Deliverable D9.1 First report on dissemination and exploitation activities

WP9 - Exploitation and Dissemination
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Document information

Abstract
This deliverable presents the outcomes of the exploitation and dissemination work of the project in its first year. In relation to exploitation, this covers the overall methodological approach to be applied, as well as a description of the outcomes of the first stage of the work, the viability assessments of the services to be piloted in the first wave of deployment sites. In relation to dissemination, the project developed its overall communication plan and conducted various dissemination activities. Further work reported on includes the project’s Advisory Boards, the co-operation with the European Innovation Partnership on Active and Healthy Ageing (EIP AHA) and networking among pilot sites.

Key words
Exploitation, dissemination, socio-economic impact assessment, cost-benefit analysis, communication, EIP AHA

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Statement of originality
This deliverable contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both.
Executive summary

This deliverable presents the outcomes of the exploitation and dissemination work of the project in its first year. In relation to exploitation, this covers the overall methodological approach to be applied, as well as a description of the outcomes of the first stage of the work, the viability assessments of the services to be piloted in the first wave of deployment sites. The document also presents a first set of lessons learned during the first stage of the exploitation work.

In relation to dissemination, the project developed its overall communication plan and conducted various dissemination activities. Further work reported on includes the project’s Advisory Boards, the co-operation with the European Innovation Partnership on Active and Healthy Ageing (EIP AHA) and networking among pilot sites.
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1. Introduction

1.1 Purpose of this document

This deliverable presents the first report on dissemination and exploitation activities undertaken in the first year of the project. It presents outcomes of two different strands of work:

- the status of exploitation support and socio-economic impact assessment;
- activities in relation to dissemination and communication of the project results.

1.2 Structure of document

Chapter 2 presents the status of exploitation support and socio-economic impact assessment, the overall methodology and viability assessments for the four 1st wave deployments sites.

Chapter 3 presents activities in relation to dissemination and communication of the project results and activities so far to a range of different target groups. This starts with the presentation of the overall dissemination strategy, while Chapter 4 has a short introduction to the SmartCare global and regional dissemination plans.

In Chapter 5, the different dissemination means and channels that have been used during the first reporting period are described in detail, followed by Chapter 6, which explains activities of the four SmartCare Advisory Boards. Chapter 7 reports on cooperation activities with the EIP AHA B3 Action Group. Chapter 8 describes networking activities among the SmartCare regions. A final Chapter 9 shortly described monitoring processes that are in place for SmartCare dissemination and communication.

1.3 Glossary

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<th>Term</th>
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<tbody>
<tr>
<td>CBA</td>
<td>Cost Benefit Analysis</td>
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<td>CR</td>
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2. Exploitation support and socio-economic impact assessment

This section of the deliverable documents the status of the project’s exploitation work (T9.1) and particularly the viability assessments conducted for the first wave pilot sites (T9.2). It starts with an introduction to the methodological approach being applied (section 2.1), gives the results of the viability assessments for the deployment sites of Aragon, Friuli Venetia Giulia, Scotland and Syddanmark (section 2.2), develops lessons learned from the first stage of the assessment (section 2.3), and finally outlines the next steps (section 2.4)

2.1 SmartCare approach to exploitation support and socio-economic impact assessment

This section presents the assessment framework for socio-economic impacts, called ASSIST - Assessment and evaluation tools for e-service deployment in health, care and ageing, that is being employed as part of the exploitation work (T9.1) in the SmartCare project.

In summary, ASSIST supports care integrators in taking strategic decisions during the development and early operation of a new service. In doing so it:

i) allows identifying and addressing stakeholders that lose through the service and thus may become strong veto players;

ii) allows monitoring of the actual and prospective service development over time;

iii) includes non-financial factors which in many cases have a major impact on the behaviour of a stakeholder;

iv) provides probabilistic methods for achieving rigorous results from data of varying quality.

The ASSIST framework consists of a methodological approach, a service assessment model, and a software toolkit. The methodological approach covers the basic characteristics of the framework, as well as descriptions of the empirical and economic methods used. The service assessment model consists of a generic set of stakeholders that can be involved in a service (divided into service users, service provider organisations and their staff, payers, and IT industry), and of a set of cost and benefit indicators for each of these stakeholders.

As a first step of an assessment, the service assessment model is adapted to the actual conditions set by the service. The software toolkit supports the adaptation of the service assessment model, the collection of data, the analysis, and the presentation of results.

ASSIST was developed in the context of a project funded by the European Space Agency which ran from 2010 to 2012. The project contained a systematic review and evaluation of existing approaches, development of its own assessment framework making use of the most valuable approaches, a software toolkit implementing the assessment framework, and a validation phase. In the course of two EU-funded pilot projects that dealt with 1) ICT-supported integrated social and health care services (CommonWell, 2012) and 2) ICT-supported integrated social, health and informal care (INDEPENDENT, 2013), respectively, the original ASSIST framework was expanded to be also applicable in the domain of integrated eCare. Basic assumptions on service models and market structures were adapted to cover a much wider area than the original domain of telemedicine. This adapted version of ASSIST is being used in SmartCare.

2.1.1 Theoretical foundation

The theoretical foundation of the ASSIST methodology is value theory, and in particular, the concept of value added. Value added in economics is the additional value resulting
from transformations of factors of production into a ready product. At its simplest, it is the difference between the value of a product and the aggregate value of its individual components provided by other participants in the value system. Over the last decade, value added has been a widely used approach supporting investment decision making. In the context of an ASSIST assessment, the effects and outcomes of a service is understood as value-added to society, either in part or as a whole, on the one hand, and value-added to the individual stakeholders involved on the other, by implementing and using the service. This combines an overall, societal perspective with an organisational and individual perspective. This societal perspective includes all stakeholders, and aggregates their respective gains and losses, or benefits and costs. Positive effects, or benefits, create value, negative effects, or costs, occur when value is reduced. The total value added is the sum of positive and negative ‘value added’, which is also referred to as net benefit. This societal perspective is aggregated from the benefits and costs of each stakeholder group. Furthermore, what may be a benefit to one group may be a cost to another, and in aggregate some of them may cancel out. The analysis must expose these shifts in value in order to provide a reasonable account of the impact of the new service on individual stakeholders as well as society as a whole. Beyond this, in particular integrated social and healthcare services system may have emergent characteristics, which lead to benefits on the aggregate level. For example, shared access to comprehensive client or patient data facilitated by data exchange or an integrated record system will produce benefits that cannot be reaped by individual stakeholders alone.

2.1.2 The assessment process

An ASSIST assessment is a comparison between a given status and an intervention, which the evaluator wants to compare. In the case of SmartCare (and almost all other services in the health and care field), the intervention is neither a single agent nor a single point in time, but a process of changing service delivery from one status to another, thereby covering multiple agents including different stakeholders as well as ICT systems. The assessment therefore covers a time span usually split up into three phases: the development of the new service (corresponding to phases 1 & 2 of the SmartCare work plan), the deployment on a pilot scale (corresponding to phase 3 of the work plan) and the deployment on a mainstreamed or full scale. Usually, data will only be collected during the first two phases, whereas the third phase is covered in terms of data modelling and scenario building.

The assessment is done in three steps:

- In **Step 1: Service Assessment Model Setup**, the service change to be evaluated is analysed to identify key components such as the applicable governance & reimbursement model(s) and other relevant framework conditions, the stakeholders involved, and the envisaged impacts (in terms of costs and benefits) on each stakeholder. The latter includes identifying possible business models for a sustainable service operation for the organisational stakeholders involved. The resulting service-
specific stakeholder and indicator set is entered into the software toolkit as a prerequisite for the following steps.

- **Step 2: Data Collection and Monetarisation**, data on all identified indicators is collected and fed into the software toolkit. Data is usually collated from various sources including an evaluation of the pilot operation of the service under analysis, data logs of health and social care IT systems, fact finding interviews with key informants in the pilot site (e.g. managerial staff, care professionals, accountants) and other primary sources, all of which are planned to be used in the framework of SmartCare. Furthermore, data from secondary sources such as literature or datasets from other studies will be used where appropriate. The software toolkit comprises a graphical user interface where the data can be entered in different formats. For subsequent analysis, all input data needs to be monetarised, i.e. be available in currency values. This is straightforward for financial input data, i.e. data for which a market price exists, such as costs for hardware or software. Personnel resources or staff time are usually transformed using full labour costs, i.e. wages plus employer contributions. Intangible costs and benefits require more complex transformation approaches, such as calculation of time cost, use of suitable monetary proxies, or valuation approaches (i.e. a subject’s perception of the relative or absolute value of a thing) such as willingness-to-pay.

- **Step 3: Calculation of Performance Measures.** On the basis of the input data, different performance measures or return indicators are calculated, as shown in Figure 1 below. The performance measures are expressed as ratios of different kinds of costs and benefits. The main outcome measure is based upon the ratio of total costs to total benefits, i.e. including financial costs and benefits, resource costs and benefits, and intangible costs and benefits. This overall ratio is referred to as socio-economic return (SER). At the overall service level, it can be seen as reflecting the perspective of a higher-level decision maker (e.g. a national policy maker); the SER can support the assessment and evaluation of options and decisions for improved service delivery. Ratios of the financial costs and benefits indicate cash flows and the affordability of the service, sometimes called the cash flow return on investment (CFROI). Ratios using the totals of financial and resource costs and benefits are tangible and a measure of an economic ROI because they measure the potential net income for the service.

![Figure 1: ASSIST calculation of performance measures](image-url)
2.1.3 Mathematics of the performance measures

The calculation of the performance measures described above is founded on individual indicators for benefits, $b_i^k$, and costs, $c_j^k$, that can be of three categories: cash, resources, and intangible impacts. In the following, the mark $k = \{\text{cash, reap, int}\}$ indicates the respective category of the benefit or cost indicator.

The sets of permanent values, $p = (p^1, p^2, p^3, \ldots)$, and of time series values $s_i = (s_i^1, s_i^2, s_i^3, \ldots)$, provide the basis for calculating the monetary value of each benefit indicator $b_i^k$ and each cost indicator $c_j^k$. The monetary values are functions of the variables $p$ and $s$ for the relevant month of calculation ($t$):

$$b_i^k(t) = f_i(s_i, p) \quad (2)$$

$$c_j^k(t) = f_j(s_j, p) \quad (3)$$

Based on this general model, specific functions are created for each individual indicator. From them, the value of Annual Benefit (AB) in month $t$ of each category $k$ can be calculated, defined as the sum of the individual benefit indicators, as shown by equation 4. The value of Annual Costs (AC) of each category $k$ is derived correspondingly, depicted by equation 5. For $n$ benefit indicators and $m$ cost indicators, the annual benefit and cost for category $k$ are:

$$AB^k = \sum_{i=1}^{n} b_i^k(t) \quad (4)$$

$$AC^k = \sum_{j=1}^{m} c_j^k(t) \quad (5)$$

The Present Value (PV) of the Annual Benefit for category $k$ in year $t$ of the initiative is the sum of the individual benefit indicators for category $k$ discounted by the discount rate $r$:

$$\text{PV of } AB^k = (1 + r)^{-(t-a)} \sum_{i=1}^{n} b_i^k(t) = (1 + r)^{(a-t)} \sum_{i=1}^{n} b_i^k(t) \quad (6)$$

Because the base year for discounting is the start year of evaluation, an additional variable $(a)$ denotes the time to this year. $a$ becomes negative when estimating future performance. The cost discounting works in the same way. Equation 7 shows the present value of the annual Net Benefit (NB) of category $k$ in year $t$, which is the discounted difference between the annual benefit and annual cost:

$$\text{PV of annual } NB^k = (1 + r)^{(a-t)} \left[ \sum_{i=1}^{n} b_i^k(t) - \sum_{j=1}^{m} c_j^k(t) \right] \quad (7)$$

The PV of the cumulative net benefit, or the Net Present Value (NPV) of category $k$ of the initiative, is the sum of discounted annual net benefits of each year, up to month $T$, the end of the horizon. The mathematical function is shown by equation 8:

$$\text{NPV}^k = \sum_{t=0}^{T} (1 + r)^{-(a-t)} \left[ \sum_{i=1}^{n} b_i^k(t) - \sum_{j=1}^{m} c_j^k(t) \right] \quad (8)$$
Written out, the NPV of the three categories cash, redeployable and intangible are illustrated by equations 9 to 11:

Cash NPV = \[\sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{cash}}(t) - \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) \right) \right) \]  

(9)

Redeployable NPV = \[\sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{redp}}(t) - \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) \right) \right) \]  

(10)

Intangible NPV = \[\sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{soc}}(t) - \sum_{j=1}^{m} c_{j}^{\text{soc}}(t) \right) \right) \]  

(11)

The economic net benefit is defined as the sum of financial and redeployable economic resources. Using the discounted values, this effectively means adding equations 9 and 10:

Economic NPV = \[\text{Cash NPV} + \text{Redeployable NPV} \]  

\[= \sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{cash}}(t) + \sum_{i=1}^{n} b_{i}^{\text{redp}}(t) - \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) - \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) \right) \right) \]  

(12)

The socio-economic impact consists of all three categories, adding the social dimension to the economic one. In a discounted form, this means adding equations 11 and 12:

Socio-Economic NPV = \[\text{Economic NPV} + \text{Social NPV} \]  

\[= \left[ (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{cash}}(t) + \sum_{i=1}^{n} b_{i}^{\text{redp}}(t) + \sum_{i=1}^{n} b_{i}^{\text{soc}}(t) - \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) - \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) - \sum_{j=1}^{m} c_{j}^{\text{soc}}(t) \right) \right] \]  

(13)

Equations 14 and 15 deal with calculations of return rates. First, the proxy economic Return on Investment (ROI) is defined in equation 14. It involves both economic indicator categories, \( k = \text{cash} \) and \( k = \text{redp} \). The economic ROI is comparable to a traditional return from an investment, say in the stock market, yet does not require the step of converting redeployable resources into cash. It is calculated as follows:

Proxy economic ROI = \[\frac{\sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{cash}}(t) + \sum_{i=1}^{n} b_{i}^{\text{redp}}(t) - \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) - \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) \right) \right) \]}{\sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) + \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) \right) \right) } \]  

(14)

In the final step, equation 15 calculates the Socio-Economic Return (SER) of the investment, which is the ratio of discounted cumulative net benefits and cumulative costs:

SER = \[\frac{\left[ (1 + r)^{t} \left( \sum_{i=1}^{n} b_{i}^{\text{cash}}(t) + \sum_{i=1}^{n} b_{i}^{\text{redp}}(t) + \sum_{i=1}^{n} b_{i}^{\text{soc}}(t) - \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) - \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) - \sum_{j=1}^{m} c_{j}^{\text{soc}}(t) \right) \right] }{\sum_{t=0}^{T} \left( (1 + r)^{t} \left( \sum_{j=1}^{m} c_{j}^{\text{cash}}(t) + \sum_{j=1}^{m} c_{j}^{\text{redp}}(t) + \sum_{j=1}^{m} c_{j}^{\text{soc}}(t) \right) \right) } \]  

(15)

The SER is the primary performance parameter used for assessment and evaluation of service viability, see below. It provides a comprehensive measure of value for money,
accounting for all social and economic impacts in relation to the costs associated with those impacts.

2.1.4 Analysis of performance measures

In general terms, the performance measures allow drawing conclusions as to how and under which conditions a sustainable operation of the evaluated service after the end of the project can be achieved. The overall socio-economic return rate, i.e. the summative return of all stakeholders involved, shows if and in what time span the benefits of the whole service will be higher than the costs. If such a socio-economic “break-even” is reached within a time that is deemed acceptable (e.g. by responsible decision makers in the deployment site), this can be used as supporting evidence for a decision in favour of mainstreamed operation. The overall socio-economic return rate can therefore be seen as reflecting the perspective of a higher-level decision maker (e.g. a national policy maker), and can support the assessment and evaluation of options and decisions for improved service delivery at that level. Due to the high aggregation of the data in this measure, and the fact that all stakeholders are viewed together and not separately, it is necessary to also consider the individual socio-economic return of each stakeholder.

The socio-economic return rate for each stakeholder likewise shows if and when benefits for that organisation or individual will be higher than costs. This information can be considered critical for success in so far as stakeholders not achieving a positive return (at all or within a time span acceptable for them) will usually not support the service. In such cases, adaptations in service design or funding mechanisms may become necessary, for example identifying additional funding or revenue for a stakeholder incurring losses, or introducing means to balance the excess costs against the excess benefits of other stakeholders (such as joint budgets).

Typically, the analysis at stakeholder level also includes the identification of those costs and benefits that have the highest weight in the overall model. This can for example be the costs for end-user devices or the staff time for service delivery on the negative side, or efficiency gains among provider staff or improved satisfaction with the service among clients / patients on the positive side. Such impacts with a high relative weight usually deserve most attention when it comes to further improving socio-economic performance.

Finally, prospective modelling of the performance measures helps to develop and test the socio-economic effects of different deployment scenarios, e.g. based on varying populations of clients / patients, or in different geographic areas from regional to national level. At all levels of analysis, probabilistic methods (Monte Carlo simulations) are used in order to determine the sensitivity of the model given existing uncertainties in the underlying data.

Within SmartCare, the analysis of the performance measures for each deployment site will be done by the staff at each site, in close collaboration with the task leader. After data collection, task leader will produce data reports for each deployment site, consisting of the overall and stakeholder socio-economic return rates, the identified key service costs and benefits per stakeholder, and a number of prospective deployment models. Each will be accompanied by a description, an initial analysis, and suggestions for possible conclusions and future actions for further improving the socio-economic performance of the service. From these data reports, deployment sites will develop the final socio-economic analysis and business model. Furthermore, the task leader will carry out a comparative analysis of the socio-economic impact assessments of all deployment sites, describing the relative strengths and weaknesses of the different socio-economic models, and analysing the dependency on framework conditions. This will allow drawing conclusions on the future uptake and mainstreaming of SmartCare pathways in further European regions.
2.1.5 Further reading

In the framework of the present deliverable, it was deemed feasible to give a only high-level overview of the ASSIST methodology and its application in SmartCare. More detailed information on the methodological background and the assessment process, as well as example results, are available from a number of public sources:

- The ASSIST website (http://assist.empirica.biz/) is the prime reference for more information on the overall methodology and detailed information on the application of ASSIST in a telemedicine context.
- A recently published book chapter (Hammerschmidt & Meyer, 2014) describes the application of ASSIST in the context of integrated care, along with details on methodological aspects, and a case example explaining how an ASSIST assessment is done in practice.
- The final outcome report of the INDEPENDENT pilot on integrated e-care contains the results of socio-economic analyses done for the six pilot sites of that project. It is available via the INDEPENDENT website: http://independent-project.eu/fileadmin/INDEPENDENT/documents/INDEPENDENT_D7-2.pdf, (see section 4.2 on pilot site perspective).
- Further results are also available from the CommonWell pilot on integrated e-care, via the project website: http://commonwell.eu/about-commonwell/the-commonwell-services/service-costs-and-benefits/.

2.2 Viability assessments, stakeholder and cost-benefits models for first wave deployment sites

The viability assessments in SmartCare (T9.2) correspond to the first step of the ASSIST process, as described above. In the first project year of SmartCare, the viability assessments were conducted for the four first wave deployment sites of Aragon, Friuli Venetia Giulia, Scotland and Syddanmark. The second wave deployment sites undergo the assessment in the second project year.

The viability assessments were carried out in an iterative process between staff at each of the deployment sites and the responsible task leader. Each deployment site received a briefing package consisting of:

- an explanation of the process; and
- an Excel-based template to collect information on economic framework conditions, the stakeholders to be involved in the service and the expected costs and benefits for each stakeholder.

Sites were then asked to produce a first completed version of the Excel template, based on the current status of planning and input received from relevant stakeholders (such as financial decision makers and service staff), as needed. These first version templates were sent back to task leader and reviewed for coherence and completeness. This involved checking against known socio-economic or business models for existing services (such as those piloted in the previous CommonWell and INDEPENDENT pilot projects), but also comparison between the templates of the four sites, in order to identify stakeholders or cost and benefit categories that might need to be included in order to achieve a complete model. The feedback was discussed in bi-lateral conference calls that led to a revision of the template by the deployment sites. Since the partner responsible for the deployment site in Aragon, BSA, has considerable experience in doing cost-benefit analyses from previous projects, the template from that site served as a learning example for the other three sites, and is being used in the same manner for the second wave sites. The revised
D9.1 First report on dissemination and exploitation activities

The definition of the cost- and benefit-indicators was done in close co-operation with the leader of the evaluation work package (WP8) in order to ensure that both strands of work were suitably dovetailed, and all necessary data collection included in the overall evaluation protocol.

On the basis of the final Excel template, first version of a graphical model was produced, covering the stakeholders, costs and benefits at a site. This graphical model was sent to the deployment sites for checking.

The results of this iterative work process are presented in the following sub-sections. Each deployment site section starts with a summary description of the service(s) to be deployed, to provide the necessary context information. This is followed by a description of general cost recovery mechanisms and overall viability, and by a graphical representation of the assessment model.

2.2.1 Aragon

2.2.1.1 Service summary

The service is address to chronic older people (+65) with home care & clinical needs living in Barbastro geographical area.

A wide range of social services will be provided, covering home and administrative tasks, follow-up schedules, home care support, telecare, wheel chair / crutch / articulated bed loans, submission of reports to court for violence of gender, translation for foreigners, support for impairment recognition applications, information or resources management, coordination with healthcare centre / hospital, and coordination with NGO. According to healthcare needs, some of the services that will be provided will be health transportation, emergency transfers, GP or home nurse assistance, remote telemonitoring, education programmes on health issues, pain management, wound care, forms filling to detect alert signs, & adherence to treatment programmes.

The social providers, third parties and healthcare professionals will coordinate actions to provide integrated care to patients, and manage alerts through a common contact centre that will be the point of contact for patients. A minimum dataset of patient information will be shared among health and social carers.

2.2.1.2 Cost recovery mechanisms and overall viability

SALUD (the sole healthcare provider in the Region) as a public institution cannot recover costs. Its main interest is to enhance the quality of care, patients' quality of life, and optimization of costs; therefore improvements in the number of healthcare services, savings in frequency of contacts / hospitalisations / dedication of health professionals, number of actions transferred from the healthcare system to the social providers etc, are key to evaluate whether this pilot (tested for a set of the population) can be affordable to be deployed for the whole population of Aragon.

Social care providers participating in the programme are non-profit organisations; therefore there are no revenue streams, but the benefit is to attract new associates. Third parties/Social Associations revenue streams will be through the loyalty of customers or the attraction of new associates.
D9.1 First report on dissemination and exploitation activities

2.2.1.3 Stakeholder and cost-benefit model

[Diagram showing stakeholder and cost-benefit model]

- Care recipient
- Staff hired by patient
- Red Cross
- Social Contact Centre
- Relatives

Costs for social service (-)
New volunteers (+)
Intangible effects (+)
Time for service provision (-)
Overhead costs (-)
Time for staff training (-)
Technology costs (-)
Avoided costs for travelling (+)
Avoided time for travelling (-)
Time for care provision (-)
Avoided time for travelling/consultations (+)
Avoided costs for travelling (+)
Time for training / use (-)
Costs for service provision (-)

SALUD
SALUD Primary Care
SALUD Specialized Care & Hospital
Healthcare contact centre

Pharmacy
La fortunada Elders Association
Barbastro's Women in the Rural Area Association
Barbastro's Alzheimer's Association

Satisfaction (+)
Intangible Effects (+)
Avoided costs for travelling (+)
Avoided time for travelling (+)

Costs for social service (-)
Intangible effects (+)
Time for service provision (-)
Overhead costs (-)
Time for staff training (-)
Technology costs (-)
Avoided costs for travelling (+)
Avoided time for travelling (-)
Time for care provision (-)
Avoided time for travelling/consultations (+)
Avoided costs for travelling (+)
Time for training / use (-)
Costs for service provision (-)

2.2.2 Friuli Venetia Giulia

2.2.2.1 Service summary

SmartCare aims to improve healthcare, social care and overall wellbeing for citizens 50+ living in Friuli Venezia Giulia. The service will address people suffering from symptomatic heart failure (NYHA II-IV), COPD, diabetes mellitus, requiring an integration of healthcare and social care services. The SmartCare programme will be structured along two major lines of intervention: a Short-Term Care Pathway (hospital discharge - 6 months) and a Long-Term Care one (12 months). The focus will be on prevention of hospitalisations or admission to intermediate care or nursing home facilities, and/or shortening the length of stay. Healthcare, social care providers and third parties will coordinate actions through the platform to provide truly integrated care to patients. A wide range of social services will be provided, such as chaperoning assistance, home care support, telecare, wheelchair/articulated bed loans, groceries. According to healthcare needs, some of the services provided will involve transportation, emergency transfers, GP or home nurse assistance, remote telemonitoring, education programmes on health issues, forms filling to detect alert signs, and adherence to treatment programmes, etc. Alerts will be handled through a common call-centre which will be the point of contact for patients. A minimum dataset of patient’s information will be shared among health and social carers.

2.2.2.2 Cost recovery mechanisms and overall viability

SmartCare will allow a more cost-efficient care approach across the service. By reducing hospitalisations and admission to intermediate care facilities or nursing homes, and lengths of stay, the service will contribute to decreasing healthcare costs while at the same time enhancing quality of healthcare and social care services. SmartCare is also expected to improve integration and connectedness among formal and informal stakeholders while fostering self-management skills and enhancing empowerment of patients and families alike. Finally, SmartCare is also expected to enhance patients’ and caregivers’ quality of life, to prevent duplication/fragmentation of services and to promote greater coordination of care to foster self-management and healthcare/social care sustainability.
2.2.2.3 Stakeholder and cost-benefit model

- **Red Cross**
  - New volunteers (+)
  - Satisfaction (+)

- **Social Contact Centre**
  - Intangible Effects (+)
  - Technology costs (-)

- **HEALTH DISTRICT**
  - GP
  - Specialized Care
  - Hospital
  - Call center
  - Costs for social service (-)
  - Time for service provision (-)
  - Time for training provision (-)

- **THIRD SECTOR**
  - Auser
  - MuNus Gonars
  - Antea Onlus
  - Satisfaction (+)
  - Costs for service provision (-)

- **Care recipient**
  - Avoided time for travelling (+)
  - Avoided costs for travelling (+)

- **Relatives**
  - Avoided costs for travelling (+)
  - Avoided time for travelling (+)

- **Overhead costs (-)**

- **Time for staff training (-)**

- **Intangible Effects (+)**

- **New volunteers (+)**

- **Satisfaction (+)**

- **Costs for social service (-)**

- **Technology costs (-)**

- **Time for service provision (-)**

- **Time for training provision (-)**

- **Avoided time for training provision (-)**

- **Time for care provision (-)**

- **Avoided costs for travelling (+)**

- **Time for training use (-)**

- **Avoided time for training consultations (+)**

- **Staff hired by patient**
2.2.3 Scotland

2.2.3.1 Service summary

SmartCare will improve the health, care and wellbeing of 10,000 people within Ayrshire and Clyde Valley by enabling a better co-ordinated and more effective approach to falls prevention and management.

SmartCare aims to improve health, care and wellbeing for people aged 50+ living in specific areas of Clyde Valley and Ayrshire by focusing on the role that ICT services and applications can play in supporting integrated care (i.e. the integration of healthcare, social care and self-care).

The SmartCare programme will initially focus on falls prevention and management, with additional activity on dementia care subject to progress.

2.2.3.2 Cost recovery mechanisms and overall viability

The SmartCare service will create service efficiencies and cost avoidance across the service - the reduction in the number of falls will reduce the need for treatment of injuries, in particular fractured hip; this will reduce the need for the provision of care at home services during the recovery and rehabilitation phase. Integrated ICT systems will reduce duplication in the assessment process, and promote co-ordinated care.
2.2.3.3 Stakeholder and cost-benefit model

- Telecare services
  - Staff training (+)
  - Increased number of users (+)
  - Costs (+/-)
  - Avoided time through improved workflow (+)
  - Intangible benefits (+)
  - Reduced care load (+)
  - Increased independence (+)
  - Avoided costs for travelling/consultations (+)
  - Fee for service (-)
  - Time for training / use (-)

- Community Rehabilitation Teams
  - Staff training (+)
  - Increased number of users (-)
  - Costs (+/-)
  - Time for service provision (-)
  - Intangible benefits (+)
  - Reduced care load (+)
  - Increased independence (+)
  - Avoided costs for travelling/consultations (+)
  - Fee for service (-)
  - Time for training / use (-)

- Care recipient
  - Reduced care load (+)
  - Increased independence (+)
  - Avoided costs for travelling (+)
  - Intangible benefits (+)
  - Time for training / use (-)

- Telehealth services
  - Time for service provision (-)
  - Costs for service / telecommunication (-)
  - Avoided time for travelling/consultations (+)
  - Avoided admissions (+/-)

- Hospitals
  - Time for service provision (-)
  - Costs for service (-)
  - Avoided admissions (+/-)
2.2.4 Syddanmark

2.2.4.1 Service summary

The SmartCare service from the Region of Southern Denmark is founded on the existing electronic messaging system, MedCom, which ensures that relevant information is sent electronically between the three care-giver organisations (GP, social care provider and hospital) according to the care pathways and joint agreements. Building on top of that is the Shared Care platform, which allows all the care givers, as well as care recipients and relatives, to have access to a complete overview of data, and the possibility to share data at any given time during the course of treatment.

The service will address citizens suffering from a chronic heart condition living in the Region of Southern Denmark. The citizens will be in need of social care (e.g. home care) and healthcare services.

Patients and relatives will be offered direct access to the Shared Care platform, if they have the necessary resources, and here they will be able to see relevant information from care professionals, such as notes, goals, plans, lab results, measurements and planned activities. They will also be able to enter relevant information on their health status as well.

The care professionals will be able to share data much more smoothly in the Shared Care platform, both with each other and with the patients themselves. They will have easier access to necessary information, instead of today where they have to call or e-mail other professionals, or perhaps rely on the patients themselves to provide it. They will also be able to get more information which is expected to increase the quality of treatment, as they are able to see on-going activities in other departments or sectors, see the information from other care professionals, and have access to the patients’ own information registered in the platform. The service can also be used as an extra motivational tool with the patient, where the goals and current status is clearly presented both in text and graphically.

2.2.4.2 Cost recovery mechanisms and overall viability

The Danish healthcare system is tax-based, and builds on the welfare state. As the Regions cannot collect taxes themselves, the health expenses of the Region are financed through subsidies from the state and the municipalities of the Region:

- Block grant from the state (79%).
- Activity based grant from the state (3%).
- Activity based grant from the municipalities (18%).

The economic framework for the Regions is decided in the yearly financial agreement between the government and Danish Regions. The provision of care is divided between the regions and the local municipalities. The Region is responsible for the hospitals (including psychiatry and social services) and the practices (GPs and dentists) of the region. Also, the Region prioritises the various areas of treatment, and establishes principles for the management of hospitals, quality assurance, service levels, etc. It has the responsibility of the working relationship between the hospitals and private medical practices. On account of their responsibility for prevention, rehabilitation and subsequent care at home, and their share in the joint financing system, the local authorities (municipalities) are key partners in the area of health. The Region advises the local authorities on prevention.
The SmartCare service in Southern Denmark is to some extent already a part of the daily work, and it is mostly developed with government funding. There are no other streams of payment.

The outcome of SmartCare is expected to be fewer contacts and also better quality of treatment, better collaboration, fewer mistakes and less duplicated work - e.g. making extra tests - ensuring more efficient and effective work processes around the patient. The overall goal for the Region is therefore not to earn more money, but instead we want better quality and better distribution of resources.
2.2.4.3 Stakeholder and cost-benefit model

Municipality (as payer)

Region (as payer)

General Practitioner

Relatives

Care recipient

Hospitals

Community nursing services

Municipality Rehabilitation Services

Tele Service Center

Home-care services

- Avoided time for requests (+)
- Improved competitiveness (+)
- Avoided time for home visits (+)
- Avoided time through improved workflow (+)
- EU funding (+)
- Equipment cost (-)
- Staff training (-)
- Costs (+/-)
- DRG Rates (+/-)
- Rates (+/-)
- Time for service provision (-)
- Intangible benefits (+)
- Avoided costs for training (+)
- Time for service provision (-)
- Time for service provision (-)
- Avoided time for consultations (+)
- Avoided costs for travelling (+)
- Time for training (-)
- Time for training (-)
- Avoided time for training (-)
- Avoided time for training (-)
- Intangible benefits (+)
- Avoided time for requests (+)
- Improved competitiveness (+)
- Avoided time for home visits (+)
- Avoided time through improved workflow (+)
- EU funding (+)
- Equipment cost (-)
- Staff training (-)
- Costs (+/-)
- DRG Rates (+/-)
- Rates (+/-)
- Time for service provision (-)
- Intangible benefits (+)
- Avoided costs for training (+)
- Time for service provision (-)
- Time for service provision (-)
- Avoided time for consultations (+)
- Avoided costs for travelling (+)
- Time for training (-)
- Time for training (-)
- Avoided time for training (-)
- Avoided time for training (-)
- Intangible benefits (+)
- Avoided time for requests (+)
- Improved competitiveness (+)
- Avoided time for home visits (+)
- Avoided time through improved workflow (+)
- EU funding (+)
- Equipment cost (-)
- Staff training (-)
- Costs (+/-)
- DRG Rates (+/-)
- Rates (+/-)
- Time for service provision (-)
- Intangible benefits (+)
- Avoided costs for training (+)
- Time for service provision (-)
- Time for service provision (-)
- Avoided time for consultations (+)
- Avoided costs for travelling (+)
- Time for training (-)
- Time for training (-)
- Avoided time for training (-)
- Avoided time for training (-)
- Intangible benefits (+)
- Avoided time for requests (+)
- Improved competitiveness (+)
- Avoided time for home visits (+)
- Avoided time through improved workflow (+)
- EU funding (+)
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- Avoided time for requests (+)
- Improved competitiveness (+)
- Avoided time for home visits (+)
- Avoided time through improved workflow (+)
- EU funding (+)
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- Staff training (-)
- Costs (+/-)
- DRG Rates (+/-)
- Rates (+/-)
- Time for service provision (-)
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- Avoided costs for training (+)
- Time for service provision (-)
- Time for service provision (-)
- Avoided time for consultations (+)
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- Time for training (-)
- Time for training (-)
- Avoided time for training (-)
- Avoided time for training (-)
- Intangible benefits (+)
- Avoided time for requests (+)
- Improved competitiveness (+)
- Avoided time for home visits (+)
- Avoided time through improved workflow (+)
- EU funding (+)
- Equipment cost (-)
- Staff training (-)
- Costs (+/-)
- DRG Rates (+/-)
- Rates (+/-)
2.3 Lessons learned in first stage of assessment process

So far, the first wave deployment sites have undergone the first stage of the assessment process. During that period, valuable lessons were learned at staff working on the task. These lessons are not only helpful for the second wave deployment sites within SmartCare, but are also potentially relevant for stakeholders in other regions (including but not limited to the SmartCare Committed Regions) in case they plan to undergo a similar socio-economic assessment.

The key lessons learned so far are described below. Further lessons will be added as deployment sites move through the remaining stages of the assessment process. Towards the end of the project, it is also planned to add lessons not so much related to the assessment process, but to the results and the building of viable business models for integrated care. Lessons will also be made available publicly together with the results of the assessments in order to facilitate reproduction in other European regions.

**Lesson 1: The socio-economic assessment is best facilitated by a dedicated contact person with economic experience at the site.**

A socio-economic assessment or cost-benefit analysis requires experience in matters of economic analysis and of empirical evaluation. With the assessment work being split between a subject-matter expert (in this case the responsible task leader within the project) and a local person or team working at the deployment site, this criterion is fulfilled in general through the presence of the expert. Practical experience has shown, however, that the assessment can be set up in a much shorter time if there is also a person with relevant experience at the site who is either responsible for the assessment work, a member of the team, or at least readily available in case of questions. Such a person can for example be an economist or a staff member involved in finance issues (managerial staff, accountants), but also someone with experience in economic assessments. Within SmartCare, assessment work with the deployment region of Aragon was much facilitated by the fact that staff members of the local partner SALUD had already engaged in cost-benefit analyses for telehealth pilots in earlier projects.

**Lesson 2: An iterative process is necessary to arrive at a complete and coherent assessment model**

Setting up a complete and coherent assessment model, detailing stakeholders to be assessed as well as all indicators (costs and benefits) to be measured for each stakeholder is critical for all subsequent stages of the socio-economic assessment, from data collection to analysis. The experience with the creation of these models within SmartCare has shown that an iterative process is necessary to arrive at a model that is: a) complete, especially in terms of covering all relevant costs and benefits caused by the service to be evaluated; and b) coherent in the sense of capturing all interdependencies between stakeholders and impacts. During the different stages of the iterative process (involving the filling in of templates and several phone meetings) people involved were shown to (further) develop an economic mindset, allowing them to deconstruct their service concept from an economic point of view, namely into sets of cost and benefit indicators.

**Lesson 3: A good understanding of the service process is needed to set up an assessment**

SmartCare achieves care innovation through the design of service process, detailing the roles and activities of different stakeholders (from care provider organisations to family carers) as they care for patients or service clients with specific needs over a period of time, and fitting ICT systems into this process in order to facilitate it. The socio-economic
assessment needs to follow this thinking, and consider the service process as the subject of the assessment. For the task of the creation of the assessment model, it has proven crucial that planning related to the service process should ideally be quite advanced, since costs and benefits to be assessed are usually closely related to very specific activities or tasks. Initial versions of the model, set up at an early stage of service process planning, were sometimes shown to neglect process-related costs and benefits, and had to be corrected at later stages.

**Lesson 4: Considering all relevant types of costs and benefits can be a challenge**

In order to capture different types of impacts in a comprehensive manner, the assessment approach distinguishes monetary, resource and intangible costs and benefits. Monetary impacts cover all costs and benefits that are directly expressed in currency, such as costs for hardware or reimbursement paid by a health insurance. Resource impacts relate primarily to time spent (costs) or time saved (benefits) by care professionals in relation to the service. Intangible impacts cover all types of costs and benefits that have no immediate financial implication but need to be monetarised using different methods. Examples of the latter are increases in health-related quality of life, reduction in carer burden, or improvements in the convenience of service use. In setting up the assessment models within SmartCare, monetary impacts seemed to be those that are most easily identified and included in the assessment. Both resource-related impacts and intangible impacts require more consideration to be defined in a suitable manner, and to set-up suitable ways of measuring them.

### 2.4 Next steps

In general terms, the remainder of the exploitation support work (T9.1) will continue to follow the steps of the assessment process as described above, aligned to the implementation and piloting time schedule of the project.

Based on the Excel templates already received from the first wave sites and those to come from the second wave sites, the task leader will produce a unified stakeholder and indicator set for SmartCare, and include this into the ASSIST software toolkit. The revised toolkit will then be used for subsequent data collection and calculation of performance measures. Where necessary, minor adaptations to stakeholder set and indicators will be implemented to accommodate site-specific requirements.

For the first wave deployment sites, data collection for the socio-economic impact assessment will begin with the pilots and their evaluation. It is currently planned that initial calculations (partly based on assumptions) will be ready by the end of the second project year, to be reported in D9.2. Final calculations and analysis are planned for the end of the pilots in the third project year, to be reported in D9.3.

For the second wave deployment sites, step 1 of the assessment are will be carried out in the spring/summer of 2014, to be reported in D9.2. Calculations and analysis are planned for the end of the pilots in the third project year, to be reported in D9.3.
3. Overall dissemination strategy

3.1 Overall approach

Dissemination activities as a horizontal activity within the SmartCare project are strongly related to all other work packages. The dissemination work package receives input from different work tasks, depending on the current project phase, and strongly interacts with the exploitation and evaluation work packages throughout the whole duration of the project. Project aims, plans and (interim) results will be disseminated to all interested parties from kick-off onwards through a wide set of different dissemination means. In order to be effective and efficient, the dissemination strategy and means need to:

- Be oriented towards the needs of the audience, using appropriate language and information levels.
- Include various dissemination methods: written text including illustrations, graphs and figures; electronic and web-based tools; and oral presentations at community meetings and (scientific) national and international conferences.
- Fully leverage existing resources, relationships, and networks.

SmartCare pursues a multi-dimensional and large scale dissemination approach as depicted in the figure below.

Figure 2: Summary of SmartCare Dissemination Approach
3.1.1 Dissemination themes

Dissemination activities will be informed by dedicated foci formulated by the consortium for time spans of around six months, according to the different project phases.

During each of these six-month phases, special emphasis will be put on the assigned topic in terms of news items, short texts / blog posts, videos etc. This does not mean that all dissemination activities will solely focus on the topic currently running, but that concentrated efforts will be taken to specially promote the current dissemination topic, with a focus on the appropriate means for the right target groups. It also facilitates overall structuring of dissemination activities and overall marketing. The suggested dissemination topics are presented in Figure 3 below.

Figure 3: Dissemination topics

For each dissemination topic, an editorial team consisting of 6-7 project partners will be set up. The editorial team will ensure the adequate dissemination of each topic and organise the collection and creation of content. In a first step, the target groups and appropriate dissemination means for the topic are defined. Further to this, key messages that the project will publish are suggested by the editorial team and agreed among all project partners. An example of how each dissemination topics will guide global and local dissemination activities is provided below for the first dissemination theme on “service requirements”.

3.1.1.1 Dissemination focus - “Service requirements meeting people’s needs”

The formulation of key message largely depends on the envisaged target group and the dissemination instrument that is being used to diffuse SmartCare results. Examples of key messages for the first dissemination topic include:

- EU Policy Makers
  - SmartCare requirements analysis shows the importance of user involvement in service design.
  - Addressing care professionals appropriately from the beginning leads to higher acceptance of ICT-supported integrated care systems.
Intermediaries (third sector, public sector, private sector)
  - Your organisation should be taking part in SmartCare initiatives because they benefit your clients.

End Users (those over age 65, carers, etc.)
  - Getting e-help is for everyone. There is help available in your area.
  - How easy it is to access many services at the touch of a button, to have e-health devices at home, and also to benefit from online communications (e.g. email, shopping, or talking to and seeing loved ones etc. via Skype).

Media
  - Sustaining quality of life and e-enabling people over age 65 to live a healthy life at home is a major opportunity.

Major available dissemination means for this topic include:
- Website.
- Press release.
- Conference papers / presentations.
- Social media.
- Newsletter.

For each dissemination topic, the editorial team will be set-up in the very beginning and kicked-off with a conference call where main objectives, means and a time planning are discussed and agreed. Furthermore, a chief editor will be selected who is responsible for overall management of the editorial team. Generally, the following activities are planned for each dissemination topic:
- Development of introductory documents (Blog, Vlog, Homepage on the website describing what the topic means for SmartCare and what the project does in this regard; literature collection).
- Development of news items featuring the topic.
- Social network activities (participation in LinkedIn discussion groups, Twitter).
- Summary of main achievements of SmartCare.
- Transition to next dissemination topic.

3.1.1.2 Dissemination themes and editorial teams

<table>
<thead>
<tr>
<th>Dissemination theme</th>
<th>Main target groups</th>
<th>Team (chief editor in italics)</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service requirements meeting people’s needs</td>
<td>Older people &amp; patients, informal carers, health and social care professionals, care providers, third sector organisations</td>
<td>Sonja Müller (EMP), Ingo Meyer (EMP), Maude Luherne (AGE), Anne-Kirstine Dyrvig (RSD), Walter Atzori (EPF), Marja Pijl (Eurocarers), Allessia Clocchiatti (EFN)</td>
<td>Jun 2013 - Feb 2014</td>
</tr>
<tr>
<td>Useful and efficient integrated care pathways</td>
<td></td>
<td>Lutz Kubitschke (EMP), Veli Stroetmann (EMP), Leo Lewis (IFIC), Michael Rigby (board member), Christina Wanscher (RSD), Giulio Antonini (FVGASS1)</td>
<td>Feb 2014 - Jun 2014</td>
</tr>
</tbody>
</table>
### 3.2 Dissemination and communication objectives

SmartCare implements and regularly updates a large set of different dissemination means that pursue different dissemination objectives and target groups respectively. Following an adapted version of the marketing principle “AIDA” (Awareness, Interest, Desire, Action), the guiding dissemination principles in SmartCare for the different groups of dissemination means are described in the figure below.

![Figure 4: Dissemination principles](image)

**Awareness** refers to informing the wider public of the rationale, aim, and (interim) results of the SmartCare project, and the make the project well known in the wider public and dedicated research and practice scenes. Usual target groups are the wider public and larger groups of special target users. Appropriate dissemination means include short documents / flyers giving some general information of the project, posters, press releases and to a limited extend also the website.

**Interest** means to make people who are already aware of the existence of the project curious and interested to know more and to get involved. Also, interest for dedicated sub-
topics can be created by means such as presentation at conferences, videos and a well-designed project website.

**Search** means to keep project dissemination means updated in order to not lose interest of the target groups as the project goes along. It also means to provide online material as well as printed materials and oral speeches at conferences and events. It will also be crucial to regularly engage in social media website such as Twitter or LinkedIn to keep up the interest in the project. The same is true for regular publication of news items on the project website and partner websites.

**Action** refers to leading dedicated target groups such as in our case public authorities or external care providers towards taking action based on SmartCare results. This may in our case mean paving the way for replication of the SmartCare services through dedicated exploitation workshops, or influencing policy making and funding topics / mechanisms through the active support of the EIP AHA initiative, or strong and interactive cooperation with the members of the advisory boards.

The SmartCare dissemination strategy comprises a set of goals:

- To widely disseminate the concept of the SmartCare project, and the innovative solutions and services which are developed within SmartCare.
- To increase public awareness on the very sensitive and important issues both in the ICT and integrated care domain that SmartCare addresses.
- Communicate the benefits of this project to the professional media, to the target service beneficiaries, to professionals working in this area (carers and those delivering healthcare to those over age 65), to policy decision makers and to other interested stakeholders.
- To communicate with other R&D and EC or internationally-funded related projects and initiatives, especially in the field of ICT-supported integrated care.
- To actively participate in forums related with the transfer of knowledge from academia and research centres to industry and help in the solid regulation of Intellectual Property Rights (IPR).
- To support policy making by actively contributing SmartCare results to ongoing policy initiatives, in particular the EIP AHA.
- To facilitate service mainstreaming and replication through the publication of SmartCare deployment guidelines and the conduct of exploitation workshops.
- To ensure that the project establishes and benefits from an effective network of stakeholders in the participating countries and elsewhere in Europe.
- To ensure that communication between stakeholders is effective and easy.
- To gain the trust and involve the media wherever possible to further help with dissemination.
- To establish a visual identity.

Based on these goals, and taking into account the target group definition, the communication & dissemination plan will not be static; but will be continuously updated as new opportunities for dissemination arise and new project results are available.

### 3.3 Dimensions and target groups

Identifying target groups is an important step in deriving the communication & dissemination plan. It is important to consider that while many dissemination means are a ‘push out’ towards the target audience, they are only effective when there are also mediums and channels for the target audiences to provide feedback and take action.
D9.1 First report on dissemination and exploitation activities

The term target group implies all groups of people with certain characteristics that could be, potentially, interested in the SmartCare project results. The reasons for being interested in SmartCare may vary, and may be either personal, scientific or professional, or they just may be EU citizens interested in developments in a specific area and how these developments are going to affect their every-day life. The appropriate definition of the target groups is a crucial task, since dissemination activities and means need to be tailored to fit the specific interests (and sometimes abilities) of each group.

3.3.1 SmartCare dissemination target groups

Dissemination activities need to be very carefully planned and need to “speak” various languages because they address totally different target groups such as older people, the technical and research community, or business managers and policy makers, etc. In order to adequately address relevant target groups, a mix of different dissemination means has been developed, and is regularly updated during the project. Each dissemination means is designed according to the dedicated target group to be addressed. Target groups for each dissemination means are shown in Table 2, and described further below.

Table 2: Target groups and dissemination means

<table>
<thead>
<tr>
<th>Target groups</th>
<th>Website</th>
<th>Poster</th>
<th>Brochure</th>
<th>Press releases</th>
<th>Presentations</th>
<th>Scientific publications</th>
<th>Newsletter</th>
<th>Policy support</th>
<th>Case studies</th>
<th>Videos</th>
<th>Study newsletters</th>
<th>Social media</th>
<th>Exploitation workshops</th>
<th>Conference</th>
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<tbody>
<tr>
<td>Older people/patients</td>
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<td>Informal carers</td>
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<td>Public authorities</td>
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<td>Wider public</td>
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<td>Academia</td>
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</table>

Older people (care clients / patients) & informal carers

Services developed in SmartCare ultimately address older people who are clients of social care providers, or patients, or both, making them a very important target group for dissemination activities. Language and format of the different dissemination means are designed specifically for this target group. Pilot participants will, in addition, receive regular newsletters about the project to keep them informed and engaged.
Healthcare and social care providers & professionals

Care providers and professionals are one of the key target groups in SmartCare. Their buy-in and engagement in the new services is of utmost importance. It is thus crucial to focus different dissemination activities on this target group.

Public authorities

Public authorities are one of the main players when it comes to care provision organisation and decision making. In SmartCare they are reached by a large basket of dissemination channels, as described in the table above. The involvement of public authorities also plays a crucial role when it comes to ensuring that the SmartCare services will be retained as mainstream services when it comes to upscaling and replication of the services.

EU policy makers

Support of policy making processes at supra-national level is one of SmartCare’s key dissemination goals. In particular, interaction the members of the EIP AHA group on integrated care ensures that SmartCare results will be exploited at EU level, and inform policy making and other related projects.

Industry

ICT industry needs to be informed on new developments in the field, in order to increase market potential for SmartCare solutions. Addressing industry players through participation in fairs and exhibitions is an important SmartCare dissemination pathway.

Wider public

Apart from dedicated target groups, SmartCare is also reachable by an interested wider public, mainly through its website and social media such as Twitter or Facebook.

Academia

SmartCare results such CBA or evaluation methods and results for ICT-supported integrated care services strongly contribute to new evidence in the field. Dissemination through journals and presentations in academic conferences is thus also crucial.

Media

Unlike many of the other groups which are reached by means of journals, conferences and industry events / networking, the media present an important but less cohesive and focused group. Media plays an important role in public education, and cannot be overlooked in that context.

As described earlier in this document, SmartCare dissemination takes place on different geographical levels in order to reach maximal outreach and impacts.

3.3.2 Local and Regional Activities

All participating regions have established strong relations with local associations of care professionals and informal care givers, patients and elderly organisations, which are being utilised for dissemination purposes. Each of these associations reaches out to their members and further larger networks. Dissemination at local and regional level includes:

- Approaching local media with prepared press releases.
D9.1 First report on dissemination and exploitation activities

- Organisation or participation in seminars dedicated to integrated care, home monitoring, active and healthy ageing, etc.
- Preparation of a promotional video in each of the pilot sites for local promotion of the initiative.
- Organisation of seminars and workshops dedicated to the SmartCare pilots.

### 3.3.3 National activities

Dissemination activities at national level are also the main responsibility of the pilot regions, and include:

- Participation in national events and fairs.
- Articles in national newspapers and magazines for both the general public and healthcare professionals and managers.
- Encourage participation in national TV programmes and debates whenever possible.

### 3.3.4 European and international outreach

European and international outreach is also a crucial part of the overall communication plan. Topics such as large scale replication of the SmartCare services, the establishment of an evidence base of effectiveness of ICT-supported integrated care service provision, and the development of deployment guidelines are topics that, amongst others, lend themselves to the European and international dissemination level. Appropriate dissemination means include:

- Website.
- Promotional video(s).
- SmartCare interim workshop and final conference.
- Participation in international events and fairs.
- Interaction with and support of EIP action group B3.

### 3.4 Dissemination principles

#### 3.4.1 General principles

To avoid confusion and misconceptions and to enhance the quality of the presented material, all dissemination activities should follow a number of important principles:

- Respect Intellectual Property Rights (IPR) of all partners.
- Respect the work of all partners.
- Ensure proper reference to all relevant parties whose work is directly or indirectly mentioned in the proposed publication.
- Follow transparent procedures.
- Respect confidential results and results where commercial issues arise.
- Avoid overlapping or duplication of dissemination events.
- Clearly distinguish between results suitable for dissemination and exploitable results.
- Target the right audience.
- Always mention SmartCare and the EC/IST financial support to the project.
- Always follow the procedures described within this document.
3.4.2 Authorship guidelines

- All persons designated as authors should qualify for authorship, and all those who qualify should be listed.
- Each author should have participated sufficiently in the work to take public responsibility for the appropriate portions of the content.
- One or more authors should take responsibility for the integrity of the work as a whole, from inception to published article.
- Authorship credit should be based only on substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content; and final approval of the version to be published.
- All others who contributed to the work who are not authors should be named, with their permission, in the Acknowledgments.
- The order of authorship on the by-line should be a joint decision of the co-authors.

3.4.3 Accessibility principles

Accessibility - that is access to content by everyone regardless of disability - is one key aspect of SmartCare’s dissemination activities, because the project does not want to exclude people from its information if this can be avoided by reasonable means. After all, key target groups of the project’s dissemination are likely to experience accessibility challenges stemming from old age, illness or disability.

In practical terms, accessibility principles are applied to the project’s different dissemination means, and partners receive support in adhering to these principles.

3.5 SmartCare’s Visual Identity

Visual identity plays a significant role in the way the project presents itself and leads to a strong recognisability of the SmartCare “brand”. Three main elements are currently planned to underpin this dissemination goal, they are described below.

3.5.1 Logo

The SmartCare logo captures the concept of the project, since it demonstrates SmartCare as something that spans a bridge or arch to bring things together, and as something that grows and is alive. It was developed in several iterations and with strong interaction between the whole group of SmartCare beneficiaries. Three initial logos were developed for and presented at the kick-off meeting in Trieste in March 2013. Based on the feedback collected from project beneficiaries, the logo versions were improved and then subject to a formal vote involving all project partners.

For the final logo, three variants were developed:

- Regular

- Black & white

- Regular with a cast shadow (as a variation, e.g. for use on white background)
D9.1 First report on dissemination and exploitation activities

The different versions of the logo were distributed to all project partners as pdf and vector format.

3.5.2 Deliverable template

The template for external and internal deliverables and reports is, as with the other templates described below, strongly aligned with the overall design of the logo.

SmartCare partners are asked to use these templates whenever they present SmartCare somewhere or write project-related documents.

3.5.3 PowerPoint template

Similar to the word template, a template for a power point presentation has been developed, underpinning the importance of presenting the project to the outside world in a coherent way. It is to be used for all presentations of SmartCare at conferences, events, seminars, and workshops, as well as internal meetings such as consortium, board or review meetings.
4. The SmartCare Communication Plan

4.1 The “global” communication plan

The purpose of this communication plan is to capture how dissemination of project progress and achievements to external parties are managed throughout the project life cycle. In its current stage, it provides a first overview of the strategy that the consortium is aiming to follow in order to achieve the dissemination objectives as described above.

The SmartCare consortium, in an effort to help the relevant stakeholders accept the overall principle of the project initiatives and raise public awareness, acknowledges dissemination as a pivotal action line. Efficient dissemination is a fundamental activity, since its success contributes decisively to both the short- and long-term impact of the project. Careful and early planning of dissemination activities, and the commitment of all partners, is thus of great importance.

This document provides key strategies for dissemination, including practical advice and specific templates that SmartCare partners can adapt for their use. It elaborates on the details of the types of dissemination activities to be undertaken during the SmartCare project lifetime, focusing on different target groups. While this deliverable is made available at the beginning (M4) of the project, it aims to capture, as well as outline, the main dissemination axes around which the activities shall revolve for the entire duration of the project, which are crucial for the evolution of other activities. The communication plan is set-up as a living document. The communication plan will be reviewed quarterly and updated as needed, as the project proceeds.

![Figure 7: The SmartCare Dissemination & Communication Plan](image)

4.2 Regional / local communication plans

At the beginning of the project, each partner / deployment site was asked to ensure the following, and report activities to the communication manager regularly:

- Put a link on their organisational website to www.pilotsmartcare.eu as soon as website is online.
D9.1 First report on dissemination and exploitation activities

- Identify one local communication manager per pilot region and report back to central communication manager.
- Identify and approach local / regional media with press release.
- Identify national events where SmartCare should be presented.
- Identify regional / national publication opportunities / channels.
- Write and publish at least two dissemination articles per year in national press and/or relevant journals / magazines.
- Attend at least two national or European events per year, and give a presentation which includes SmartCare and their activities in the project.
- Inform relevant national stakeholders about SmartCare and your role in SmartCare.
- Develop at least four news items per year featuring your activities in SmartCare.
- Send a list of relevant events for publication on the website to communication manager using the events collection template.
- Follow SmartCare on Twitter and actively retweet.
- Provide feedback to suggestions of editorial team set-up.

A checklist was provided to the partners in order to support SmartCare project partners in choosing the right communication means for the different target groups:

Table 3: Checklist to choose the right communication means for the different target groups

<table>
<thead>
<tr>
<th>Study Participants and Participating Agencies</th>
<th></th>
<th>Older people not participating in the study</th>
<th>Healthcare and social care professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Distribute flyers, brochures &amp; research briefs (i.e. in health centres, clinics, agencies, and neighbourhoods).</td>
<td>- Host community forums to discuss the project activities.</td>
<td>- Distribute flyers, brochures &amp; research briefs (i.e. in health centres, clinics, agencies, and neighbourhoods).</td>
<td>- Organise workshops presenting SmartCare results and collect feedback.</td>
</tr>
<tr>
<td>- Send a regular newsletter summarising research in progress.</td>
<td>- Send letter of thanks (anonymous or targeted).</td>
<td>- Publish interesting and “speaking” case studies and videos.</td>
<td>- Invited them to the final conference.</td>
</tr>
<tr>
<td>- Host or attend seminars.</td>
<td>- Ask agencies to feature the project in their newsletters &amp; websites.</td>
<td></td>
<td>- Publish interesting and “speaking” videos and case studies.</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>
## D9.1 First report on dissemination and exploitation activities

<table>
<thead>
<tr>
<th>Third sector organisations</th>
<th>Public authorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Distribute flyers, brochures &amp; research briefs.</td>
<td>• Organise workshops presenting SmartCare results and collect feedback.</td>
</tr>
<tr>
<td>• Distribute summary document.</td>
<td>• Invite them to the final conference.</td>
</tr>
<tr>
<td>• Send a regular newsletter summarising research in progress.</td>
<td>• Publish interesting and “speaking” videos and case studies.</td>
</tr>
<tr>
<td>• Present posters in seminars, workshops and conferences.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EU policy makers</th>
<th>Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Distribute flyers, brochures &amp; research briefs.</td>
<td>• Present project poster.</td>
</tr>
<tr>
<td>• Distribute summary document.</td>
<td>• Engage in social media.</td>
</tr>
<tr>
<td>• Send a regular newsletter summarising research in progress.</td>
<td>• Invite them to final conference.</td>
</tr>
<tr>
<td>• Host or attend seminars and conferences, workshops.</td>
<td>• Attend fairs and exhibitions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wider public</th>
<th>Academia</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Distribute flyers, brochures &amp; research briefs.</td>
<td>• Engage in social media.</td>
</tr>
<tr>
<td>• Engage in social media.</td>
<td>• Publish in books and scientific journals.</td>
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<tr>
<td></td>
<td>• Have an interesting and up-to-date project website.</td>
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</table>
5. Dissemination Activities in Reporting Period 1

5.1 SmartCare Website

The project website is one of the most important dissemination means of the SmartCare project, and provides an entry point for a variety of stakeholders such as the scientific community, care providers and professionals, industry, policy makers and a wider audience.

The long-term objective of the website is to create a community of interested parties around the project to accelerate their involvement, to create awareness of the results, and to inform them about the latest evolutions in the field.

The structure of the website is described in the figure below. It was set-up and became public in June 2013 (www.pilotsmartcare.eu).

![Website structure diagram]

Figure 8: Website structure

The content of the website will of course become richer once the project progresses further. In particular, each dissemination topic will be featured on the homepage of the website.
Technically, the web site is based on recent technology throughout. For its interface, it uses the latest version of the Twitter bootstrap template to allow for responsive design, i.e. seamless output on different types of user agents (including mobile phones and tablets of different sizes). The design follows the SmartCare look and feel that was developed to appear serious and clear-cut in keeping with the objectives of the project. In practical terms, the design of the website emphasises usability and guides visitors’ attention to content matter. Regarding content update, see above and reference to project communication plan, where the updating schedule is specified.

![Figure 9. SmartCare website- Homepage](image)

The homepage contains a very short introduction of the SmartCare project. The homepage also includes “Latest news” boxes providing easy access to everything that is new and interesting to the project, e.g. when SmartCare has been presented at a recent conference, produced a new public report, had an advisory board meeting etc. It also shows a newly designed map of the SmartCare regions.

![Figure 10: SmartCare website - Region map](image)

The “News” pages are continuously updated and contain relevant project news and events as well as presentations for download. A significant number of news items were published on the project website in the last reporting period, ranging from reports about the current status of the SmartCare deployment sites to information about project presentations at workshops and other events.
D9.1 First report on dissemination and exploitation activities

Figure 11: SmartCare website - News section

Figure 12: SmartCare website - News item on site visit in Italy

The most recent news items are always automatically presented on the homepage of the website, which makes it appearance change regularly, and makes users curious to further explore the website.

Further to this, a separate section on the website provides detailed information on all SmartCare regions, accessible either via a Dropdown menu or the SmartCare region map.
In order to provide accessibility of website contents for all users, the website is also accessible as high contrast version (see Figure 14 below).

Time planning for website updates and revisions

Mainly following the different dissemination topics that last for about six months each, the website will be regularly updated and revised (cf. figure below).
5.2 Promotion via partner websites

Apart from the dedicated project website, the project is also being promoted on most of the websites of the partner organisations, that on the one hand informs partners’ clients about the project, but also attracts visitors to the SmartCare website. Each of these websites provides a summary of the project and a link to the more comprehensive project website, so that the interested user can have easy and quick access to more information on the project.
5.3 Project Leaflet

Dissemination activities are further supported by print materials. A four page leaflet was generated to enable communication of basic project information to a wider audience.

The leaflet was designed in a way that is sufficiently generic to ensure usage throughout the remainder of the project, thus avoiding costs to develop and print updated versions as the project progresses. In relation to the latter, the brochure points the reader towards dissemination means which are subject to regular updating, such as the website and a project newsletter.

![Image of SmartCare leaflet]

Figure 17. SmartCare leaflet

In the 1st reporting period, the leaflet was distributed at a range of conferences and other events, as described elsewhere in this report.

Apart from the English leaflet, the leaflet was also developed in Spanish and Greek language in order to facilitate regional / national dissemination and communication.

5.4 Publications, press releases, news, announcements and articles

Several news items, announcements, press releases and articles in newspapers were published during the first reporting period of SmartCare. Table 4 below provides an overview of all activities conducted in this regards.
D9.1 First report on dissemination and exploitation activities

**Table 4: Press releases, news, announcements and newspaper articles**

<table>
<thead>
<tr>
<th>Type</th>
<th>Date</th>
<th>Topic</th>
<th>Target group</th>
<th>More info.</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newsletter article</td>
<td>01.03.2013</td>
<td>Announcement of the launch of the project and of the kick off meeting in Trieste</td>
<td>Wider public</td>
<td><a href="http://www.age-platform.eu">www.age-platform.eu</a>.</td>
<td>AGE</td>
</tr>
<tr>
<td>Newsletter article</td>
<td>01.05.2013</td>
<td>Information on the project, and on how to follow the project activities</td>
<td>Wider public</td>
<td><a href="http://www.age-platform.eu">www.age-platform.eu</a>.</td>
<td>AGE</td>
</tr>
<tr>
<td>Newsletter article</td>
<td>01.06.2013</td>
<td>Two articles: one on the Users Advisory Board meeting on 5/06 and one on the event of 28/06 by AER</td>
<td>Wider public</td>
<td><a href="http://www.age-platform.eu">www.age-platform.eu</a>.</td>
<td>AGE</td>
</tr>
<tr>
<td>Newsletter article</td>
<td>01.09.2013</td>
<td>Announcement of the launch of the project website</td>
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<td><a href="http://www.age-platform.eu">www.age-platform.eu</a>.</td>
<td>AGE</td>
</tr>
</tbody>
</table>

**Figure 18:** Press release issued by AER

**Figure 19:** Newsletter issued by NHS24

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**Building a bridge between health and social care**

European regions follow the track of ICT-based Integrated care

Barcelona, EuskoTIN, 8th June 2012

How to organise the future of health and social care?

This is the question that European regions discussed during the Seminar on ICT-based Integrated care, organized by the Association of European regions ARPP in the framework of smartcare, a project funded by the European programme ICT FP7.

Integrated care aims at bridging the traditional gap that exists between health and social care in terms of delivery, management and organization, thus bringing a benefit to the improvement of services, and creating opportunities for economical and increased quality of services.

Why do we need to integrate health and social care?

- to improve the quality and continuity of care for our patients;
- to unlock the increasing demand for care due to demographic and social changes;
- to reduce cancer systems costs efficiently.

The services constitute an opportunity for European regions to learn about the need for and the concept of integrated care, and the experience should be shared across the regions.

*"First and foremost, we are open to better understand the potential of integrated care. We are at the beginning of a long journey. Our experience of policy makers in the context of integrated care service delivery can be further deployed. The European project, to which AER is a partner, is having a role in spreading this experience, and if other regions should follow its results clearly concluded Partner Arnao PEREIRO, President of the AER Commission on Social Policy and Public Health.

"smartCare - A project to join ICT and Service Processes for Quality Integrated Care"

Over 2 years, 10 regions will develop and pilot ICT-based integrated care services to collect evidence on the impacts of integrated care services and will develop new pilots and models.

"With this event, our intention was to give an introduction to integrated care services to regional policy-makers and civil servants. It is useful to get familiar with the tools we have to give a better understanding of it, and to give them the tools to achieve future care models", affirmed Olalla Arnao, Coordinator of smartCare.

The Assembly of European Regions (AER), a network of the independent networks of regions in Europe, brings together 28 regions from 12 countries and 15 institutional organizations, AER to the political voice of its members and a forum for interchange of experience.

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**Table 4:** Press releases, news, announcements and newspaper articles

<table>
<thead>
<tr>
<th>Type</th>
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<th>Topic</th>
<th>Target group</th>
<th>More info.</th>
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<td>Type</td>
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<td>More info.</td>
<td>Partner</td>
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<tr>
<td>Journal Article</td>
<td>17.02.2014</td>
<td>Diario Medico. &quot;Telemedicina: No era tan facil&quot;</td>
<td>Care practitioners, healthcare professionals and nurses</td>
<td></td>
<td>Aragon deployment site</td>
</tr>
<tr>
<td>Press release</td>
<td>30.11.2013</td>
<td>Press release announcing project start</td>
<td>European regions, policy makers, researchers, industry, service providers</td>
<td></td>
<td>Eksote</td>
</tr>
<tr>
<td>Journal Article</td>
<td>7.3.2013</td>
<td>Press release informing about the commitment of Ministry of Health and Social Policy to the implementation of ICT in the social health area</td>
<td>Policy makers, researchers, industry, service providers</td>
<td><a href="http://www.europapress.es">www.europapress.es</a></td>
<td>Extremadura region</td>
</tr>
<tr>
<td>Journal Article</td>
<td>09.10.2013</td>
<td>Press release informing that SEPAD belongs to Red Coral and the proposal of the SmartCare project</td>
<td>Policy makers, researchers, industry, service providers</td>
<td><a href="http://gobex.es">http://gobex.es</a></td>
<td>Extremadura region</td>
</tr>
<tr>
<td>Journal Article</td>
<td>15.06.2013</td>
<td>Interview in the magazine Grada</td>
<td>Readers of Grada Magazine</td>
<td><a href="http://socialgrada.es">http://socialgrada.es</a></td>
<td>Extremadura region</td>
</tr>
<tr>
<td>Press release</td>
<td>06.02.2014</td>
<td>El SEPAD y FUNDECYT-PCTEX muestran el proyecto ‘Smartcare’ en la Feria del Mayor</td>
<td>Policy makers, researchers, industry, service providers</td>
<td><a href="http://www.gobex.es">http://www.gobex.es</a></td>
<td>Extremadura region</td>
</tr>
<tr>
<td>Interview</td>
<td>24.10.2013</td>
<td>Interview in the Program &quot;Las Cuatro Aspas&quot; in Canal Extremadura radio</td>
<td>Listeners of the radio channel in general</td>
<td>-</td>
<td>FUNDECYT</td>
</tr>
<tr>
<td>Press release</td>
<td>15.04.2013</td>
<td>Ministerial announcement of the SmartCare project in Scotland</td>
<td>All health and care partners, voluntary sector, service users.</td>
<td>-</td>
<td>NHS24</td>
</tr>
<tr>
<td>Publication</td>
<td>03.03.2013</td>
<td>E-health future in health and social care Prime time news</td>
<td>Estonian residents</td>
<td><a href="http://arhiiv.err.ee">http://arhiiv.err.ee</a></td>
<td>Tallinn &amp; EITCH</td>
</tr>
<tr>
<td>News item</td>
<td>04.04.2013</td>
<td>Informing local and national general public about the ATTICA pilot participation in the SmartCare Programme</td>
<td>General public</td>
<td><a href="http://mazinotia.blogspot">http://mazinotia.blogspot</a></td>
<td>Agdimitrios, Alimos, Palfaliro</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td><a href="http://www.airetros.gr">http://www.airetros.gr</a></td>
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<td><a href="http://now24.gr">http://now24.gr</a></td>
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<td><a href="http://www.insurance.world.gr">www.insurance.world.gr</a></td>
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<td></td>
<td><a href="http://www.vimaonline.gr">www.vimaonline.gr</a></td>
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<td></td>
<td></td>
<td></td>
<td><a href="http://www.iator.gr">www.iator.gr</a></td>
<td></td>
</tr>
</tbody>
</table>
### D9.1 First report on dissemination and exploitation activities

#### Table of Dissemination and Exploitation Activities

<table>
<thead>
<tr>
<th>Type</th>
<th>Date</th>
<th>Topic</th>
<th>Target group</th>
<th>More info.</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Publication</td>
<td>01.12.2013</td>
<td>Compilation of Good Practices in Integrated Care</td>
<td>Policy makers, researchers, industry, service providers, service improvement managers, managers, service users</td>
<td><a href="http://ec.europa.eu">http://ec.europa.eu</a></td>
<td>FIC</td>
</tr>
</tbody>
</table>

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**Figure 20: AGE newsletter**

*Telemédecina: no era tan fácil*

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**Figure 21: Journal article published by Aragon**
Figure 22: Newsletter article developed by FUNDECYT

5.5 Book “Achieving Effective Integrated eCare Beyond the Silos”

5.5.1 Background to the book

In recent scientific and policy debates at global and national level, it has been frequently highlighted that the demographic change, rising incidence of chronic disease, and unmet needs for more personalised care are trends demanding a new, integrated approach to health and social care. In this context, it has been stated that professionals must work across care sectors as a team with common goals and resources to deliver a coordinated response to each citizen’s care requirements. A recent OECD report also highlights that interface problems in the coordination of services of acute, rehabilitative and social care can both lead to unsatisfactory outcomes for patients and also result in inefficient use of resources across health and social care systems taken together (Huber, M., Long-term care for older people: The future of Social Services of General Interest in the European Union, in: The future of Social Services of General Interest, European Centre for Social Welfare Policy and Research 2007).

Advanced ICTs are a major opportunity to realise care integration across social care and healthcare and involve third-sector organisations, superseding today’s chain of disjoint responses to discrete threats to health. With the issue still being very much at a concept stage, much remains to be learned how it can be made a reality, how framework conditions have to shift to accommodate new necessities and how service and business models have to be build to get buy-in from all stakeholders involved. At the same time, the first real-life examples of integrated eCare are emerging across Europe and can provide useful lessons.

Empirica and their consortia of integrated eCare projects (INDEPENDENT, CommonWell, SmartCare) thus thought that the time had come to take stock of what already exists in the area of integrated eCare, and give people active in the field the opportunity to publish their knowledge and experiences in a dedicated book, thus allowing others to learn. The book is to our knowledge the first collection available on the topic of integrated eCare.
5.5.2 Topics and types of contributions

The overall aim of the book is to produce a collection of knowledge that provides relevant insights to practitioners, researchers and decision makers engaging in integrated eCare. Altogether 15 chapters will be published in the book, which underwent a double-blind review process:

- Foreword (Nick Goodwin)
  - Introduction (Sonja Müller, Ingo Meyer, Lutz Kubitschke).

- Conceptual Approaches to Integrated eCare
  - The Core Vision of Person Centred Care in a Modern Information-based Society (Michael Rigby).
  - Do All Roads Lead to Rome? Models for Integrated eCare Services in Europe (Lutz Kubitschke, Sonja Müller, Ingo Meyer).
  - Implementing and Scaling Up Integrated Care through Collaboration (Prof. George Crooks, Donna Henderson).

- Technologies for Integrated eCare
  - Understanding Integrated Care: the Role of Information and Communication Technology (Nick Goodwin, Albert Alonso).
  - Technology for Integrated eCare (Wil Rijnen, Ilse Bierhoff, Rafael Llarena Gómez, Eleftheria Vellidou, Pantelis Angelidis).
  - Informatics and Socio-technical Challenges when Designing Solutions for Integrated eCare (Sabine Koch, Maria Hägglund, Isabella Scandurra).

- Evaluating Integrated eCare Services
  - Socio-economic Impact Assessment and Business Models for Integrated eCare (Reinhard Hammerschmidt, Ingo Meyer).
  - Evaluating Integrated eCare - Discussions and Guidance of a Diverse Field (Anne-Kirstine Dyrvig).

- Integrated eCare Services in Practice
  - Telemedically Augmented Palliative Care: Empowerment for Patients with Advanced Cancer and their Family Caregivers (Romina Nemecek, Patrick Huber, Sophie Schur, Eva Masel, Stefanie Porkert, Barbara Hofer, Matej Stefan, Egger Georg, Herbert Watzke, Christoph Zielinski, Michael Binder).
  - The Development of BelRAI, a Web Application for Sharing Assessment Data on Frail Older People in Home Care, Nursing Homes and Hospitals (Dirk Vanneste, Anja Declerq).
  - Making Integrated eCare a Reality in the UK: Past Failures, Current Successes and Future Challenges (Mark Gretton).
  - Integrating Social and Health Services in Greece: Implementation of Three Pilot CIP-PSP-ICT-Programs (ISISEMD, INDEPENDENT, Renewing Health) (George E. Dafoulas, Christina N. Karaberi, Lamprini Ch. Oikonomou, Kalliopi P. Liatou).
  - From Agreement to Realisation: Six Years of Investment in Integrated eCare in Kinzigtal (Birgit Reime, Udo Kardel, Christian Melle, Monika Roth, Marcus Auel, Helmut Hildebrandt).
  - The eCare Network in Bologna: No Longer Home Alone (Carla Fiori).
  - Integrated eCare in Dementia. The Irish Experience in the INDEPENDENT Project (Sarah Delaney).

The publisher is IGI Global http://www.igi-global.com/. The publication date is summer 2014.
5.6 Presentations at conferences and other events

Personal contacts with relevant stakeholders are a great way to promote and demonstrate projects goals and results as well as network with the interested members of the community. This is particularly important for the project as the results are of interest to people at the intersection of three main areas, namely social care, healthcare, and ICT, as well as administration and politics.

![Invited speaker Prof. Michael Rigby at AER event in Barcelona 2013](image1)

Figure 23: Invited speaker Prof. Michael Rigby at AER event in Barcelona 2013 (MIHealth)

![Project manager Guido Antonini presenting SmartCare at MIHealth 2013 in Barcelona](image2)

Figure 24: Project manager Guido Antonini presenting SmartCare at MIHealth 2013 in Barcelona

A list of conferences and events where SmartCare was presented in the third reporting period is presented below.

Table 5: List of conferences and events where SmartCare was presented

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Participation manner</th>
<th>Target audience</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.10.2013</td>
<td>AGE Health Expert Group</td>
<td>Information shared on the SmartCare project and invitation to take part - information on the Users Advisory Board</td>
<td>Organisations of older people</td>
<td>AGE</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Participation manner</td>
<td>Target audience</td>
<td>Partner</td>
</tr>
<tr>
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<td>-------------------------------------------------------------------------------------</td>
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<td>---------------</td>
</tr>
<tr>
<td>21.11.2013</td>
<td>AGE Universal Access and Independent Living Expert Group</td>
<td>Information shared on the SmartCare project and invitation to take part - information on the Users Advisory Board - questions about their knowledge on integrated care initiatives</td>
<td>Organisations of older people</td>
<td>AGE</td>
</tr>
<tr>
<td>04.04.2013</td>
<td>AALIANCE2 plenary meeting</td>
<td>Short introduction to the SmartCare project to the AALIANCE2 project partners</td>
<td>Research institutes, service providers, technology developers</td>
<td>AGE</td>
</tr>
<tr>
<td>22.10.2013</td>
<td>Jornada para la Estrategia de Atención Al Paciente Crónico en Aragón</td>
<td>Speaker and moderator</td>
<td>Healthcare professionals and nurses, researchers, policy makers</td>
<td>Aragon deployment site</td>
</tr>
<tr>
<td>19.11.2013</td>
<td>National Telemedicine Forum and II Meeting of the Technological Platform in Health</td>
<td>Speaker and moderator</td>
<td>Healthcare professionals, researchers, healthcare managers, policy makers</td>
<td>Aragon deployment site</td>
</tr>
<tr>
<td>09.11.2013</td>
<td>International conference on integrated care</td>
<td>Presentation provided, panel discussion, workshop</td>
<td>Policy makers, researchers, industry, service providers</td>
<td>Aragon deployment site</td>
</tr>
<tr>
<td>27.11.2013</td>
<td>V Days of Quality and Research at Barbastro Hospital</td>
<td>Presentation of the SmartCare project and its challenges. Expected great interest among nurses and healthcare professionals, specially GPs</td>
<td>“Healthcare professionals and nurses Health researchers Service improvement managers Policy makers”</td>
<td>Aragon deployment site</td>
</tr>
<tr>
<td>10.10.2013</td>
<td>Third Conference on “Sharing experiences in improving continuity of care: integrating processes and professionals”</td>
<td>Invited speaker</td>
<td>Policy makers, researchers, service providers, managers, clinicians</td>
<td>Basque region</td>
</tr>
<tr>
<td>27.03.2013</td>
<td>VI National Congress on Chronic Patient Healthcare. First National Conference of the Expert Patient</td>
<td>Invited speaker</td>
<td>Policy makers, researchers, service providers, managers, clinicians</td>
<td>Basque region</td>
</tr>
<tr>
<td>04.09.2013</td>
<td>Mutual learning seminar on innovative procurement (in cooperation with Engaged partner)</td>
<td>Invited speaker</td>
<td>Administration, technology provider, private sector and research organisation.</td>
<td>Basque region</td>
</tr>
<tr>
<td>20.02.2014</td>
<td>Presentation of SMARTCARE in the Spanish Ministry of Health and Social Affairs</td>
<td>Presentation</td>
<td>Spanish R&amp;D policy makers</td>
<td>Valencia region</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Participation manner</td>
<td>Target audience</td>
<td>Partner</td>
</tr>
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<td>------------</td>
<td>-----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>18.02.2014</td>
<td>Presentation of SMARTCARE in the Valencia region for different researchers and key decision makers</td>
<td>Presentation</td>
<td>Hospital managed and leading researchers</td>
<td>Valencia region</td>
</tr>
<tr>
<td>12.04.2013</td>
<td>Integrated Care conference Berlin</td>
<td>Flyer distribution, networking, organisation</td>
<td>Conference was attended to meet people in the field of integrated care and to discuss recent developments. The CfC for the book on integrated eCare was distributed and some contacts made as regards potential committed regions for SmartCare.</td>
<td>Eksote, IFIC, empirica</td>
</tr>
<tr>
<td>13.11.2013</td>
<td>National eHealth &amp; connection seminar 2013</td>
<td>Present the Eksote eHealth services and home care technology (include SmartCare plans)</td>
<td>Healthcare professionals, decision makers,</td>
<td>Eksote</td>
</tr>
<tr>
<td>6.2.2014</td>
<td>IFEBA: Regional Senior Fair</td>
<td>Presentation, explain the objectives of the SmartCare project.</td>
<td>Service providers, industry, society</td>
<td>Extremadura region</td>
</tr>
<tr>
<td>18.10.2013</td>
<td>Workshop &quot;Fostering exchange of experiences among European Regions on the issues of assisted living and demographic change&quot;</td>
<td>Session attendance, networking, promotion of Extremadura Region</td>
<td>European regions, policy makers, researchers, industry, service providers</td>
<td>FUNDECYT</td>
</tr>
<tr>
<td>29.01.2014</td>
<td>SmartCare Show and Tell Event</td>
<td>Presentation</td>
<td>Service users, service providers, business enterprise</td>
<td>NHS24</td>
</tr>
<tr>
<td>13.12.2013</td>
<td>Ayrshire &amp; Arran Telehealth Telecare Innovation Network Event</td>
<td>To support the event and share SmartCare knowledge, as well as engagement with all relevant potential SmartCare customers.</td>
<td>Service users, service providers, health and care staff from the 4 partner areas in Ayrshire and Arran.</td>
<td>NHS24</td>
</tr>
<tr>
<td>31.10.2013</td>
<td>SmartCare Carers Conference</td>
<td>Event co-ordination and presentation.</td>
<td>Service Users, Service providers, Informal carers</td>
<td>NHS24</td>
</tr>
<tr>
<td>04.06.2013</td>
<td>UNIK conference</td>
<td>Presentation</td>
<td>Danish healthcare contributors, including private companies and public organisations</td>
<td>RSD</td>
</tr>
<tr>
<td>05.06.2013</td>
<td>The High-Level Roundtable on Public Sector Innovation</td>
<td>Presentation, roundtable discussion</td>
<td>High level people from different organisations e.g. EU commission, OECD, companies, governments</td>
<td>RSD</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Participation manner</td>
<td>Target audience</td>
<td>Partner</td>
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</tr>
<tr>
<td>19.06.2013</td>
<td>Presentation for the Danish Health Ministry</td>
<td>Presentation</td>
<td>Danish Health and Medicines Authority, municipalities and hospitals</td>
<td>RSD</td>
</tr>
<tr>
<td>25.06.2013</td>
<td>AER Conference</td>
<td>Workshop</td>
<td>Decision makers and IT experts in Europe</td>
<td>RSD</td>
</tr>
<tr>
<td>26.06.2013</td>
<td>Presentation for Danish Regions</td>
<td>Presentation</td>
<td>Decision makers and officials</td>
<td>RSD</td>
</tr>
<tr>
<td>03.07.2013</td>
<td>Presentation for secretariat director at Integrated Care</td>
<td>Presentation</td>
<td>Local project group</td>
<td>RSD</td>
</tr>
<tr>
<td>13.08.2013</td>
<td>Presentation at MedComs project meeting</td>
<td>Presentation</td>
<td>Department of telehealth and telecare and MedCom</td>
<td>RSD</td>
</tr>
<tr>
<td>13.08.2013</td>
<td>Presentation for directors and leaders in RSD</td>
<td>Presentation</td>
<td>Directors and leaders in the Region of Southern Denmark</td>
<td>RSD</td>
</tr>
<tr>
<td>22.08.2013</td>
<td>MedInfo</td>
<td>Stand/booth</td>
<td>National and international scientists, public organisations and private providers</td>
<td>RSD</td>
</tr>
<tr>
<td>26.08.2013</td>
<td>Presentation for the Integrated Care group in RSD</td>
<td>Presentation</td>
<td>Odense University Hospital, Odense Municipality, DAK-E</td>
<td>RSD</td>
</tr>
<tr>
<td>27.08.2013</td>
<td>Presentation for quality department at Middelfart hospital</td>
<td>Presentation</td>
<td>Quality unit employees</td>
<td>RSD</td>
</tr>
<tr>
<td>04.09.2013</td>
<td>Presentation for the Turkish Health Ministry</td>
<td>Presentation</td>
<td>Government officers, Hospital CEOs</td>
<td>RSD</td>
</tr>
<tr>
<td>06.09.2013</td>
<td>Presentation for the Danish Health and Medicines Authority</td>
<td>Presentation</td>
<td>Decision makers and officials</td>
<td>RSD</td>
</tr>
<tr>
<td>10.09.2013</td>
<td>Presentation for the UK embassy in Denmark</td>
<td>Presentation</td>
<td>Danish decision makers</td>
<td>RSD</td>
</tr>
<tr>
<td>20.09.2013</td>
<td>Presentation at Nordic Authority conference</td>
<td>Presentation</td>
<td>Employees at Nordic Health Authorities</td>
<td>RSD</td>
</tr>
<tr>
<td>21.10.2013</td>
<td>Presentation at Kick off conference on the patient pathway for cancer</td>
<td>Presentation</td>
<td>Directors, Staff working with cancer patients, GPs, Municipalities, Hospitals, Patients associations</td>
<td>RSD</td>
</tr>
<tr>
<td>23.10.2013</td>
<td>Presentation at UNIK conference</td>
<td>Presentation</td>
<td>Regions, KMD; IBM, Universities, DAK-E, Alexandra Institute</td>
<td>RSD</td>
</tr>
<tr>
<td>24.10.2013</td>
<td>Presentation for the innovation committee</td>
<td>Presentation</td>
<td>Political board for innovation</td>
<td>RSD</td>
</tr>
<tr>
<td>29.10.2013</td>
<td>Edinburgh telemedicine conference</td>
<td>Presentation</td>
<td>Healthcare delivery organisations, governmental leaders, clinicians, researchers and university faculty</td>
<td>RSD</td>
</tr>
<tr>
<td>31.10.2013</td>
<td>Conference call with Informa</td>
<td>Presentation</td>
<td>Informa Analysis Company</td>
<td>RSD</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Participation manner</td>
<td>Target audience</td>
<td>Partner</td>
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</tr>
<tr>
<td>01.11.2013</td>
<td>Presentation at conference on initiatives on telemedicine in the regions</td>
<td>Presentation</td>
<td>Experts, health care providers, decision makers, consultants</td>
<td>RSD</td>
</tr>
<tr>
<td>08.11.2013</td>
<td>Presentation for the CEO of Odense University Hospital</td>
<td>Presentation</td>
<td>CEO of OUH, doctors, municipalities</td>
<td>RSD</td>
</tr>
<tr>
<td>09.11.2013</td>
<td>World Congress on Integrated Care</td>
<td>Workshop, session, plenary discussion</td>
<td>National and international scientists, public organisations and private providers</td>
<td>Empirica, RSD, IFIC</td>
</tr>
<tr>
<td>12.11.2013</td>
<td>Presentation for hospital in Southern Jutland</td>
<td>Presentation</td>
<td>Directors and employees</td>
<td>RSD</td>
</tr>
<tr>
<td>12.11.2013</td>
<td>Presentation at Esbjerg hospital</td>
<td>Presentation</td>
<td>Politicians</td>
<td>RSD</td>
</tr>
<tr>
<td>21.11.2013</td>
<td>Presentation for the regional diabetes committee</td>
<td>Presentation</td>
<td>Doctors, GPs, Hospitals and municipalities working with diabetes patients</td>
<td>RSD</td>
</tr>
<tr>
<td>25.11.2013</td>
<td>Presentation for the department for health collaboration</td>
<td>Presentation</td>
<td>Health actors</td>
<td>RSD</td>
</tr>
<tr>
<td>02.12.2013</td>
<td>Presentation at Esundsobservatoriet</td>
<td>Presentation</td>
<td>Danish Health Care contributors, including private companies and public organisations</td>
<td>RSD</td>
</tr>
<tr>
<td>13. - 15.4.2013</td>
<td>WoHIT</td>
<td>Presentation</td>
<td>Hospital executives, hospital CIOs, government officials, healthcare practitioners, IT professionals</td>
<td>RSD</td>
</tr>
<tr>
<td>09.05.2013</td>
<td>Welfare Development Seminar</td>
<td>General introduction of the project, aims, targets, structure of project</td>
<td>Welfare system workers, social workers</td>
<td>Tallinn &amp; ETCH</td>
</tr>
<tr>
<td>22.05.2013</td>
<td>Conference “Telemedicine possibilities for hospitals”</td>
<td>General introduction of the project, aims, targets, structure of project</td>
<td>Welfare system workers, social workers, hospital leaders</td>
<td>ETCH</td>
</tr>
<tr>
<td>30.05.2013</td>
<td>Conference “How to build community based social services in cities for vulnerable groups”</td>
<td>General introduction of the project, aims, targets, structure of project</td>
<td>Policy makers, social work leaders</td>
<td>Tallinn</td>
</tr>
<tr>
<td>01.10.2013</td>
<td>Conference “Festival of the elderly”</td>
<td>General introduction of the project, aims, targets, structure of project</td>
<td>Estonian elderly</td>
<td>Tallinn &amp; ETCH</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Participation manner</td>
<td>Target audience</td>
<td>Partner</td>
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<td>------------</td>
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<td>---------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>13.12.2013</td>
<td>Welfare Seminar 2014+</td>
<td>General introduction of the project, aims, targets, structure of project. Outcomes-raising the awareness of participants, presentation of new ideas,</td>
<td>Department of International Projects, Ministry of Social Affairs, social workers, other interest groups</td>
<td>Tallinn &amp; ETCH</td>
</tr>
<tr>
<td>05.02.2014</td>
<td>Monthly Meeting of Social Welfare and Health Care Department</td>
<td>overview of project development</td>
<td>Social work coordinators, other interest groups</td>
<td>Tallinn &amp; ETCH</td>
</tr>
<tr>
<td>28.02.2014</td>
<td>Integrated Care Partnership Committees</td>
<td>Organiser, host</td>
<td>Representatives from health and social care providers including; GPs, Pharmacists, Clinical staff from local Healthcare Trusts, service users and carers as well as representatives from the voluntary and community sectors</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>21.02.2014</td>
<td>Clinical leadership development workshop</td>
<td>Organiser, host</td>
<td>Medical and pharmacy leaders involved in Integrated Care Partnerships</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>27.01.2014</td>
<td>ICP Stakeholder Reference Group</td>
<td>Organiser, host</td>
<td>Stakeholder organisations</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>16.12.2013</td>
<td>Regional Risk Stratification Group</td>
<td>Organiser/Host</td>
<td>Healthcare staff from across the service</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>10.02.2014</td>
<td>ICP Project Team</td>
<td>Organiser/Host</td>
<td>Representatives from health care organisations across the province</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>22.01.2014</td>
<td>ICP Project Board</td>
<td>Organiser/Host</td>
<td>Senior Managers /Directors from across the Health System</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>09.12.2013</td>
<td>ICP Workshop for the Third Sector</td>
<td>Lead Contributor</td>
<td>Members of the community and voluntary sector across Northern Ireland</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>13.01.2014</td>
<td>ICP Pharmacy Workshop</td>
<td>Organiser/host</td>
<td>Community Pharmacists involved with ICPs</td>
<td>Northern Ireland</td>
</tr>
<tr>
<td>28.06.2013</td>
<td>Barcelona workshop</td>
<td>Presentations, workshop organisation</td>
<td>European regions, policy makers, researchers</td>
<td>IFIC, RSD, empirica, FVG, HIM SA</td>
</tr>
<tr>
<td>01.07.2013</td>
<td>Third Annual International Congress on Telehealth and Telecare</td>
<td>Presentation</td>
<td>Care practitioners, managers, ICT managers, service improvement managers, telehealth and telecare industry suppliers, service users, policy-makers</td>
<td>IFIC</td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td>Participation manner</td>
<td>Target audience</td>
<td>Partner</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>07.06.2013</td>
<td>EIP-AHA B3 Action Group meeting</td>
<td>Attendance &amp; networking</td>
<td>Managers, service improvement managers, policy-makers, researchers</td>
<td>IFIC, empirica</td>
</tr>
<tr>
<td>07.11.2013</td>
<td>Pre-conference workshop at International conference on integrated care</td>
<td>Workshop organiser, moderator, presenter</td>
<td>Care practitioners, managers, ICT managers, service improvement managers</td>
<td>Empirica, IFIC, RSD</td>
</tr>
<tr>
<td>24.09.2013</td>
<td>Session with EIP AHA at AAL Forum 2013 in Norrköping</td>
<td>AAL Forum Side Event</td>
<td>European regions, policy makers, researchers, industry, service providers</td>
<td>empirica</td>
</tr>
<tr>
<td>01.07.2013</td>
<td>Presentation &quot;SmartCare: a breakthrough in integrated care&quot; at the Telehealth and Telecare congress organised by the King's Fund</td>
<td>Presentation</td>
<td>Policy makers, researchers, industry, service providers</td>
<td>HIM SA</td>
</tr>
<tr>
<td>21.11.2013</td>
<td>Presentation &quot;SmartCare: a breakthrough in integrated care&quot; at the XI Reunión del Foro de Telemedicina y la II Reunión de la Plataforma Tecnológica para la Innovación en Salud</td>
<td>Presentation</td>
<td>Service providers, industry, healthcare managers</td>
<td>HIM SA</td>
</tr>
<tr>
<td>11.11.2013</td>
<td>Presentation of tele-assistance for elderly people at the Kos Annual Convention</td>
<td>Presentation</td>
<td>Elderly and health care managers</td>
<td>HIM SA</td>
</tr>
<tr>
<td>16.10.2013</td>
<td>Presentation &quot;Da DREAMING a SmartCare&quot; at the Smart City Exhibition</td>
<td>Presentation</td>
<td>Service providers, industry, healthcare managers</td>
<td>HIM SA</td>
</tr>
<tr>
<td>17.10.2013</td>
<td>Presentation &quot;Da DREAMING a SmartCare&quot; at the conference &quot;L'Anziano e la Tecnoassistenza, Il Servizio Sanitario Nazionale e l'Industria&quot;</td>
<td>Presentation</td>
<td>Policy makers, researchers, industry, service providers</td>
<td>HIM SA</td>
</tr>
</tbody>
</table>
Figure 25: Workshop at International Conference on Integrated Care in Singapore 2013

Figure 26: Panel discussion at International Conference on Integrated Care in Singapore 2013

Figure 27: Panel discussion at Plataforma Tecnológica para la Innovación en Salud
D9.1 First report on dissemination and exploitation activities

The list of conferences presented below includes events that are seen as important events where SmartCare needs to be present. Empirica takes care of monitoring deadlines for these conferences, and circulates an invitation to SmartCare partners to submit papers on time. However, as for all dissemination means, this depends on the active engagement of all project partners.

In order to monitor deadlines for other relevant events, SmartCare uses an events collection template which is circulated to all project partners. This is used to report relevant events to the dissemination manager.

Table 6: Suggestions for obligatory conferences

<table>
<thead>
<tr>
<th>Rank</th>
<th>Title</th>
<th>Link</th>
<th>Main Focus</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>International Conference on Integrated Care</td>
<td><a href="http://www.integratedcarefoundation.org/">www.integratedcarefoundation.org/</a></td>
<td>Integrated care (without ICT component), chronic disease management, patient-centered care</td>
<td>Annual/Spring</td>
</tr>
<tr>
<td>1</td>
<td>Annual International Congress on Telehealth and Telecare</td>
<td><a href="http://www.kingsfund.org/events">www.kingsfund.org/events</a></td>
<td>Telehealth, telecare, integration, evaluation, telemedicine, care for people with chronic conditions, ehealth</td>
<td>Annual/Summer</td>
</tr>
<tr>
<td>2</td>
<td>IAGG World Congress</td>
<td><a href="http://www.iagg2013.org">http://www.iagg2013.org</a></td>
<td>Gerontology, homecare, care in nursing homes, mobility (decline), cognitive functions, loneliness, inequality, active ageing, dementia, psychological well-being</td>
<td>Every four years/Summer (next in 2013)</td>
</tr>
<tr>
<td>1</td>
<td>International Telecare and Telehealth Conference</td>
<td><a href="http://www.telecare.org.uk/conference">http://www.telecare.org.uk/conference</a></td>
<td>Telehealth, telecare, integration, chronic disease management, large exhibition</td>
<td>Annual/Winter</td>
</tr>
<tr>
<td>1</td>
<td>ISG</td>
<td><a href="http://www.ogerontechnology.info">http://www.ogerontechnology.info</a></td>
<td>Gerontechnology, AAL, robotics, ICT for informal care, mobility support, dementia support, support of ADs, assistive technology, homecare...all with ICT component</td>
<td>Every two years/Spring (next in 2014)</td>
</tr>
<tr>
<td>2</td>
<td>eTeledoro</td>
<td><a href="http://www.varia.org/">http://www.varia.org/</a></td>
<td>E-health data records, eHealth technology and devices, Telemedicine/telehealth applications, clinical telemedicine</td>
<td>Early Spring</td>
</tr>
<tr>
<td>1</td>
<td>World of Health IT</td>
<td><a href="http://worldofhealth.org">http://worldofhealth.org</a></td>
<td>EHealth, ICT-supported social care, large exhibition</td>
<td>Annual/Spring</td>
</tr>
<tr>
<td>2</td>
<td>AAL Forum</td>
<td><a href="http://www.aalforum.eu/">http://www.aalforum.eu/</a></td>
<td>Ambient Assisted Living, ICT-based solutions for: mobility, dementia, social interaction, daily living support, living with chronic conditions, informal carer support, robotics</td>
<td>Annual/Autumn</td>
</tr>
<tr>
<td>2</td>
<td>ESN Conference</td>
<td><a href="http://www.esn-eu.org/home/index.html">http://www.esn-eu.org/home/index.html</a></td>
<td>ESN is a network of Member organisations which are associations of directors of social services; regions, provinces, counties and municipalities; funding and regulatory agencies, universities, research &amp; development bodies serving closely with public authorities in the development of social services. Usually the conference has a dedicated strand focusing on ICT in social services.</td>
<td>Annual/Summer</td>
</tr>
<tr>
<td>2</td>
<td>EHTEL annual symposium</td>
<td><a href="http://www.ehtel.org/activities/ehtel-symposium">http://www.ehtel.org/activities/ehtel-symposium</a></td>
<td>EHTEL: eHealth Focal Point for Europe. Founded in 1999, EHTEL (the European Health Telematics Association) is a pan European multi-stakeholder forum providing a leadership and networking platform for European corporate, institutional and individual actors dedicated to the betterment of healthcare delivery through eHealth.</td>
<td>Annual/Winter (and Nov-early Dec)</td>
</tr>
<tr>
<td>2</td>
<td>Med-e-Tel</td>
<td><a href="http://www.medetel.eu">http://www.medetel.eu</a></td>
<td>INTERNATIONAL eHEALTH, TELEMEDICINE AND HEALTH ICT FORUM For Education, Networking and Business: Med-e-Tel is an official event of the International Society for Telemedicine &amp; eHealth (ISfTeH), THE international federation of national associations who represent their country's Telemedicine and eHealth stakeholders.</td>
<td>Early-mid April</td>
</tr>
</tbody>
</table>

5.7 Videos

Project videos are published via YouTube and the SmartCare website to reach the widest possible audience. Videos are produced according to standards that allow their use in TV broadcasts to become part of the project’s media relation activities.

In the first project year, altogether five videos have been published: three deployment site videos, one on user requirements, and the last on a consortium meeting in Brussels.

Pilot stories: The videos are about 10 minutes long on average, and present an overview of the SmartCare service at each of the ten pilot sites. This is complemented by interviews with the SmartCare team onsite on the one hand, and the care professionals / teleoperators or case managers who use the new SmartCare service on the other. They explain what SmartCare in their view brings to the patients, and how it has changed their working processes. This way, the viewer of the videos gets a comprehensive and lively impression of each SmartCare service. This is an excellent add-on to the use cases and service descriptions that are also available on the website.

Video reports from meetings and events: In the first project year, one special video was developed and published showing a summary of one of the consortium meetings in Brussels. Key project people were interviewed and gave short statements about the progress of SmartCare. A second video showing the workshops and sessions organised at the International Conference on Integrated Care in Singapore is currently under preparation.
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Video on user requirements: Following the first dissemination theme on “service requirements”, a video was recorded at the workshop organised by AER at MIHealth in Barcelona. Prof. Michael Rigby was interviewed on user/informal carer needs in relation to integrated care.

A dedicated intro and outro was developed for SmartCare, accompanied by the SmartCare song.

Figure 28: SmartCare video intro and outro

Figure 29: SmartCare video Friuli- Venetia Giulia
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Figure 30: SmartCare deployment site videos

Figure 31: Publication of video on the SmartCare website

5.8 Roll-up

A roll-up banner was developed by AER and distributed to all partners for use at conferences, workshops and other events.
5.9 Social media presence

Social networks are used to flank dissemination efforts in order to reach a wider audience and to facilitate the dialogue with relevant stakeholders. In the past few years, social networks (on the global scale, particularly LinkedIn, Twitter, Google+) have had a major impact on how people interact online and have attracted users in the millions.

A twitter feed @pilotsmartcare was established and a common hash tag for project partners identified.
Through regularly publishing tweets, the project as a whole has so far attracted 107 followers amongst which are high-profile follower such as IFIC, BeyondSilos, CareWell, INTEGRATE, EIP AHA, ICT 2013 EU, AGE, IROHLA, EPF.

Further to this, a LinkedIn discussion group was initiated by dissemination topic 1 leader.

Figure 34: LinkedIn discussion initiated by AGE
6. SmartCare Advisory Boards

6.1 Summary

SmartCare avails itself of four advisory boards representing the voice of four extremely relevant groups of stakeholders: Users, European Regions, scientific experts and industry. The advice and recommendations from the various Advisory Boards is not compelling, but is thoroughly considered by the consortium and its management which, in case it does not follow the advice and recommendations, has to justify the reasons why they have not been followed. The Committed Regions Board is an exception to this rule, because its role is not that of an advisor, but it collaborates very closely with the regions hosting the SmartCare pilots. The four project advisory boards are:

- Users’ Advisory Board (UAB)
- Industry Advisory Board (IAB)
- Internal Scientific Board (ISB)
- Committed Regions Board (CRB)

All advisory boards have been formally constituted in the first reporting period, and meetings held in order to develop and finalise working schedules, roadmaps and means of cooperation.

6.2 User Advisory Board

The User Advisory Board (UAB) was set up to act both as advisors and quality assurance to the project, and as liaison at European and national level through their organisation and networks. Six members from organisations representing the interests of older people and other potential end users of SmartCare, such as informal carers or professional carers were selected for the UAB. A briefing document and terms of reference were developed that served as input for the first meeting of the UAB held in M4, during which the members were introduced to SmartCare. Board members agreed on the terms of reference, including specification of work tasks of the Board, operational modes and meeting schedule. The documents specify amongst others work-tasks and cooperation modes throughout the whole of the project. A series of meetings was also scheduled at the first UAB meeting.

In Reporting Period 1, the members of the UAB were involved in different project activities. They have commented on and revised the project flyer as well as text for the website. They are members of the editorial team for the first dissemination topic “Requirements for integrated eCare”, and have in this role produced various texts for the SmartCare website. Further to this, members of the UAB have revised D1.1 Requirements for SmartCare Pathways and Integration Infrastructure and D10.2 Ethics and Data Protection Framework.

6.3 Industry Advisory Board

The Industry Advisory Board (IAB) advises the project on the technical issues which are relevant for the implementation of the pilots and for the further deployment of services.

The IAB is chaired by Continua Health Alliance which designated a person from its staff to co-ordinate this Board. In Reporting Period 1, activities of the IAB have been conducted by Continua itself, and included the technical architecture of the services and standards to ensure openness and scalability. More specifically, Continua were strongly involved in the
preparation of D3.1 Pilot Level Service Specification and D3.2 SmartCare Service Specification. Several meetings between Continua and the WP3 leader IFIC were held in the reporting period.

6.4 Internal Scientific Board

The Internal Scientific Board (ISB) is chaired by the Scientific Coordinator (HIM SA). It constitutes a Board with responsibilities to discuss and decide on overall project evaluation issues, and develop a scientific dissemination strategy. Activities of the ISB have been initiated by the Scientific Coordinator together with the WP8 leader on evaluation. All deployment regions have nominated a scientific manager. Bi-weekly conference calls with first wave deployments sites, WP8 and WP9 leader have taken place in order to progress and discuss evaluation protocols, methods and time planning of evaluation (WP8) and socio-economic impact assessment (WP9) activities. Further to this, a roadmap document on change management has been developed and discussed with the deployment sites. They have all initiated change management processes within the framework of WP1 and WP2 work. The leader of dissemination work has closely cooperated with the ISB, and a draft scientific dissemination strategy was included in the overall communication and dissemination plan.

6.5 Committed Regions Board

An initial roadmap was developed for the Committed Regions Board (CRB) in cooperation with AER, the leader of the CRB, and circulated among key project partners. The roadmap includes work-tasks and cooperation modes of the CRB throughout the whole of the project. A first workshop was organised in M4, where the CRB manager AER and other SmartCare partners presented SmartCare objectives and initial pathways to a range of AER regions. The CRB kick-off meeting took place in M10, where the WP1 templates were explained in detail, and CRB regions had the opportunity to ask questions and comment. Further to this, the overall roadmap that guides CRB work throughout the whole project was presented by CRB manager AER and next steps agreed. As part of WP1, members of the CRB were invited to complete a research template to initially identify the regulatory/legislative situation in relation to their region.
## 7. Cooperation with EIP AHA B3 Action Group on Integrated Care

A strong cooperation with (members of the) EIP AHA B3 Action Group took place during the first project year. First of all, means and topics of cooperation were identified with the B3 Action group leader NHS24. Topics identified that lend themselves as topics for networking, learning and synergies included amongst others: pathways, change management, user empowerment, and ICT.

A series of workshops with members of European Innovation Partnership on Active and Health Ageing (EIP AHA) B3 and C2 at the AAL conference in Norrköping were developed, organised and conducted. This free interactive side event engaged participants in understanding and providing their own insights into the potential of ICT solutions to integrate care and support person-centred care, including home care. Through case study examples of innovative person-centred services, the event specifically examined two main topics: the challenges and barriers that have hindered the scaling up of integrated care and self-care, and solutions for independent living at regional and national levels. It also explored the success strategies for accelerating the wider adoption of eHealth solutions. The event comprised four different workshops, each one focusing on a different aspect of the EIP on AHA B3 and C2 Action Group activities

- Multi-actor collaborative care pathways.
- User empowerment.
- Change management.
- ICT / Teleservices / eHealth.

A next joint workshop was organised at the international conference on integrated care in Berlin in April 2014, organised by IFIC and supported by the SmartCare project.

<table>
<thead>
<tr>
<th>Workstream</th>
<th>IFIC Deliverables</th>
<th>SmartCare Deliverables</th>
<th>Reporting Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.1</td>
<td>Organisational and service requirements, operational ecosystems, incentives &amp; business cases</td>
<td>D1.1</td>
<td>Available soon after SmartCare launch</td>
</tr>
<tr>
<td>A.2</td>
<td>Service process models in D2.1</td>
<td>D2.1</td>
<td>Available soon after SmartCare launch</td>
</tr>
<tr>
<td>A.3</td>
<td>Deployment guidelines in D9.3</td>
<td>D9.3</td>
<td>Finalised in Feb 2015</td>
</tr>
</tbody>
</table>

Figure: EIP AHA B3 Action Group and SmartCare mapping exercise

A detailed analysis was conducted in order to identify common topics and goals, as presented in the figure above. Following this, a conference call between empirica and B3 Action group leaders took place to organise bilateral conference calls between all action...
D9.1 First report on dissemination and exploitation activities

area leaders within B3 and empirica, and attendance of empirica at B3 monthly phone calls.
8. Pilot site networking

During the projects start-up phase, pilot site networking activities focused on mutual exchange by means of a number of meetings, and on defining further networking means in collaboration with the pilot site teams. This started with a dedicated workshop held in Trieste where deployment site teams exchanged experiences in relation to pathway and use case development, as well as requirements elicitation. The workshop was attended by first and second wave deployment sites to enable mutual learning across all sites. The workshop was followed by two meetings held in Brussels to continue mutual exchange on use case development and implementation requirements. The deployment site teams also started to exchange approaches to dissemination. Apart from networking among deployment sites from first and second wave, and ensuring the smooth transition of lessons learned in first wave sites to second wave sites, networking activities also concern knowledge and experience transfer between deployment regions, CRB regions and regions external to the consortium but involved in CRB activities. Further to this, each deliverable in SmartCare includes a dedicated section on experiences gained and lessons learned, ensuring a structured collection of lessons learned and timely transition to other deployment sites / CRB regions, as appropriate.

Further networking means were developed in collaboration with the deployment sites and described in a draft networking plan.
9. Monitoring and reporting of dissemination activities

A dissemination reporting template has been developed and circulated to all partners for reporting of dissemination activities. It is circulated twice a year. The reporting template (see figure below) includes instructions on how to complete the template and facilitates overall reporting of dissemination activities.
10. References


