivery models capable of wider application. DOH collaborates also with Basque Country in the project MIDAS that intends to have a real impact on these problems, and to release some of the potential of Big Data to improve health, and health care delivery.
NATIONAL/ REGIONAL/ INTERNAL PROJECTS	**MoH (Czech Republic):** A national project supervised by Technological agency of the CR in programme Omega has focused on the use of EIP on AHA tools for scaling up of AHA good practices. NTMC also participates in three relevant Twinning in 2017 and newly in a Twinning organized by RSCN, together with Catalonia. MOH has accepted a new "Strategic Framework for Health Care Development in the Czech Republic by 2030" in 2019, where there are - besides all the focus on healthcare transformation and modernization - 3 most relevant specific goals: Primary care reform, Implementation of integrated care models and Digitalization of

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CALLS	Current and previous grants
	healthcare. Implementation plans for these goals will be developed and pertinent projects supporting them will follow. It is expected that the knowledge and other findings from **RND**: Telecare North: TeleCare North is an ambitious, large-scale telemedicine project, where the region of North Denmark offer telemedicine to all COPD patients in North Jutland who could benefit from it; Strategic Digital management in Region of North Denmark, where a strategy for digital transformation of the entire organization with over 12.000 Employees (Doctors, nurse, scientists etc.) was develop; Innovation unit in the Municipality of Aalborg. The Innovation Unit was the project office for many different innovation projects. Projects like innovative procurement of medical medical equipment financed by the European Regional Development Fund. The Digital health unit has a project portfolio current with over 40 active projects. **MSAE**: Developing and piloting integrated care model to better support people recovering their first psychosis; Piloting the model of care co-ordination with a focus on people with complex care needs (with a special focus on frail elderly). The purpose of the project was to create a person-centered coordination system for people with complex needs on the primary level. For that, new roles of care-coordinators were developed in test municipalities, that aimed to better connect primary healthcare and the social welfare system. interRAI contact assessment tool was used, cross-sectoral service plans were created, and in-risk people were monitored regularly. The model was tested in 6 groups of municipalities (in some cases within a single municipality and in other cases up to three different municipalities). **EUSTRAS**: The Eurométropole of Strasbourg has managed European structural funds (ERDF et ESF) and has taken part in an URBACT project on social innovation. It has signed with the regional health agency a contract to set up a local health observatory, to take health into account in all its policies (town planning, mobility…). **BAGSFI**: has different on-going projects related with integrated healthcare as e-healthy ship, Telwunde, I/E-Health NRW (eHealth in cross-sectorial Health Services); Solimed ePflegebericht (digital nursing documentation); ELSA-APP (EHR in palliative, pediatric care); GerNe Digital! (Cross-sectorial Health Services in Geriatrics); HeLP (Independent living with impairments with support in the neighbourhood; NephroTeTe (Cross-sectorial Health Services / Case Management for people with kidney disease); SMITH – Smart Medical Information Technology for Healthcare (German Medical Informatics Initiative);Upcoming e.g. Telemedizin@NRW– Permanent Implementation Platform for Telemedicine in Routine care; **4THYPE**:Health Education and Prevention Network Program (national project). **AEEK**: “Development of Social Human Resources” project. The overall objective of the project is to improve the quality resources in human public services through professional tetraining in order to meet professional challenges and expectations as well as service standards to be further developed. "Professional methodological development of health care system" project This project delivers solutions to improve patient safety by creating and developing organizational culture and approach that enables workers to identify sources of danger in carrying out activities and make suggestions for their protection. The National eHealth Infrastructure (EESZT) is an integrated platform, developed for end-users and healthcare personnel, available 24 hours a day. Its central services can be accessed anytime through the users’ own IT systems and equipment. VEKOP-7.2.2-17-2017-00010. “Establishment of a health promotion office (HPO) and implementation of a comprehensive set of health promotion programs in Pesterzsébet” **AGENAS:** The National project “Proposal for the definition of organizational models that favour work carried out in multisciplinary and multiprofessional teams within network care pathways” was carried out for 12 months, in the context of the research projects for the years 2017-2018, and foresaw the involvement of four regions (Campania, Lombardia, Toscana, Piemonte) in relation to their geographical representativeness, as well as the participation of the National Institute of Health (ISS). The Ministry of Health has asked Agenas to provide support to the Project Management in the implementation of the National Operating Programme “Chronicity” (PON GOV Cronicità) financed by EU structural funds, for all lines of activity and particularly for the implementation of Line no. 1 “Promoting the emergency, the collection and the knowledge of good practices”.

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CALLS	Current and previous grants
	NVD-CCUH: Development and Implementation of Health Network Development Guidelines and Quality Assurance System in Priority Health Areas»; «Role of Team in Ensuring Patient Safety and Quality of Treatment Processes; Implementation of a widely used recognized "Planetree" patient experience systems, competencies at the Children's Clinical University Hospital; Development of Patient experience system in collaboration with the MeS Lab research lab at Sant'Anna University (Pisa, Italy) (EC project no. SRSS / S2017 / 019 "Establishment of a health system performance evaluation system in Slovenia and Latvia"); Implementation of a monitoring system of patient experience in the Children's hospital in collaboration with Meyer Children's hospital, Italy. **LR SAM**: Improvement of primary health-care infrastructure (funded by European Structural funds for addressing health inequalities in Lithuania) Target group - 200 primary health care institutions in Lithuania. Prescription- Drug interaction database Electronic sale of medicines and delivery to patient, other automatic checks and reminders. (Implemented in 2019) (National budget and EU funds). Online Doctor Appointment Booking System; System deployment at national level for all health care institutions and integration with other eHealth processes. system will be integrated with Lithuanian e- health system and enable Waiting for appointment time management, decrease waiting times. Presently, Innovative models of care of multimorbid patients using Methodological recommendations issued by CHRODIS are under development. In order to ensure quality and sustainability of primary health care services in Lithuania is extremely important to have science-based methodological recommendations for treatment of patients with multimorbidity. European structural funds, will provide an opportunity to test other possible since based multimorbidity treatment models, select the most effective model for adoption of it on the national level. The Pilot project for testing innovative effective care models for multimorbid patients is planned in the nearest future. **ACSS**: ACSS was involved in a national strategy to scale up integration of care (SNS + proximidade). ACSS has also opened a national call with a 35M€ budget to finance integrated care projects at a local level with the goal of boosting integration of care. ACSS in partnership with SPMS is improving the health information systems in order to allow following the patient through the health system (SIGA). Several other initiatives are being developed to improve integration of care and people centered care such as hospital at home, family nurse in primary care, teleconsultation, telescreening, telemonitoring of chronic disease patients, decentralized specialists' consultations, monitoring of avoidable hospital admissions. ACSS is also improving care financing models to support integration.

CURRENT APPLICATIONS RELEVANT TO THE PROGRAMME

Some of the partners have current applications relevant to the programme apart from the continuous working in improving the delivery of integrated care:

Partner	Current applications relevant to the programme
KG	KG has just been recently awarded by the EC as a coordinator in the topic **SC1-DTH-11-2019** — Large Scale pilots of personalised & outcome based integrated care which main objective is to improve the quality of life of senior people with Advanced Chronic Diseases by providing innovative integrated intelligent personalized care. ADLIFE will deploy a large-scale implementation of digitally enabled holistic and integrated supportive care. Denmark will be one the piloting region in the project and South Denmark will be the area where the pilot will be implemented in Denmark.
NIJZ	Has been invited to participate JA-01-2019 Joint Action on implementation of validated best practices and JA-02-2019 Joint Action to strengthen health preparedness and response to biological and chemical terror attacks

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EXCEPTIONAL UTILITY

JADECARE fulfils the requirements to be considered of exceptional utility:

- The 62% of the total budget of JADECARE has been allocated in Member States whose GNI per inhabitant is less than 90% of the EU average. The total costs for these countries are 3,086247,71 € where the global amount is 4,999,032€.
- In addition, JADECARE **joints 17 European countries where 11 of them** (Spain, Croatia, Czech Republic, Estonia, Greece, Hungary, Latvia, Lithuania, Portugal, Serbia and Slovenia) have a GNI per inhabitant lower than the 90% of the EU average, according to the data provided by CHAFEA.

COLLABORATING STAKEHOLDERS

Institution	Contact Person (full name)	Country & City
International Foundation for Integrated Care (IFIC)	[redacted]	United Kingdom
The European Institute for Innovation through Health Data (i~HD)	[redacted]	Belgium
EIT Health Spain	[redacted]	Spain
European Health Telematics Association (EHTEL)	[redacted]	Belgium
Technology Enabled Care and Digital Healthcare Innovation Scotland	[redacted]	United Kingdom
EMPIRICA	[redacted]	Germany
Medical University of Graz/Austrian Society of Geriatric Medicine and Gerontology	[redacted]	Austria
Gesundheitswirtschaft Hamburg GmbH	[redacted]	Germany
MedCom	[redacted]	Denmark

ESTIMATED BUDGET FOR THE ACTION

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

	Estimated eligible[1] costs (per budget category)					EU contribution			Action's estimated receipts		
	A. Direct personnel costs	**B. Direct costs of subcontracting**	**C. Other direct costs**	**D. Indirect costs[2]**	**Total costs**	**Reimbursement rate %[3]**	**Maximum EU contribution[4]**	**Maximum grant amount[5]**	**Income generated by the action**	**Financial contributions given by third parties to the beneficiaries**	**Action's total receipts**
	A.1 Employees (or equivalent) A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services								
Cost form[6]	Actual	Actual	Actual	Flat-rate[7] 7%							
	a	b	c	d = 0.07 * (a+b+c)	e = a+b+c+d	f	g = e * f	h	i	j	k = i + j
1. KG	434 000.00	0.00	68 457.46	35 172.02	537 629.48	80.00	430 103.58	430 103.56	0.00	0.00	0.00
- CSFJA	20 500.00	0.00	0.00	1 435.00	21 935.00	80.00	17 548.00	17 548.00	0.00	0.00	0.00
- SCS	25 625.00	0.00	0.00	1 793.75	27 418.75	80.00	21 935.00	21 935.00	0.00	0.00	0.00
- SACYL	81 000.00	0.00	23 760.00	7 333.20	112 093.20	80.00	89 674.56	89 674.56	0.00	0.00	0.00
- AQUAS	71 000.00	0.00	10 800.00	5 726.00	87 526.00	80.00	70 020.80	70 020.80	0.00	0.00	0.00
- IDIBAPS	112 000.00	0.00	18 800.00	9 156.00	139 956.00	80.00	111 964.80	111 964.80	0.00	0.00	0.00
- FPS	59 000.00	0.00	24 520.00	5 846.40	89 366.40	80.00	71 493.12	71 493.12	0.00	0.00	0.00
- IDIVAL	48 000.00	0.00	23 760.00	5 023.20	76 783.20	80.00	61 426.56	61 426.56	0.00	0.00	0.00
- SMS	66 090.00	0.00	8 640.00	5 231.10	79 961.10	80.00	63 968.88	63 968.88	0.00	0.00	0.00
- FFIS	22 739.25	0.00	15 880.00	2 703.35	41 322.60	80.00	33 058.08	33 058.08	0.00	0.00	0.00
Σ beneficiary	939 954.25	0.00	194 617.46	79 420.02	1 213 991.73		971 193.38	971 193.36	0.00	0.00	0.00
2. MCA	20 400.00	0.00	10 640.00	2 172.80	33 212.80	80.00	26 570.24	26 570.24	0.00	0.00	0.00
- ZZJZFBIH	47 750.00	0.00	23 760.00	5 005.70	76 515.70	80.00	61 212.56	61 212.56	0.00	0.00	0.00
- MHSw-RS	47 750.00	0.00	23 760.00	5 005.70	76 515.70	80.00	61 212.56	61 212.56	0.00	0.00	0.00
Σ beneficiary	115 900.00	0.00	58 160.00	12 184.20	186 244.20		148 995.36	148 995.36	0.00	0.00	0.00
3. CIPH	31 555.80	0.00	29 760.00	4 292.11	65 607.91	80.00	52 486.33	52 486.33	0.00	0.00	0.00

ESTIMATED BUDGET FOR THE ACTION

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

	Estimated eligible[1] costs (per budget category)					EU contribution			Action's estimated receipts		
	A. Direct personnel costs	**B. Direct costs of subcontracting**	**C. Other direct costs**	**D. Indirect costs[2]**	**Total costs**	**Reimbursement rate %[3]**	**Maximum EU contribution[4]**	**Maximum grant amount[5]**	**Income generated by the action**	**Financial contributions given by third parties to the beneficiaries**	**Action's total receipts**
	A.1 Employees (or equivalent) A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services								
Cost form[6]	Actual	Actual	Actual	Flat-rate[7] 7%							
	a	b	c	d = 0.07 * (a+b+c)	e = a+b+c+d	f	g = e * f	h	i	j	k = i + j
- CHIF	11 060.66	0.00	5 400.00	1 152.25	17 612.91	80.00	14 090.33	14 090.33	0.00	0.00	0.00
Σ beneficiary	42 616.46	0.00	35 160.00	5 444.36	83 220.82		66 576.66	66 576.66	0.00	0.00	0.00
4. MZCR	33 167.00	0.00	14 960.00	3 368.89	51 495.89	80.00	41 196.71	41 196.71	0.00	0.00	0.00
- UHO	87 494.50	0.00	22 360.00	7 689.82	117 544.32	80.00	94 035.46	94 035.46	0.00	0.00	0.00
Σ beneficiary	120 661.50	0.00	37 320.00	11 058.71	169 040.21		135 232.17	135 232.17	0.00	0.00	0.00
5. RND	187 875.00	0.00	29 760.00	15 234.45	232 869.45	80.00	186 295.56	186 295.56	0.00	0.00	0.00
- RSD	111 243.75	0.00	22 040.00	9 329.86	142 613.61	80.00	114 090.89	114 090.89	0.00	0.00	0.00
Σ beneficiary	299 118.75	0.00	51 800.00	24 564.31	375 483.06		300 386.45	300 386.45	0.00	0.00	0.00
6. MSAE	19 800.00	0.00	10 640.00	2 130.80	32 570.80	80.00	26 056.64	26 056.64	0.00	0.00	0.00
- VH	62 750.00	0.00	24 520.00	6 108.90	93 378.90	80.00	74 703.12	74 703.12	0.00	0.00	0.00
Σ beneficiary	82 550.00	0.00	35 160.00	8 239.70	125 949.70		100 759.76	100 759.76	0.00	0.00	0.00
7. EUSTRAS	65 000.00	179 000.00	26 520.00	18 936.40	289 456.40	80.00	231 565.12	231 565.12	0.00	0.00	0.00
8. BAGSFI	78 018.08	0.00	16 040.00	6 584.07	100 642.15	80.00	80 513.72	80 513.72	0.00	0.00	0.00
- ZTG-GmBH	56 510.52	0.00	30 400.00	6 083.74	92 994.26	80.00	74 395.41	74 395.41	0.00	0.00	0.00
- LGL	50 785.67	0.00	17 400.00	4 773.00	72 958.67	80.00	58 366.94	58 366.94	0.00	0.00	0.00
Σ beneficiary	185 314.27	0.00	63 840.00	17 440.81	266 595.08		213 276.07	213 276.07	0.00	0.00	0.00
9. 4THYPE	79 500.00	0.00	29 000.00	7 595.00	116 095.00	80.00	92 876.00	92 876.00	0.00	0.00	0.00

ESTIMATED BUDGET FOR THE ACTION

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

	Estimated eligible[1] costs (per budget category)					EU contribution			Action's estimated receipts		
	A. Direct personnel costs	**B. Direct costs of subcontracting**	**C. Other direct costs**	**D. Indirect costs[2]**	**Total costs**	**Reimbursement rate %[3]**	**Maximum EU contribution[4]**	**Maximum grant amount[5]**	**Income generated by the action**	**Financial contributions given by third parties to the beneficiaries**	**Action's total receipts**
	A.1 Employees (or equivalent) A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services								
Cost form[6]	Actual	Actual	Actual	Flat-rate[7] 7%							
	a	b	c	d = 0.07 * (a+b+c)	e = a+b+c+d	f	g = e * f	h	i	j	k = i + j
- AUTH	93 000.00	0.00	11 200.00	7 294.00	111 494.00	80.00	89 195.20	89 195.20	0.00	0.00	0.00
Σ beneficiary	172 500.00	0.00	40 200.00	14 889.00	227 589.00		182 071.20	182 071.20	0.00	0.00	0.00
10. AEEK	55 050.00	0.00	18 200.00	5 127.50	78 377.50	80.00	62 702.00	62 702.00	0.00	0.00	0.00
- SU-HSMTC	67 500.00	0.00	52 800.00	8 421.00	128 721.00	80.00	102 976.80	102 976.80	0.00	0.00	0.00
- JFDPK	71 500.00	0.00	22 360.00	6 570.20	100 430.20	80.00	80 344.16	80 344.16	0.00	0.00	0.00
Σ beneficiary	194 050.00	0.00	93 360.00	20 118.70	307 528.70		246 022.96	246 022.96	0.00	0.00	0.00
11. AGENAS	180 196.31	0.00	20 800.00	14 069.74	215 066.05	80.00	172 052.84	172 052.84	0.00	0.00	0.00
- LOMBARDIA	90 625.00	0.00	23 760.00	8 006.95	122 391.95	80.00	97 913.56	97 913.56	0.00	0.00	0.00
- UMBRIA	70 330.00	0.00	23 760.00	6 586.30	100 676.30	80.00	80 541.04	80 541.04	0.00	0.00	0.00
- MARCHE	138 840.00	0.00	23 760.00	11 382.00	173 982.00	80.00	139 185.60	139 185.60	0.00	0.00	0.00
- PROMIS	3 899.00	9 363.00	5 400.00	1 306.34	19 968.34	80.00	15 974.67	15 974.67	0.00	0.00	0.00
- MhH	27 286.00	0.00	8 640.00	2 514.82	38 440.82	80.00	30 752.66	30 752.66	0.00	0.00	0.00
- TOSCANA	106 677.00	0.00	24 520.00	9 183.79	140 380.79	80.00	112 304.63	112 304.63	0.00	0.00	0.00
- ASL NA2	102 800.00	0.00	23 760.00	8 859.20	135 419.20	80.00	108 335.36	108 335.36	0.00	0.00	0.00
Σ beneficiary	720 653.31	9 363.00	154 400.00	61 909.14	946 325.45		757 060.36	757 060.36	0.00	0.00	0.00
12. NVD	8 330.00	0.00	5 400.00	961.10	14 691.10	80.00	11 752.88	11 752.88	0.00	0.00	0.00
- CCUH	51 888.00	0.00	29 000.00	5 662.16	86 550.16	80.00	69 240.13	69 240.13	0.00	0.00	0.00

ESTIMATED BUDGET FOR THE ACTION

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	Estimated eligible[1] costs (per budget category)					EU contribution			Action's estimated receipts		
	A. Direct personnel costs	**B. Direct costs of subcontracting**	**C. Other direct costs**	**D. Indirect costs[2]**	**Total costs**	**Reimbursement rate %[3]**	**Maximum EU contribution[4]**	**Maximum grant amount[5]**	**Income generated by the action**	**Financial contributions given by third parties to the beneficiaries**	**Action's total receipts**
	A.1 Employees (or equivalent) A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services								
Cost form[6]	Actual	Actual	Actual	Flat-rate[7] 7%							
	a	b	c	d = 0.07 * (a+b+c)	e = a+b+c+d	f	g = e * f	h	i	j	k = i + j
Σ beneficiary	60 218.00	0.00	34 400.00	6 623.26	101 241.26		80 993.01	80 993.01	0.00	0.00	0.00
13. LR SAM	48 204.00	0.00	29 760.00	5 457.48	83 421.48	80.00	66 737.18	66 737.18	0.00	0.00	0.00
14. ACSS	48 371.00	0.00	23 600.00	5 037.97	77 008.97	80.00	61 607.18	61 607.18	0.00	0.00	0.00
- SPMS	25 090.98	0.00	5 400.00	2 134.37	32 625.35	80.00	26 100.28	26 100.28	0.00	0.00	0.00
- ENSP/NOVA	19 350.00	0.00	5 400.00	1 732.50	26 482.50	80.00	21 186.00	21 186.00	0.00	0.00	0.00
Σ beneficiary	92 811.98	0.00	34 400.00	8 904.84	136 116.82		108 893.46	108 893.46	0.00	0.00	0.00
15. MoHRS	42 340.00	0.00	29 000.00	4 993.80	76 333.80	80.00	61 067.04	61 067.04	0.00	0.00	0.00
16. NIJZ	203 500.00	0.00	59 440.00	18 405.80	281 345.80	80.00	225 076.64	225 076.64	0.00	0.00	0.00
- ZZZS	68 940.00	0.00	19 120.00	6 164.20	94 224.20	80.00	75 379.36	75 379.36	0.00	0.00	0.00
Σ beneficiary	272 440.00	0.00	78 560.00	24 570.00	375 570.00		300 456.00	300 456.00	0.00	0.00	0.00
17. HSCB	24 000.00	0.00	8 640.00	2 284.80	34 924.80	80.00	27 939.84	27 939.84	0.00	0.00	0.00
Σ consortium	3 478 332.52	188 363.00	1 005 297.46	327 039.53	4 999 032.51	80.00[7]	3 999 226.02	3 999 226.00	0.00	0.00	0.00

[1] See Article 6 for the eligibility conditions.
[2] The indirect costs claimed must be free of any amounts covered by an operating grant (received under any EU or Euratom funding programme). A beneficiary that receives an operating grant during the action's duration cannot claim any indirect costs for the year(s)/reporting period(s) covered by the operating grant (see Article 6.2.D).
[3] See Article 5.2 for the reimbursement rate.
[4] This is the theoretical amount of the EU contribution, if the reimbursement rate is applied to all the budgeted costs. This theoretical amount is capped by the 'maximum grant amount'.

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[5] The 'maximum grant amount' is the maximum grant amount decided by the Agency. It normally corresponds to the requested grant, but may be lower.
[6] See Article 5 for the cost forms.
[7] Flat rate : 7% of eligible direct costs.

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ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

MINISTRY OF CIVIL AFFAIRS (MCA), established in Trg Bosne i Hercegovine 1, SARAJEVO 71000, Bosnia and Herzegovina, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('2')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Mirna Pavlović with ECAS id n003dye7 signed in the Participant Portal on 07/08/2020 at 12:33:39 (transaction id SigId-49545-YH3OGJZtyrDkd3ECzqirv9xxxUCVQJszUc4x62rilzcQu3uOcSt XD3Kw8EMktkJzGzQbU3pEAkCnzujKTCWPGkrG-jpJZscgsw0KGD3CAcLrniC-crQr2EvBzxTqfy1P0nc0DYfztcJyzaPngXaJkEsNynzclehXzhWu r54MBYwjeCIlzyEjIlg6RuTbs6oTVeev4i3W). Timestamp by third party at Fri Aug 07 13:33:52 CEST 2020

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ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

HRVATSKI ZAVOD ZA JAVNO ZDRAVSTVO (CIPH), established in ROCKEFELLEROVA 7, ZAGREB 10000, Croatia, VAT number: HR75297532041, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('3')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Krunoslav Capak with ECAS id n003ph9b signed in the Participant Portal on 10/08/2020 at 08:16:31 (transaction id SigId-55360-2UdF7kC6TVdzSzxMP0hgExMnQWtttqK3EgFRY7zwrOGqY6FRK DgBgsSEtCKMEceftAoBuYJsCge3gnIBKgaLTdG-jpJZscgsw0KGD3CAcLrniC-PMpTPHzN9uSiYZ0q10rhoUvItx9U6DrwvOojFiJsTwsJnn6afc55V2 PeWalgziLiOq4TeVr2lKJwLhnuP2ruI8). Timestamp by third party at Mon Aug 10 09:16:36 CEST 2020

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ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

MINISTERSTVO ZDRAVOTNICTVI CESKE REPUBLIKY (MZCR), established in PALACKEHO NAMESTI 375/4, PRAHA 12801, Czech Republic, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('4')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Adam Vojtěch with ECAS id n003f2zf signed in the Participant Portal on 17/08/2020 at 12:10:59 (transaction id SigId-104392-lvWZad1ozzagjhd25Zzn2oo7PasPhSASh5RWpjZSgq0ORoujDgYzaKkOlhG26DoDheZZf0JNgdca2C4tt0YYbta-jpJZscgsw0KGD3CAcLrniC-CSaj1c1bL6zWD3zNCNzwzIzaNZygc0BrsnQeZVtCykqGtxzzMQ8FxIL13oiMrJaoGb4O1nBk2ezUBEJM9p1zxh65m). Timestamp by third party at Mon Aug 17 13:11:09 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

REGION NORDJYLLAND (NORTH DENMARK REGION) (RND), established in Niels Bohrs Vej 30, AALBORG 9220, Denmark, VAT number: DK29190941, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('5')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Tina Archard Heide with ECAS id n002y04n signed in the Participant Portal on 03/08/2020 at 10:53:31 (transaction id SigId-8323-8bVPzxyxGCraiJJY1cmCN8na5JHINDwYh6XJqHmdvnfav7nha0DfiAfEuIQzXhTzxuD9uUACwbzQyXs4gczlc9R-jpJZscgsw0KGD3CAcLrniC-GHVCUy1SsP2FpfTzcdt5lfbNQxDzeh2CiKP8dLelbCgTeHGmzsRFszt5QEwEHZf71Z8iUgm1AGK5LwhtTSbTRIi). Timestamp by third party at Mon Aug 03 11:53:43 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

SOTSIAALMINISTEERIUM (MSAE), established in Suur-Ameerika 1, TALLINN 10122, Estonia, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('6')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Marika PRISKE with ECAS id nprmaika signed in the Participant Portal on 07/08/2020 at 06:50:41 (transaction id SigId-45099-AzJKZHWKBgkjteWfBo4S9MGDf6N853cs2HOjzr0zGNMs0AXVlp6xAlozYEkMaziNBdohxzyzzmpjdagJ5vPFBrjb-jpJZscgsw0KGD3CAcLrniC-zULk8jfzeWJtfsJQc9ozyNVT5HKanuwo9n6VuMMXv2SW9VIfZWgCqdoGbFhw4gX11tOkizMSNarT82cfMurczzfW). Timestamp by third party at Fri Aug 07 07:50:54 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

EUROMETROPOLE DE STRASBOURG (EUSTRAS), established in 1 PARC DE L'ETOILE, STRASBOURG CEDEX 67076, France, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('7')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Rémy Banuls with ECAS id n002txha signed in the Participant Portal on 31/07/2020 at 11:33:46 (transaction id SigId-9825-EGt4ozR61yJPHL9hoSIF7LWXJAiwSgOYfhfDADUwyDLtVkQnzu9m3MGhZRxJsW5U2JT5F0cQWlLUqDxy6V0yzeW-rS0vSrmBGYCoND65K3fS5K-TQszYIaFAYjQlZTCy2dzY4t5oUF9g2kzHAKfBdUP17oTcSOUupHq8Cput9sfD4qFcK09g8J0YtjlHUlizHgiwQ8). Timestamp by third party at Fri Jul 31 12:34:05 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

BEHOERDE FUER ARBEIT, GESUNDHEIT, SOZIALES, FAMILIE UND INTEGRATION HAMBURG (BAGSFI), established in Billstrasse 80, Hamburg 20539, Germany, VAT number: DE118509725, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('8')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Anke Schwerin with ECAS id n0037hxq signed in the Participant Portal on 20/07/2020 at 14:43:55 (transaction id SigId-1871-3rOzeQzRXWYPf5Xumdr01ZZDM2IBiX1XhYkTRCPe33Q2TqLA5Dog69QuCAiQE2Ug9SEk14VIIlEvCKnXlwFA0V-rS0vSrmBGYCAvZK87YqHD0-3Q9whRRYwJZgQp8IVslhxuc3zb54rVm3pmISiNJrGhpuHZL3EdOl4sirmcMAEksBsaD3ftCwhwY3j08bzzwznaW). Timestamp by third party at Mon Jul 20 16:56:16 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

4I DIOIKISI YGEIONOMIKIS PERIFEREIAS MAKEDONIAS KAI THRAKIS (4THYPE), established in 16 ARISTOTELOUS STR, THESSALONIKI 54623, Greece, VAT number: EL999122126, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('9')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

TSALIKAKIS DIMITRIOS with ECAS id ndimtsal signed in the Participant Portal on 11/08/2020 at 12:15:15 (transaction id SigId-68813-zYrrDHtWafAnzPGzlTVfJiUnkppIFKZH112iRiAHgUbyhL92zobU2wTCvzpw8U0uyedj6Co94MmfzGttxMnvhzfe-jpJZscgsw0KGD3CAcLrniC-Jo2Z18XBKmuTrVi105tnXDn5sbM8GgTedOXOK4sThRakqrBR4KLEo4zluzUM38t9J0H5chexwaXu888txBUKQ4). Timestamp by third party at Tue Aug 11 13:15:27 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

ALLAMI EGESZSEGUGYI ELLATO KOZPONT (AEEK), established in DIOS AROK 3, BUDAPEST 1125, Hungary, VAT number: HU15324683, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('10')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Miklós GONDOS DR. with ECAS id n00298lv signed in the Participant Portal on 14/08/2020 at 08:07:30 (transaction id SigId-93382-Y3RzvLXHx0UAcU5XKqZ7vKGddvGC9MIWuBc9LHjwh8IhOmQzzlWQuCTEwMEO6CjheneVTsJy3NnJHBK2VfpSBkG-jpJZscgsw0KGD3CAcLrniC-levOZcwisqY6afVtzgCB6VKzoifzzLBYsdjMYDbxLZwLupWjnJ46HmKnHZGzmuunm5xcmiCUAPSvWHk7ezOze6V8). Timestamp by third party at Fri Aug 14 09:07:37 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

AGENZIA NAZIONALE PER I SERVIZI SANITARI REGIONALI (AGENAS), established in VIA PUGLIE 23, ROMA 00187, Italy, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('11')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Alessandro Ghirardini with ECAS id n003l5uh signed in the Participant Portal on 20/07/2020 at 14:19:58 (transaction id SigId-1403-puGcyoLkoUIxhMIj2NpW6Ysde5EjLRkhCtwma4lO1ABgt85LHzaeA6LhkqdgK9jLu3j92KE22q1mEvHd7cxea0-rS0vSrmBGYCAvZK87YqHD0-x3zpFwzUhIkwMfACb3IYqcLfpUULGJzmerazKxkBaUYOqLuJAw4HP5D4K19R0gjUnLmp8fzLPBy8TcgTjjmiho8). Timestamp by third party at Wed Jul 22 10:17:16 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

NACIONALAIS VESELIBAS DIENESTS (NVD), established in 31 Cēsu str., k-3, 6.entrance, Riga LV-1012, Latvia, VAT number: 90009649337, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('12')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Inga MILAŠEVIČA with ECAS id nmilasin signed in the Participant Portal on 06/08/2020 at 15:03:39 (transaction id SigId-42510-PBYTG3MTPMqeu1Cecsztne0OjSGwdsiRmc5ZzrfnH2TLwQZPF0nvi5gMGoCGGLnQsUlzzwODWAnIlQejsHkzxM4-jpJZscgsw0KGD3CAcLrniC-qrxzy5FyNX4enUAROaVRUrgvlebuZ2zfuOzbnJpzOdzGbKNH4gpiEH774LMFqq7KmCg2zhQShMpuTUWZPw5x0fy0). Timestamp by third party at Thu Aug 06 16:03:52 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

LIETUVOS RESPUBLIKOS SVEIKATOS APSAUGOS MINISTERIJA (LR SAM), established in VILNIAUS G 33, VILNIUS LT 01506, Lithuania, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('13')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Gitana Ratkienė with ECAS id n002f8h2 signed in the Participant Portal on 20/07/2020 at 13:06:58 (transaction id SigId-200-aWXGjXJQETcoNhiUhxNU5Ou0wys1U1ZUXJEHMfWMRSLpqKiKma80v5aNf650bAZssUZTcMxaiBcYUZ71YEXTvW-rS0vSrmBGYCAvZK87YqHD0-7Om9TVIV54VzszVfECOENvf3GKKbOU9prBDit7hQfHjebFIm41AeaY4VMLXmbMjeL5FfAIfKgEBsudrph3la8a). Timestamp by third party at Mon Jul 20 14:07:06 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

ADMINISTRACAO CENTRAL DO SISTEMA DESAUDE IP (ACSS), established in AVENIDA DO BRASIL 53, PARQUE DE SAUDE DE LISBOA EDIFICIO 16, Lisboa 1700-063, Portugal, VAT number: PT508188423, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('14')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Márcia Roque with ECAS id n00348n5 signed in the Participant Portal on 31/07/2020 at 11:39:24 (transaction id SigId-9884-jU8p9hIlukAzmAuchWG8MXvC5JBzkECtqaLNiTZvfHmbf3PK7T4CvpcVzXVuPV7iiD58rToPGKLWFAPYzfU8RES-rS0vSrmBGYCoND65K3fS5K-TybthPKswvFza5CLCLSM2k4ykkzSb4yXPO29x525o2eOGmUTbungWlfaIZuGJgZzu4pMfixzzsLuQXHkrobJR9n). Timestamp by third party at Fri Jul 31 12:39:36 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

MINISTARSTVO ZDRAVLJE (MoHRS), established in NEMANJINA 22-26, BELGRADE 11000, Serbia, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('15')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Zlatibor Loncar with ECAS id n00388hc signed in the Participant Portal on 03/08/2020 at 12:14:41 (transaction id SigId-9372-jhyF2vuULAWlJQltb9TgXzx8rzRom4zineFmf6s86oKlprPOV2tPll9MTBS8ZTGXGwQ6OVmazisRFWRi63E0YBK-jpJZscgsw0KGD3CAcLrniC-Z5ti3sRPQzoxikaT6UxlMFpDceYbirrC6AO8yRJuWzLEYofzLNvsA71H7qGr8QFlSVlzkwj3r0UpsX0Zf8qCU9y). Timestamp by third party at Mon Aug 03 13:14:49 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

NACIONALNI INSTITUT ZA JAVNO ZDRAVJE (NIJZ), established in TRUBARJEVA CESTA 2, LJUBLJANA 1000, Slovenia, VAT number: SI44724535, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('16')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Milan Krek with ECAS id n003bif0 signed in the Participant Portal on 03/08/2020 at 16:37:20 (transaction id SigId-13215-VtpRDIrJPTEYeMWnHVeTEim8IzaALyUszb9ocKaIAcVOwKnR1b6mZhQ6K4R3zynLLorB10fhsbbzo53aYBRFMRu-jpJZscgsw0KGD3CAcLrniC-R4WzmX9NH6lamGdcx3dk7x3QJPqFzHYBuHX6l4zzStzXeIhV9ysqFNn09CdHcJBE4QUFnRhTEKabgFbER5PMlcZ). Timestamp by third party at Mon Aug 03 17:37:27 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

REGIONAL HEALTH AND SOCIAL CARE BOARD (HSCB), established in LINENHALL STREET 12-22, BELFAST BT2 8BS, United Kingdom, VAT number: GB888808059, ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary No ('17')

in Grant Agreement No 951442 ('the Grant Agreement')

between ASOCIACIÓN INSTITUTO DE INVESTIGACIÓN EN SERVICIOS DE SALUD-KRONIKGUNE **and** the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission'),

for the action entitled Joint Action on implementation of digitally enabled integrated person-centred care (JADECARE).

and mandates

the coordinator *to submit and sign in its name and on its behalf any* ***amendments*** *to the Agreement, in accordance with Article 39.*

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement it in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary/new beneficiary/new coordinator

Sloan HARPER with ECAS id nharpesl signed in the Participant Portal on 23/07/2020 at 09:31:10 (transaction id SigId-7729-f6BC8w01hPMOvQRmcmQT0LH4yCAliNsvkI52WBzg7eY4ustp xNmKocAbN2c5bSHxrcjvk8zYw1qPXkrx1TXc8f-jpJZscgsw0KpCPo0JF2kjq-4HjzrKemqFwVzvqbIcklUzOcK759VRJUoh8T1FzPQH1okuRUw 6PbQ4Rwqut0JSo87nN7jzNLzPPUElnZqGI3mUqW).
Timestamp by third party at
Thu Jul 23 10:31:22 CEST 2020

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ⓘ print format A4 landscape

MODEL ANNEX 4 CHAFEA MGA — MULTI

FINANCIAL STATEMENT FOR *[BENEFICIARY [name]/AFFILIATED ENTITY [name]]* FOR REPORTING PERIOD [reporting period]

	Eligible [1] costs (per budget category)					Receipts			EU contribution		
	A. Direct personnel costs	B. Direct costs of subcontracting	C. Other direct costs	D. Indirect costs [2]	Total costs	Income generated by the action	Financial contributions given by third parties to the beneficiaries	Total receipts	Reimbursement rate % [3]	Maximum EU constribution [4]	Requested EU contribution
	A.1 Employees (or equivalent) A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services								
Cost form [5]	Actual	Actual	Actual	Flat-rate [6] 7%							
	a	b	c	d = 0,07 * (a + b + c)	e= a+ b + c + d	f	g	h= f + g	i	j	k
[short name beneficiary / affiliated entity]											

The beneficiary/affiliated entity hereby confirms that:

The information provided is complete, reliable and true.

The costs declared are eligible (see Article 6).

The costs can be substantiated by adequate records and supporting documentation that will be produced upon request or in the context of checks, reviews, audits and investigations (see Articles 12, 13 and 17).

For the last reporting period: that all the receipts have been declared (see Article 5.3.3).

ⓘ Please declare all eligible costs, even if they exceed the amounts indicated in the estimated budget (see Annex 2). Only amounts that were declared in your individual financial statements can be taken into account lateron, in order to replace other costs that are found to be ineligible.

[1] See Article 6 for the eligibility conditions.

[2] The indirect costs claimed must be free of any amounts covered by an operating grant (received under any EU or Euratom funding programme). A beneficiary that receives an operating grant during the duration of the action cannot claim any indirect costs for the year(s) covered by the operating grant (see Article 6.2.D).

[3] See Article 5.2 for the reimbursement rate

[4] This is the theoretical amount of EU contribution that the system calculates automatically (by multiplying the reimbursement rate by the total costs declared). The amount you request (in the column 'requested EU contribution') may have to be less.

[5] See Article 5 for the cost forms.

[6] Flat rate : 7% of eligible direct costs.

Associated with document Ref. Ares(2020)3808356 - 20/07/2020

ANNEX 5

MODEL FOR THE CERTIFICATE ON THE FINANCIAL STATEMENT (CFS)

This document sets out:

- the objectives and scope of the independent report of factual findings on costs declared under a EU grant agreement financed under the Health Programme (2014-2020) or Consumer Programme (2014-2020) and

- a model for the certificate on the financial statement (CFS).

1. Background and subject matter

[OPTION 1 for actions with one RP and NO interim payments: Within 60 days of the end of the reporting period, the coordinator must submit to the Commission a **final report**, which should include (among other documents and unless otherwise specified in Article 15 of the Grant Agreement) a **certified financial statement** (CFS; see proposed model below) for each beneficiary and (if applicable) each affiliated entity, if:

- it requests an EU contribution of EUR 150 000 or more as reimbursement of actual costs and

- the maximum EU contribution indicated for that beneficiary/affiliated entity in the estimated budget (see Annex 2) as reimbursement of actual costs is EUR 200 000 or more.***]***

[OPTION 2 for actions with several RPs and interim payments: Within 60 days of the end of each reporting period, the coordinator must submit to the Commission a **periodic report**, which should include (among other documents and unless otherwise specified in Article 15 of the Grant Agreement) a **certified financial statement** (CFS; see proposed model below) for each beneficiary and (if applicable) each affiliated entity, if:

- the cumulative amount of EU contribution the beneficiary/affiliated entity requests as reimbursement of actual costs is EUR 150 000 or more and

- the maximum EU contribution indicated for that beneficiary/affiliated entity in the estimated budget (see Annex 2) as reimbursement of actual costs is EUR 200 000 or more.

The CFS must be submitted every time the cumulative amount of payments requested (i.e. including in previous financial statements) reaches the threshold (i.e. a first certificate once the cumulative amount reaches 150 000, a second certificate once it reaches 300 000, a third certificate once it reaches 450 000, etc.).

Once the threshold is reached, the CFS must cover all reporting periods for which no certificate has yet been submitted.***]***

The beneficiary must provide the CFS for itself and, if applicable, for its affiliated entity(ies).

The **purpose** of the audit on which the CFS is based is to give the Agency 'reasonable assurance'[1] that costs declared as eligible costs under the grant (and, if relevant, receipts generated in the course of the action) are being claimed by the beneficiary in accordance with the relevant legal and financial provisions of the Grant Agreement.

The **scope** of the audit is limited to the verification of eligible costs included in the CFS. The audit must be conducted in line with point 3 below.

Certifying auditors must carry out the audits in compliance with generally accepted **audit standards** and indicate which standards they have applied. They must bear in mind that, to establish a CFS, they must carry out a compliance audit and not a normal statutory audit. The eligibility criteria in the Grant Agreement always override normal accounting practices.

The beneficiary and the auditor are expected to address any **questions on factual data or detailed calculations** before the financial statement and the accompanying certificate are submitted. It is also recommended that the beneficiary take into account the auditor's preliminary comments and suggestions in order to avoid a qualified opinion or reduce the scope of the qualifications.

Since the certificate is the main source of assurance for cost claims and payments, it will be easier to consider amounts as eligible if a **non-qualified certificate** is provided.

The submission of a certificate does not affect the Agency's right to carry out its **own assessment or audits**. Neither does the reimbursement of costs covered by a certificate preclude the Agency or the Commission, the European Anti-Fraud Office or the European Court of Auditors from carrying out checks, reviews, audits and investigations in accordance with Article 17 of the Grant Agreement.

The Agency expects the certificates to be issued by auditors according to the highest professional standards.

2. Auditors who may deliver a certificate

The beneficiary is free to choose a **qualified external auditor**, including its usual external auditor, provided that:

- the external auditor is **independent** from the beneficiary and
- the provisions of **Directive 2006/43/EC**[2] are complied with.

[1] This means a high degree of confidence.

[2] Directive 2006/43/EC of the European Parliament and of the Council of 17 May 2006 on statutory audits of annual accounts and consolidated accounts or similar national regulations (OJ L 157, 9.6.2006, p. 87).

Independence is one of the qualities that permit the auditor to apply unbiased judgement and objective consideration to established facts to arrive at an opinion or a decision. It also means that the auditor works without direction or interference of any kind from the beneficiary.

Auditors are considered as providing services to the beneficiary/affiliated entity under a **purchase contract** within the meaning of Article 9 of the Grant Agreement. This means that the costs of the CFS may normally be declared as costs incurred for the action, if the cost eligibility rules set out in Articles 6 and 9.1.1 of the Grant Agreement are fulfilled (especially: best value for money and no conflict of interests; see also below eligibility of costs of other goods and services). Where the beneficiary/affiliated entity uses its usual external auditor, it is presumed that they already have an agreement that complies with these provisions and there is no obligation to find new bids. Where the beneficiary/affiliated entity uses an external auditor who is not their usual external auditor, it must select an auditor following the rules set out in Article 9.1.1.

Public bodies can choose an external auditor or a competent public officer. In the latter case, the auditor's independence is usually defined as independence from the audited beneficiary 'in fact and in appearance'. A preliminary condition is that this officer was not involved in any way in drawing up the financial statements. Relevant national authorities establish the legal capacity of the officer to carry out audits of that specific public body. The certificate should refer to this appointment.

3. Audit methodology and expected results

3.1 Verification of eligibility of the costs declared

The auditor must conduct its verification on the basis of inquiry and analysis, (re)computation, comparison, other accuracy checks, observation, inspection of records and documents and by interviewing the beneficiary (and the persons working for it).

The auditor must examine the following documentation:

- the Grant Agreement and any amendments to it;
- the periodical and/or final report(s);
- *for personnel costs*
    - salary slips;
    - time sheets;
    - contracts of employment;
    - other documents (e.g. personnel accounts, social security legislation, invoices, receipts, etc.);
    - proofs of payment;
- *for subcontracting*
    - the call for tender;
    - tenders (if applicable);
    - justification for the choice of subcontractor;
    - contracts with subcontractors;
    - invoices;
    - declarations by the beneficiary;
    - proofs of payment;

  - other documents: e.g. national rules on public tendering if applicable, EU Directives, etc.;
- *for travel and subsistence costs*
  - the beneficiary's internal rules on travel;
  - transport invoices and tickets (if applicable);
  - declarations by the beneficiary;
  - other documents (proofs of attendance such as minutes of meetings, reports, etc.);
  - proofs of payment;
- *for equipment costs*
  - invoices;
  - delivery slips / certificates of first use;
  - proofs of payment;
  - depreciation method of calculation;
- *for costs of other goods and services*
  - invoices;
  - proofs of payment; and
  - other relevant accounting documents.

General eligibility rules

The auditor must verify that the costs declared comply with the general eligibility rules set out in Article 6.1 of the Grant Agreement.

In particular, the costs must:

- be actually incurred;
- be linked to the subject of the Grant Agreement and indicated in the beneficiary's estimated budget (i.e. the latest version of Annex 2);
- be necessary to implement the action which is the subject of the grant;
- be reasonable and justified, and comply with the requirements of sound financial management, in particular as regards economy and efficiency;[3]
- have been incurred during the action, as defined in Article 3 of the Grant Agreement (with the exception of the invoice for the audit certificate and costs relating to the submission of the final report);
- not be covered by another EU or Euratom grant (see below ineligible costs);
- be identifiable, verifiable and, in particular, recorded in the beneficiary's accounting records and determined according to the applicable accounting standards of the country where it is established and its usual cost-accounting practices;
- comply with the requirements of applicable national laws on taxes, labour and social security;
- be in accordance with the provisions of the Grant Agreement (see, in particular, Articles 6 and 9-11a) and
- have been converted to euro at the rate laid down in Article 15.6 of the Grant Agreement:

[3] To be assessed in particular on the basis of the procurement and selection procedures for service providers.

- for beneficiaries with accounts established in a currency other than the euro:
  Costs incurred in another currency must be converted into euros at the average of the daily exchange rates published in the C series of the EU Official Journal determined over the corresponding reporting period.
  If no daily euro exchange rate is published in the EU Official Journal for the currency in question, the rate used must be the average of the monthly accounting rate established by the Commission and published on its website;
- for beneficiaries with accounts established in euro:
  Costs incurred in another currency should be converted into euros applying the beneficiary's usual accounting practice.

The auditor must verify whether expenditure includes **VAT** and, if so, verify that the beneficiary:

- cannot recover the VAT (this must be supported by a statement from the competent body) and
- is not a public body acting as a public authority.

The auditor should base his/her audit approach on the **confidence level** following a review of the beneficiary's internal control system. When using sampling, the auditor should indicate and justify the sampling size.

Specific eligibility rules

In addition, the auditor must verify that the costs declared comply with the specific cost eligibility rules set out in Article 6.2 and Articles 9.1.1, 10.1.1, 11.1.1, 11a.1.1 and 11a.2.1 of the Grant Agreement.

Personnel costs

The auditor must verify that:

- personnel costs have been charged and paid in respect of the actual time devoted by the beneficiary's personnel to implementing the action (justified on the basis of time sheets or other relevant time-recording system);
- personnel costs were calculated on the basis of annual gross salary, wages or fees (plus obligatory social charges, but excluding any other costs) specified in an employment or other type of contract, not exceeding the average rates corresponding to the beneficiary's usual policy on remuneration;
- the work was carried out during the period of implementation of the action, as defined in Article 3 the Grant Agreement and
- the personnel costs are not covered by another EU or Euratom grant (see below ineligible costs);
- for additional remunerations: the 2 conditions set out in Article 6.2.A.1 are met (i.e. that it is part of the beneficiary's usual remuneration practices and is paid in a consistent manner whenever the same kind of work or expertise is required and that the criteria used to calculate the supplementary payments are objective and generally applied by the beneficiary, regardless of the source of funding used);
- for in-house consultants: the 3 conditions set out in Article 6.2.A.2 of the Grant Agreement are met (i.e. that the in-house consultant works under the beneficiary's

instructions, that the result of the work carried out belongs to the beneficiary, and that the costs are not significantly different from those for personnel performing similar tasks under an employment contract).

The auditor should have assurance that the management and accounting system ensures proper allocation of the personnel costs to various activities carried out by the beneficiary and funded by various donors.

Subcontracting costs

The auditor must verify that:

- the subcontracting complies with best value for money (or lowest price) and that there was no conflict of interests;
- the subcontracting was necessary to implement the action for which the grant is requested;
- the subcontracting was provided for in Annex 1 and Annex 2 or agreed to by the Agency at a later stage;
- the subcontracting is supported by accounting documents in accordance with national accounting law
- public bodies have complied with the national rules on public procurement.

Travel and subsistence costs

The auditor must verify that travel and subsistence costs:

- have been charged and paid in accordance with the beneficiary's internal rules or usual practices;
- are not covered by another EU or Euratom grant (see below ineligible costs);
- were incurred for travels linked to action tasks set out in Annex 1 of the Grant Agreement.

Equipment costs

The auditor must verify that:

- the equipment is purchased, rented or leased at normal market prices;
- public bodies have complied with the national rules on public procurement;
- the equipment is written off, depreciation has been calculated according to the tax and accounting rules applicable to the beneficiary and only the portion of the depreciation corresponding to the duration of the action has been declared and
- the costs are not covered by another EU or Euratom grant (see below ineligible costs).

Costs of other goods and services

The auditor must verify that:

- the purchase complies with best value for money (or lowest price) and that there was no conflict of interests;
- public bodies have complied with the national rules on public procurement;
- the costs are not covered by another EU or Euratom grant (see below ineligible costs).

Ineligible costs

The auditor must verify that the beneficiary has not declared any costs that are ineligible under Article 6.4 of the Grant Agreement:

- costs relating to return on capital;
- debt and debt service charges;
- provisions for future losses or debts;
- interest owed;
- doubtful debts;
- currency exchange losses;
- bank costs charged by the beneficiary's bank for transfers from the Agency;
- excessive or reckless expenditure;
- deductible VAT;
- VAT incurred by a public body acting as a public authority;
- costs incurred during suspension of the implementation of the action;
- in-kind contributions from third parties;
- costs declared under other EU or Euratom grants (including those awarded by a Member State and financed by the EU or Euratom budget or awarded by bodies other than the Agency for the purpose of implementing the EU or Euratom budget); in particular, indirect costs if the beneficiary is already receiving an operating grant financed by the EU or Euratom budget in the same period;
- costs incurred for permanent staff of a national administration for activities that are part of its normal activities (i.e. not undertaken only because of the grant);
- costs incurred for staff or representatives of EU institutions, bodies or agencies.

3.2 Verification of receipts

The auditor must verify that the beneficiary has declared receipts within the meaning of Article 5.3.3 of the Grant Agreement, i.e.:

- income generated by the action (e.g. from the sale of products, services and publications, conference fees) and
- financial contributions given by third parties, specifically to be used for costs that are eligible under the action.

3.3 Verification of the beneficiary's accounting system

The auditor must verify that:

- the accounting system (analytical or other suitable internal system) makes it possible to identify **sources of financing** for the action and related expenses incurred during the contractual period and
- expenses/income under the grant have been recorded systematically using a numbering system that **distinguishes** them from expenses/income for other projects.

Certificate on the financial statement (CFS)

To
[Beneficiary/affiliated entity's full name
address]

We, [**full name of the audit firm/organisation**], established in [full address/city/country], represented for signature of this audit certificate by [name and function of an authorised representative],

hereby certify

that:

1. We have **conducted an audit** relating to the costs declared in the financial statement of [name of beneficiary/affiliated entity] (the *[*'beneficiary'*][*'affiliated entity'*]*), to which this audit certificate is attached and which is to be presented to the Consumers, Health, Agriculture and Food Executive Agency under Grant Agreement No [insert number] — [insert acronym], covering costs for the following reporting period(s): [insert reporting period(s)].

2. We confirm that our audit was **carried out in accordance with generally accepted auditing standards** in compliance with ethical rules and on the basis of the provisions of the **Grant Agreement** and its Annexes (and in particular the audit methodology described in Annex 5).

3. The financial statement was examined and all necessary tests of *[*all*][*[X]%*]* of the supporting documentation and accounting records were carried out in order to obtain **reasonable assurance that**, in our opinion and on the basis of our audit

   - total **costs** of **EUR** [**insert number**] ([insert amount in words]) are eligible, i.e.:
     - actual;
     - determined in accordance with the *[*beneficiary's*][*affiliated entity's*]* accounting principles;
     - incurred during the period referred to in Article 3 of the Grant Agreement;
     - recorded in the *[*beneficiary's*][*affiliated entity's*]* accounts (at the date of this audit certificate);
     - comply with the specific eligibility rules in Article 6.2 of the Grant Agreement;
     - do not contain costs that are ineligible under Article 6.4 of the Grant Agreement, in particular:
       - costs relating to return on capital;
       - debt and debt service charges;
       - provisions for future losses or debts;
       - interest owed;
       - doubtful debts;
       - currency exchange losses;

- bank costs charged by the *[*beneficiary's*][*affiliated entity's*]* bank for transfers from the Agency;
- excessive or reckless expenditure;
- deductible VAT;
- VAT incurred by a public body acting as a public authority;
- costs incurred during suspension of the implementation of the action;
- in-kind contributions provided by third parties;
- costs declared under other EU or Euratom grants (including those awarded by a Member State and financed by the EU or Euratom budget or awarded by bodies other than the Agency for the purpose of implementing the EU or Euratom budget); in particular, indirect costs if the *[*beneficiary*][*affiliated entity*]* is already receiving an operating grant financed by the EU or Euratom budget in the same period;
- costs incurred for permanent staff of a national administration, for activities that are part of its normal activities (i.e. not undertaken only because of the grant);
- costs incurred for staff or representatives of EU institutions, bodies or agencies;

– ***[***are claimed according to the euro conversion rate referred to in Article 15.6 of the Grant Agreement;***]***

– total **receipts** of **EUR** [**insert number**] ([insert amount in words]) have been declared under Article 5.3.3 of the Grant Agreement and

– the *[*beneficiary's*][*affiliated entity's*]* **accounting procedures** are in compliance with the accounting rules of the state in which it is established and permit direct reconciliation of the costs incurred for the implementation of the action covered by the EU grant with the overall statement of accounts relating to its overall activity.

[However, our audit opinion is **qualified** for:

– costs of EUR [**insert number**]

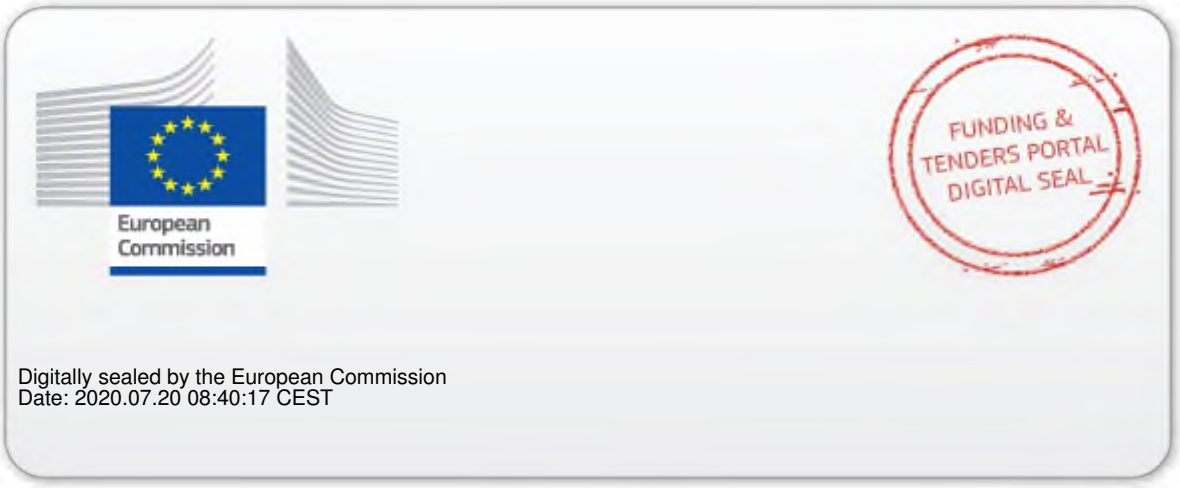
– receipts of EUR [**insert number**]

which in our opinion do not comply with the applicable rules.***]***

4. We are qualified/authorised to deliver this audit certificate *[*(for additional information, see appendix to this certificate)*]*.

5. The *[*beneficiary*][*affiliated entity*]* paid a **price** of EUR [insert number]) (including VAT of EUR [insert number]) for this audit certificate. ***[OPTION 1:*** These costs are eligible (i.e. incurred within 60 days of the end of the action referred to in Article 3 of the Grant Agreement) and included in the financial statement.***][OPTION 2:*** These costs were not included in the financial statement.***]***

Date, signature and stamp



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