DELIVERING INTEGRATED CARE TO FRAIL PATIENTS THROUGH ICT
CareWell will enable the delivery of integrated healthcare to frail elderly patients through comprehensive multidisciplinary programmes. ICTs will facilitate the coordination and communication of healthcare professionals and support patient-centred delivery of care at home.

**WHAT IS CAREWELL ABOUT?**

CareWell supports the integration of care in six European Regions. The regions share the aim of improving support for frail elderly patients through multidisciplinary programmes facilitated by ICTs. A shared approach, mutual learning and evaluation are expected to create synergies among the partners and to bring forward integration of care in Europe.

CareWell will focus on the provision of care and support to older people who have complex health and social care needs, are at high risk of hospital or care home admission and require a range of high-level interventions due to their frailty and multiple chronic diseases. This will be achieved through ICT
WHAT IS CAREWELL ABOUT?
enabled health and social care services coordination, monitoring, patients’ self-management, and informal care givers’ involvement. The ICT platforms and communication channels will avoid duplication of effort when dealing with patients’ diagnostic, therapeutic, rehabilitation, or monitoring and support needs. Additionally, ICT-based platforms can improve treatment compliance, enhance self-care and self-management, and increase awareness of the patient’s health status. All of which will improve clinical outcomes and enable people to lead fulfilled lives. In addition, technologies will support the patients’ informal caregivers, highlighting when respite care or additional professional input is required.

**DOMAINS OF AN INTEGRATED APPROACH TO FRAIL PATIENTS**

**Health System**

Patient identification and target group management

1. **Integrated care coordination pathway**

   Social and health care coordination/communication and information sharing
The two CareWell services are based on two pathways supported by ICT:

- integrated care coordination and
- patient empowerment & home support.

These care pathways will cut across organisational boundaries and ensure that healthcare resources are more efficiently and effectively used. Information sharing will comply with European and national regulations relating to consent and privacy. The ICT platform will be based, wherever possible, on open standards and multi-vendor interoperability and collaboration among ICT suppliers will be strongly encouraged.
WHO IS INVOLVED?

CareWell supports the integration of care in six European Regions. These regions aim to demonstrate the viability of its integrated services. They implement and test the interconnection of different ICT systems and complement existing systems with new ones where this aids patients and professionals. These six European regions aim to be lighthouses and good learning examples for other regions in Europe.

BASQUE COUNTRY, SPAIN

In Carewell, the deployment of telehealth among frail elderly patients will be promoted as well as the use of the Personal Health Folder where patients can access their own health reports, appointment calendar and information on self-management. Moreover, coordination between healthcare professionals will be boosted by using videoconferencing and programming workflows of integrated care pathways in the CRM.
APULIA, ITALY
The Integrated Care Coordination Pathway will be realized through multi-professional care and the use of ICT tools. These tools will integrate social services by connecting municipalities with local health authorities. Physicians, nurses, pharmacists, AHPs and patients will all be involved. New software components, namely a videoconferencing tool, will be introduced in order to enable tele-consultation. The Patient Empowerment and Home-support Pathway will help patients to remain at home through continuous ICT-supported follow-up including: telemonitoring, patient access to personal data, education and self-management, improved communication and coordination.

VENETO REGION, ITALY
ULSS N.2’s integrated care programme will target patients affected by multiple chronic diseases with a need for frequent care and recurrent and regular monitoring. The coordination of these services relies on the improvement of networking between the numerous professionals. The different care services (hospital, home and social care) will be coordinated by a case manager and an integrated case record. The needs of patients will be analysed through shared and codified tools in a multidimensional assessment. Each assessment leads to a personalised project of integrated care.

ZAGREB, CROATIA
In the region of Zagreb plans are underway to introduce new and innovative healthcare ICT tools and work procedures within the Field Nurse service – already existing as an active part of the healthcare service delivery system in Croatia. Work will focus on better coordination of the healthcare workers providing services to multi-morbid, frail chronic patients in out-of-hospital environments, as well as patient empowerment and education with the goal of changing patients’ lifestyles and enabling them to take an active role in their treatment.

LOWER SILESIA, POLAND
In CareWell LSV Marshal’s Office plans to realize a ‘Patient-Centred’ healthcare approach. High quality care can be ensured by effective collaboration among healthcare professionals. To support active and healthy ageing at home, health care team members will be assigned specialised roles in the treatment process. For this approach to work professionals will be informed of changes in their patients’ treatment. Clinical Guidelines and personalisation are the two guiding principles clinicians must be attentive to.

POWYS, WALES, UK
For the Integrated Care Coordination Pathway mobile communication devices will enable community workers to share health and social care information in a live environment across community services, alongside wide access to a local directory of services and improved communication links between hospital doctors and GPs. For the Patient Empowerment and Home Support Pathway remote telemonitoring will be introduced and patient access to education materials, will improve patients’ health literacy and self-care. The Health Board’s video consultation approach will be enhanced to include patients in their own homes.
CONTACT
Ane Fullaondo Zabala, project coordinator
Torre del BEC (Bilbao Exhibition Centre)
Ronda de Azkue 1 – 48902 Barakaldo - Spain
phone +34 944 007 790
carewell@carewell-project.eu

www.carewell-project.eu