*Commitment**	*Action**	*Denominazione Ente/Organizzazione/ Azienda*	*Tipo di struttura**	*Regione di provenienz**	*ersona di contatt*	*Breve rissunto della Action*	*Lista dei partner*	*Stato dell'arte*
1°	A1	AIFA	Pubblica	Lazio	Pecorelli Sergio	Tackling non-adherence requires a multi-stakeholder, patient-centered approach including interventions aiming to ensure optimal drug prescribing, good patient-physician relationships and improvement of patients health literacy and empowerment. The project will be led by AIFA and its scientific content is fully supported by European Medicines Agency's (EMA). It is structured in a four principle sub-actions with a common objective - the improvement of adherence to the prescribed treatment in older patients at regional level: 1. Monitoring adherence through the utilization of observatories and databases: AIFA in collaboration with IRCCS San Raffaele Pisana, Rome and The University of Florence and The University of Groningen. 2. Monitoring adherence through electronic tools and alerting systems: Università Cattolica del Sacro Cuore at Policlinico Gemelli of Rome; Gestione Sistemi per l'Informatica-GESI; University of Bologna; Merck Serono; National Centre for Scientific Research-NCSR, Greece. 3. Piloting adherence programs with use of elderly-friendly devices and medicine products and development of information/awareness and health literacy strategies, including life-style recommendations:Philips Research; European Generic medicines Association-EGA; Merck Serono; European Patients' Forum –EPF; GlaxoSmithKline-GSK. 4. Public-Private collaborative and innovative organizational models for pro-active care: GSK; ASL Brescia.		
1°	A1	Università Federico II, Facoltà di Farmacia, CIRFF	Pubblica	Campania	Enrica Menditto	The project aims to develop and operate a remote monitoring and early warning system that can improve adherence to treatment of chronic diseases in the primary care. A General Practitioner who is aware of the level of adherence of their patients to chronic therapies of interest (i.e. heart failure, hypertension, osteoporosis and its complications), may act intensively to improve the level compliance, if necessary. Therefore, the project aims to develop, from administrative/clinical databases, an algorithm to identify indicators of levels of adherence and persistence to the treatment and predictors of discontinuation (i.e. demographic, clinical and therapeutic characteristics). The algorithm will result in a score identifying the intervention level for each patient. Subsequently, an early warning system will be designed to allow rapid and effective communication between the doctor and his high intervention level patients.	Research and Development Unit, Federico II University Hospital of Naples Coordinating Office to the Sub-Commissar for the Health Department, Campania Region Department of Clinical and Molecular Endocrinology Federico II Unina University Hospital, University of Salerno.	Abbiamo raccolto dati dalla Agenzia Regionale Sanitaria e creato un database della popolazione già pronto per essere utilizzato. Attualmente stiamo definendo un gruppo di studio, che si concentri su osteoporosi, ipertensione diabete, CHF. E' in cantiere l'ideazione di una piattaforma.
1°	A1	FBK/P.A. Trento	Pubblica	Trentino-Alto Adige	Nollo Giandomenico	In order to tackle diabetes, APSS has so far adopted a traditional approach, being it managed at the point of acute need, a hospital specialized Centre (CAD). Indeed, the difficult task of delivering the complex treatment plans, including both the medication management and all actions required to empower individuals to take a greater control of their own health through self-care, is being performed outside the CAD, with limited overall coordination. In order to improve outcomes in diabetic patients, APSS recently decided to expand its focus to cover patient's needs outside CADs, both before and after episodic consultations, by implementing a multidisciplinary and integrated program for diabetes management. In supporting this change, APSS is adopting two major enablers: i) a Diabetes integrated care program and ii) a recently developed Information System (TreC) which provides more complete electronic care records. The integrated care program consists in a shared, evidence-based, diagnostic and therapeutic pathway. The second enabler, TreC, is a comprehensive platform which is already implemented alongside other IT systems (e.g. Hospital IS, EM Rs used by GPs), for collecting daily observations by the patient (or caregivers) and to provide specific functionalities for self-care. Further developing this platform in the context of Diabetes and other chronic conditions is a task assigned by APSS and other stakeholders within the remit of action B3.	Fondazione Bruno Kessler (FBK); Provincia Autonoma di Trento; Provincial Medical Council; Graduate school of General Practitioners; patients associations, University of Trento, local industries.	In una area geografica limitata, come il centro per diabetici della Val di Non, è stata avviata la terapia combinata localizzata. Attraverso strumenti di autodiagnosi il paziente è continuamente monitorato e può compiere azioni medicali in autonomia. L'appalto di gara per la fornitura di tali strumenti è appena stata assegnata. Occorrerà un periodo di formazione e ai pazienti per imparare l'utilizzo di tali strumenti ed un sucessivo monitoraggio. Sono coinvolti, attualmente 10 medici x 100 pazienti di cui almeno il 10% avranno una comorbilità alla cura (scompensi cardiaci). In tal caso servirà cambiare gli strumenti utilizzati. Affianco a questi strumenti si pone anche la diffusione di sani stili di vita sempre attraverso il portale.
1°	A1	Centro Universitario Ricerca Interdipartimentale Attività Motoria –CURIAMO	Pubblica	Umbria	De Feo Pierpaolo e Caracciolo Maria Ragano	Quality lifestyles are generally considered by the scientific community essential to prevent and cope elderly diseases. It is is necessary to realize a complete action plan constituted of an in-depth background analysis, a user friendly health behaviour tool kits and a transferable experienced active ageing model to spread an effective health life culture. People can be approached and committed to a virtuous change of personal life styles if directly called to defeat own sedentary tendency. The emulation effects of this commitment are enhanced by a social environment of participants to outdoor activities. In such a way the medical approach is not perceived as external and aseptic but as an important added value to own health condition. The positive concrete results after the "on the road" trials areparticularly able to encourage physical activity and health diet day by day. HAPPY WALK project is a 2 years model experience based on i) a model to motivate middle age and older people with or without chronic disease to healthy lifestyles and to improve their physical performance in order to participate to organized outdoor activities, ii) training for health operators from different EU countries, iii) evaluation of results and transferability of the experienced model in collaboration with academic institutions, elderly associations and research centres specialized in health lifestyles and prevention of ageing diseases, iv) dissemination of the results		
1°	A2	Agenzia Sanitaria e Sociale Regionale (ASSR)	Pubblica	Emilia Romagna	Antonio Addis	Building on a number of seminal regional initiatives involving different Local Health Authorities (LHAs), research institutions and industrial stakeholders, this action aims to establish a regional network for falls prevention. The action will substantiate in the following steps, involving to different extents both inpatients and outpatients: 1) Collection, digitalisation, and retrospective analysis, within the FSE (Electronic Health Dossier) of relevant fall-related information (Registro Regionale Cadute, RRC); 2) Development and validation of a personalised fall risk model, integrating known fall risk factors, clinical balance measures, and parameters extracted from wearable inertial sensors through appropriate epidemiological methods and psychometrically sound techniques; 3) Deployment and evaluation of tailored ICT-based solutions for fall detection and prevention; 4) Classification of fall risk factors according to the International Classification of Functioning, Disability and Health (ICF) to allow interoperability among different clinical specialties and, in perspective, across European Regions; 5) Mapping of the identified fall risk model into an operational programme for the prescription of personalized interventions and/or ICT-based assistive devices for falls prevention and rehabilitation in community dwelling older subjects; intensive monitoring of high-risk patients at hospital discharge; specific training for personal carers of high-risk subjects.	Modena: operative units of Rehabilitation Medicine, Geriatrics, and Neurology; Forlì: operative unit of Geriatrics; the University of Bologna Health Sciences and Technologies Interdepartmental Center for Industrial Research (HST-ICIR); Industrial partners. EU State involved German: Stuttgart, Stadtkreis;	Il commitment regionale (PROFITER) ha sin qui consentito di 1- costruire una vasta rete di competenze cliniche multidisciplinari distribuite sul territorio regionale; 2- censire alcune delle numerose iniziative presenti sul territorio per la prevenzione delle cadute; 3- approntare strumenti innovativi, basati su tecnologie ICT, per il monitoraggio del movimento e la somministrazione di scale cliniche strumentate; 4-Iniziare il percorso per la costruzione di una base di conoscenze comune ed il possibile ancoraggio di futuri interventi e strategie preventive, comprendenti l'impiego di tecnologie wearable, nella cornice classificativa dell'ICF (OMS).
1°	A2	IRCSS Salvatore Maugeri	Privata	Lombardia	Ambrosini Emilia	A MULTIDISCIPLINARY TELEHEALTH INTERVENTION TO REDUCE FALLS AMONG OLDERS DISCHARGED FROM HOSPITAL Main objective of the proposal will be to evaluate the efficacy of a homebased intervention programme delivered by a multidisciplinary team through available information and communication technologies for chronic patients after hospital discharge. The proposal would answer to the following questions: • Is the programme more effective than usual care in preventing falls after hospital discharge? • Is the programme cost-effective compared to usual care when assessed from a societal perspective? All patients aged ≥65 years, with high risk profile of recurrent falling, will be enrolled by Telehealth during 1 year after the hospital discharged. The Telehealth program would consist of 3 steps: intervention, telemonitoring and tele-exercise. The care model provides 24/24 h 1 year-assistance with six months of high intensity and six-months of low intensity support. A nurse-tutor (NT) follows up patients through scheduled and occasional appointments performed by a nurse on duty in case of falls, symptoms, or any doubt about therapy occurred. Enrolled patients receive a wireless transmitter for emergency phone call. Moreover, remote monitoring of biometric parameters will be performed. The physical therapist will set-up a personal exercise programme on a DVD aimed at improving balance, flexibility, muscle strength and gait and carried out and monitored during a videoconference session. Home exercise program will be 2 times/week, lasting 40 minutes each time.		

1°	A2	Azienda Ospedaliera (AO) Città della Salute e della Scienza di Torino (Molinette) e di CSI-Piemonte (Consorzio per il Sistema Informativo)	Pubblica	Piemonte	Ylenia Sacco	ReFaCo (Regional Falls prevention Cooperation) is a regional initiative about prevention and monitoring of Falls in hospital focused on the cooperation between a pool of public health providers and hospitals coordinated by Azienda Ospedaliera (AO) Città della Salute e della Scienza di Torino (Molinette) of Turin with the technological support of CSI-Piemonte (Consortium for Information Systems). The initiative intends to develop a common and centralized monitoring systems trough the introduction of an integrated database collecting and sharing data and information about the Falls in hospital environment. The database includes information on intrinsic (related to the patient) and extrinsic risk factors (related to the environment) of Falls, mode and accident site, diagnostic tests and treatments provided and consequences of the Fall. It represents a first common and integrated solution shared among the largest local health providers and hospitals of the Piedmont territory. In perspective, this is the first step towards the setting up of a regional Falls Register extending to all public health providers and hospitals in Piedmont. The aim of the initiative is the total Fall risk monitoring, the construction of a data warehouse to guide decisions in the prevention of Falls and monitor the results of the implementation of organizational/technological actions.		
1°	A3	AOU Federico II	Pubblica	Campania	Illario Maddalena	"OSTEOCARE"- An integrated model of care, cure and prevention for frailty osteoporosis and its complications. It is often difficult for osteoporotic patients to enter an appropriate follow-up, that needs a multidimensional approach based on the integration of different specialties, properly fitted at the different levels of care. Taking into account that the majority of morbidity and mortality are caused by multifactorial diseases, the reduction of several risk factors may reset their prevalence. One of the main issues EU is facing is providing all EU citizen with equal access to equal standard care. An endocrinological network is already present in Campania, "ProgettoCaRE", that provides all doctors with a tool allowing the real-time consulting of the II and III level care structures operating in the territory. Osteoporosis is among the diseases managed by "ProgettoCaRE". Our action aims to establish a diagnostic and therapeutic route to prevent and reduce osteoporosis and the associated comorbidities, as well as 'preclinical' conditions such as sarcopenia, osteopenia, nonspecific balance disorders, endocrine and nutritional problems. The implementation of a shared diagnostic-therapeutic route would help fill in the gaps, would be achieved through local regional networks, allowing the identification of some 'preclinical' conditions, and the reduction of both mortality and disability, thus improving short and long term functional outcomes.		
1°	A3	Agenzia Sanitaria e Sociale Regionale (ASSR)	Pubblica	Emilia Romagna	Antonio Addis e Lara Calzà	The actual definition of "frailty" indicates a state of high vulnerability to negative health-related outcomes. Frailty definition is based on a scoring system related to physical fitness (weakness, slowness, poor endurance, weight loss and physical inactivity), not including mood and cognitive status. This is quite surprising in view of hypothesized molecular, physiological, and clinical pathway to frailty, of the high impact of cognitive status in the multisystemic decline and vulnerability, of the neuroendocrine and nutritional status on brain performance, on the role of neural input on sarcopenia, etc. This is also more evident in the attempt to develop sensitive and reliable approaches to detect prefrailty states among the senior population. This action aims to implement and validate a multi-level approach to screen senior population in order to identify cognitive pre-frailty and introduce new guidelines for pre- and frailty recognition. Screening (General Practitioners GPs, level 1) will be based on validated questionnaires of frailty and novel easy-to-use devices for clock-wise test and language corpora analysis. Data will be centralized using the SOLE platform and Regional Index of Clinical Events (IREC). Cognitive pre-frail subjects will access a second diagnostic level (biomarkers for inflammation, nutrition, endocrine profile), corrective action, and clinical warning for personalized analgesic, anxiolytic and antidepressant treatments and for anaesthesia ale.	Local Health Authorities in Emilia-Romagna Region (see in CHIANTI group coordinated by Tuscany Regional Health Agency supported by NIH/Nia, NeuroBioTech supported by Emilia Romagna Region, the PROVIDE study, Touch4Senior). Pharmaceutical industries (see clinical studies by Chiesi Farmaceutici SpA); CNA- National Craftsman Association ; Italian Minister for University, FIRB); EU State involved: Sweden: Stockholms län;	Questo gruppo di lavoro sta implementando (per poi validare) un approccio multi-livello per lo screening della popolazione anziana, al fine di 1) identificare la fragilità cognitiva utilizzando test cognitivi brevi basati su dispositivi ICT; 2) introdurre dispositivi personali e ambientali per la valutazione oggettiva della performance fisica; 3) introdurre nuove linee guida per il riconoscimento della pre-e fragilità anche attraverso indici personalizzati; 4) proporre nuove linee guida per la prevenzione secondaria e terziaria in funzione del rischio personalizzato di fragilità. Strumenti in via di sviluppo: Lo screening sarà basato su questionari validati della fragilità, implementati con i dati derivati da sensori indossabili e domestici per il monitoraggio della performance fisica, e con i dati derivati da test cognitivi brevi. Tali dati saranno centralizzati utilizzando la piattaforma SOLE (buona pratica regionale) e l'Indice Regionale degli Eventi Clinici (IREC).
1°	B3	CSI-Piemonte (Consorzio per il Sistema Informativo) con l'Azienda Sanitaria Locale del Verbano-Cusio-Ossola (ASL VCO)	Pubblica	Piemonte	Ylenia Sacco	TelMed VCO is a telemedicine project implemented in the Area Verbano Cusio Ossola (VCO) in Piedmont (Italy). It is a monitoring and assistance service "on-going" since 2009 for patients with chronic diseases or with stable care needs, remotely assisted at home. It permits to virtually connect experts, nurses, health operators etc. and it addresses different pathologies by integrating hospital, specialists and territory care services. The patients' monitoring follows the protocols for their specific illness, and it allows to give indications about how to proceed in the care. Patients can be directly contacted by their practitioners using videoconference. The telemedicine service provides a proved better health-care quality to people living in VCO mountain territory and it is focused on the most common pathologies associated to elderly: hyperthension, diabetes and cardiopathy. Since 2009 the project TelMed VCO has been sponsored yearly by the local Authorities (Regione Piemonte) despite the current scarcity of public financing resources, our commitment for 2012-13 is to maintain actively the service and to extend the monitoring field towards other pathologies and to other Piedmont's Areas.		
1°	B3	Agenzia Sanitaria e Sociale Regionale (ASSR)	Pubblica	Emilia Romagna	Antonio Addis	The Emilia-Romagna healthcare system is aware that in order to be more sustainable from a financial point of view, and thus, more targeted on the seniors' precise exigencies, the welfare state needed to undergo substantial variations through the re-organization of assistential pathways utilization of new technologies, provided that these tools are adequately supported and, in return, support the decisional and organizational processes. The aim of our commitment is to overcome the senior people's limitations in ADLs, with an integration of social and healthcare services. Given the characteristic of such population, the main action will consist in building a network for remote monitoring tools (for heart failure, diabetes, COPD, fall prevention, cognitive and functional decline), with the purpose of renewing the assistential pathway. The action will develop a collaborative model involving all social and healthcare-related workers (Local Health Authorities-LHAs, social services, third bodies such as call centers and service coordination structures), and with a special emphasis on informal carers (family support, substitutive figures).	LHAs of Bologna and Ferrara; the LHA of Reggio Emilia; the LHA of Piacenza; IRCCS of the LHA and the University of Bologna; the LHA of Parma; the LHA of Modena; the LHA of Cesena; the Montecatone Rehabilitation Institute. EU States involved: Austria: Wien; Belgium: Bruxelles; Czech Republic: Hlavní město Praha; France: Paris; German: Stuttgart, Stadtkreis;	Meetings / emails to contribute to the implementation of the EU B3 Action Plan (Deliverables, etc.) - Contacts with Agencies / Universities / Hospitals / Local Health Autorities of Emilia Romagna Region in order to define the insertion of collaborators in the ASSR B3 A.G. - Meetings with regional Pulmonologists and Nephrologists opinion leaders to explain the EIP on AHA B3 Plan - Contribution to the definition of the EU B3 Combined Work Plan Collection and delivering to EU B3 coordinators of some good care and organizational practices present in Emilia Romagna - Interfacing with the ASSR AG A2 and C2 team leaders to identify joint regional research projects
1°	B3	A.O.U.FEDERICO II	Pubblica	Campania	Iaccarino Guido e Natale Lara	We propose to generate an integrated, web-based network between the hospital, the outpatient clinic, general practitioners, territorial geriatrics, relatives and social assistant workers and volunteers to evaluate the impact of such organization on handling the high risk of the fragile elder patient. In our vision, the elder patient that is admitted in hospital is enrolled in a follow up program at discharge, that encloses a short term visit in the outpatient clinic soon after. Within this first visit, prescriptions are made for the elder patients that are conveyed to the general practitioner attending the patient, and the territorial network is alerted, including the territorial geriatric, the relatives of the patient, and the social workers and volunteers of the territory. All care and cure providers are given controlled access to a web-based database they can feed with new data regarding the patient after each visit. The purpose of such a network is the early identification of markers of evolution of the condition that if not corrected will lead to a new hospitalization. In this network, each stakeholder will be given controlled access to placing redflag alerts that will require the intervention from the hospital specialist, acting as the Case Master. The specialist will fill a new prescription, or require a new visit at the outpatient clinic of the hospital, or a new admission to the hospital, if required.		

1°	B3	Fondazione Democenter-Sipe	Privata	Emilia Romagna		Thanks to its network of partners, gathering Enterprises, Health care providers and advocacy organizations, Democenter acts as a collector of needs, ideas and knowledge rising from different fields. It supports the development of new projects dealing with chronic diseases, with a particular focus on dialysis treatment and pain management. The interest in dialysis topic spans from the new materials of devices and disposables to processes of cure, to telemedicine and integrated care systems. Democenter is strictly connected with the biomedical district of Mirandola, the most important BIOMED site in Europe. On the other hand, the attention for pain management stems from the strict collaboration with ISAL foundation, promoting research and therapy for chronic pain relief. Democenter commits itself at representing a bundle of stakeholders from a privileged perspective actively integrating with the ASSR. It is expected to take part to all the meeting initiatives for B3 action. Democenter as technology transfer centre, is committed to promoting research project,		
1°	B3	Fondazione Bruno Kessler (FBK) / P.A. Trento	Pubblica	Trentino-Alto Adige	Nollo Giandomenico /Piras Enrico Maria e Centonze Roberta	Since 2008 FBK has activated a Living Lab to design and implement TreC (www.trec.trentinosalute.net), a Personal Health Record aimed at providing the whole population of the Province with access to the services of local healthcare authority. TreC, tested by approx. 800 citizens, will be released to the general public by 2012. On top of this infrastructures, in 2011 we designed two dedicated applications for chronic condition (youth asthma, type 1 diabetes) and two pilot studies were activated to test new forms of personal health information management and sharing among patients, relatives and doctors. In 2012 we will start a pilot study on shared monitoring of elderly with type II diabetes. Building on on-going experiences and making use of the same digital and institutional infrastructure we will adopt a Living Lab approach and participatory design techniques to involve the key actors (elderly patients, relatives, care workers, healthcare operators) in the early stage of the process to co-design, refine, test and assess in real life conditions the technologies, the organizational impact and clinical benefits. TreC is designed to support the network of formal/informal care people build		E' stata realizzata una cartella del cittadino nel quale vengono inseriti i referti degli esami svolti nel territorio trentino (occorrerà sviluppare un sistema che accolga anche altri territori). Attualmente vi sono circa 7000 iscritti. Si sta studiando il modo di poter accedere alla propria cartella digitale tramite un portale e permettere di aggiornarla in autonomia utilizzando anche software open sorce per non pesare sui conti delle Amministrazioni Pubbliche.
1°	B3	IRCSS Salvatore Maugeri	Privata	Lombardia	Scalvini Simonetta	The Telehomecare programme for patient with multiple chronic diseases is a multidisciplinary care approach referring to biological signals monitoring and medical/nursing intervention made over the telephone. The care model provided 24/24 h assistance, 365 days/year. Briefly, a nurse-tutor (NT) followedup the enrolled patients for 6 months managing the weekly contacts with them, mainly through scheduled appointments (from Monday to Friday from 8:30 am to 4:00 pm). Occasional appointments could also be required by patients and performed by a nurse on duty in case of symptoms, signs of possible instabilization of the disease or any doubt about therapy occurred in urgency during the day, nights or on weekends. The patients received some portable device (1-lead ECG, pulse oxymeter etc…) depending from their diseases; the biological signals are transferred during each call by a fixed or mobile telephone to a receiving centre, where a nurse or a doctor was always available for consultation. All the patient's data are present on an electronic health record present on a web platform. Educational Video, games for brain training, CDRom with callisthenic exercise for physiokinesis therapy		
1°	B3	ARES	Pubblica	Puglia	Avolio Francesca	It is based on the promotion of the empowerment approach in an integrated system of care, by supporting, coaching, and educating patients - by trained Nurses (Care manager) - to selfmanage their condition, involving them in decision-making related to their diseases. Patient education produces better adherence to follow up and compliance to treatment, improves patients and health professionals satisfaction, and improves clinical outcomes. The introduction of new professionals such as CMs helps the promotion of healthy lifestyles and also increases the changing of lifestyles by counselling patients.The project introduces the telemedicine as a basic tools to support CMs , GPs and specialists in treating patients improving care in quality, efficiency and ffectiveness. Common training on quality systems, shared guidelines, clinical pathways, will be delivered to all involved health professionals to share objectives and methodology of the project. Data will be collected in a Web-based database to support CMs in coaching and educating patients, to help the reporting about each patient to inform consulted specialists and for hospital admissions, to help action monitoring, and to facilitate statistical analysis. The model is expected to: Promote/increase health security through an integrated approach by care teams (GP, CM and Specialist); Reduce health inequalities facilitating proper access to healthcare service; Reduce need for access to Casualties & Emergency.		
1°	C2	Agenzia Sanitaria e Sociale Regionale (ASSR)	Pubblica	Emilia Romagna	Antonio Addis e Tania Salandin	The Emilia-Romagna Region intends to start a new phase of policies promoting a culture of valorization of seniors' contribution to society, and favoring healthy ageing. Emilia-Romagna is one of the Regions with the higher ageing rates, but 22% of seniors between 65 and 75 still feels active and able to participate to the society life. The action's objective is to face the problem of elderly care from a systemic point of view. The main scope is to build a federative environment where different open and personalized solutions could be implemented and where several agencies (belonging to the public sector and volunteer associations) could use the available services to support and assist the elderly. The Region intends to acknowledge the work done in the past few years, and is determined to transform good practices into a real "system" through fostering new initiatives and realizing innovative implementations of social networking at large scale.	The LHA of Bologna;. the LHA of Forlì. EU States involved: Austria: Wien; Belgium: Bruxelles; Czech Republic: Hlavní město Praha; France: Paris; German: Stuttgart, Stadtkreis;	Il servizio coinvolge ad oggi oltre 11.000 anziani soli ultrasettantacinquenni, seguiti attraverso un Centro Servizi specializzato che eroga servizi di telemonitoraggio, teleassistenza e telecompagnia con finalità di prevenzione dell'aggravamento di situazioni di fragilità socio-sanitaria e di individuazione precoce di segnali di allerta di tali possibili aggravamenti, in rapporto costante sia con i servizi sociali e assistenziali dei Comuni, che con quelli sanitari erogati all'Azienda Sanitaria di Bologna. Il Centro Servizi di CUP 2000 costituirà l'Hub di questo articolato sistema di interventi, e verrà quindi dotato di strumenti e nuove funzionalità in grado erogare e/o supportare l'erogazione di nuovi servizi alla persona anziana e ai professionisti socio-sanitari. Numerose Aziende Sanitarie della Regione hanno espresso il loro commitment all'azione e collaboreranno per raggiungere gli obiettivi proposti.
1°	C2	Istituto di Scienza e Tecnologie dell'Informazione "A. Faedo" CNR Pisa	Pubblica	Toscana	Furfari Francesco	AAL Open Association. Coordination of the community that will provide technology bricks for the building of open, flexible ICT platform solutions to enable interoperable AHA applications through AALOA, the AAL Open Association. • AALOA was initially promoted by the partners of the PERSONA and universAAL projects. Discussion about its organization was coordinated by CNR-ISTI (Italy), Fraunhofer-IGD (Germany), ITACA-UPV (Spain), and SINTEF (Norway) • AALOA started operations in 2010 with the publication of a manifesto, defining the rationale and the purposes of the association. This manifesto was contributed by MonAmI, OASIS, OsAmI-commons, PERSONA, SOPRANO, universAAL and WASP projects. • AALOA organized the preparation of a joint declaration ratified in September 2011 by 44 research projects calling to the creation of ICT ecosystems based on open platforms. The declaration was prepared by the DOC (declaration organization committee), involving Francesco Furfari (CNR-ISTI, Italy) Antonio Kung (Trialog, France), Saied Tazari (Fraunhofer-IGD, Germany) • As of May 2012, the AALOA coordinates 4 community projects, involving 109 participants and 19 countries.		
1°	C2	Emilia Romagna's Regional Centre for Assistive Technology. **ATT.NE: questo è unito in un unico working group C2 con quello della ASSR**	Pubblica	Emilia Romagna	Malavasi Massimiliano e Teresa Galelli	The Centre is available to participate in the Action Plan by gearing its institutional activities towards shared goals. This includes the monitoring of cost effectiveness of technology based assistive solutions in interventions aiming at maintaining independence and a good quality of life of elderly (100 yearly). It further includes training activities and awareness raising activities in the Region Emilia Romagna and beyond, building on the network of statutory and non statutory bodies having similar goals (100 yearly) and serving general service providers and professionals in health and social work (800 yearly). Our existing tools to measure outcomes include the SIVA cost analysis tool and the Quest to measure the impact on the quality of life of the adopted solutions. We are available to review these under the Action Plan.		

	C2	FBK/P.A. Trento	Pubblica	Trentino-Alto Adige	Fabio Pianesi	The main goal of this action is to develop, deliver and test an advanced tele-assistance service for older people living at home that leverages innovative ICT to extend and improve the traditional human-based tele-assistance business model by reducing the operational costs while increasing the quality of the service. Starting from an initial version, the improvement will be pursued by means of smart technologies that can understand the environmental context, the users' behaviours and their affective and cognitive states in order, allowing for the usage of that information for the purpose of primary and secondary prevention. The system and the offered services will be designed following a strict User-Centred approach and will be validated service through extensive testing in the Trento Territorial Lab (TTL), part of the EIT ICT Labs network of Experience and Living Labs.		
1°	D4	ASL n. 5 Bassa Friulana	Pubblica	Friuli-Venezia Giulia	Gian Matteo Apuzzo; Giulio Antonini	The proposed action builds upon the experience of the regional Lab on Accessibility, Domotics and Innovation (LADI) started in 2009 as strategic project funded under art.22 of Regional Law 26/2005. FVG regional authority has determined to officially establish the Lab as permanent regional initiative, and ASS 5 has been entrusted the implementation of the activity. Within this framework and fully in line with EIP AHA objectives, ASS 5 proposes FVaGe as umbrella initiative aiming at strengthening partnership between regional public and private actors to develop an integrated vision on accessibility of the built environment and ICT contribution for the quality of life of elderly. The core of the action lies in FVaGe partnership agreement to be signed by the regional authority, local research institutes and an e-health provider. Following to this step, a number of activities will be implemented: - Creation of online platform for knowledge sharing - Establishment of a Working group that will participate in the study visits on assistive solutions foreseen by CASA project (Interreg IVC) - Realization of accessibility assessment on 10 public buildings - Studies on the legal and economic feasibility of "community-based foundations", i.e. an innovative management model integrating stakeholders and resources - Capacity building meetings on integrated planning of social services management - Seminars on Innovation for age friendly living environments	Friuli Venezia Giulia Region, Central Directorate for health, social and health integration and social policies and Central Directorate for education, university, research, family, associations and cooperation	In Friuli Venezia Giulia è stato costituito il tavolo "FVG as @ lab", al quale appartengono attori che lavorano nel campo della tecnologia per i life enviroments. Una rete regionale che opera nel campo della ricerca e innovazione per migliorare la qualità della vita e promuovere un invecchiamento sano e attivo della popolazione, e che regola i rapporti tra i firmatari del "White Paper". Attualmente sono state realizzate 4 delle 9 visite studio da realizzarsi come obiettivo del commitment: sullo sviuppo della interazione sociale e della comunità; sicurezza e auto gestione; riabilitazione e diffusione degli stili di vita sani; assistenza informale.
1°	D4	Agenzia Regionale Sanitaria ARS	Pubblica	Marche	Di Furia Lucia	Integrated Social, Technological and Financial Innovation for Active and Healthy Ageing. It wants to build a model interfacing Regional Active and Healthy Ageing Integrated Innovation Plans with Pension Fund Investment in Social Infrastructure, so opening a possible pathway to re-open a condition following Financial Crisis, through: i. Analysis of the state-of-the-art; ii. Analysis of the needs of the target population; iii. Drafting of the model. Its main objectives are: Economic innovation, Cultural and social innovation, Policy innovation, Active & Healthy Ageing. It comes from a long preliminary stage with contacts with Presidency of EU Commission, DG INFSO, DG SANCO, DG REGIO, DG Research, DG Enterprise, European Parliament, Committee of the Regions, EESC, EIB, EU Pension Funds Associations, Public Research Centres, LSE, OECD, HCN, YF, SIE, EPHA, ECHAA, EFN, Age Platform, FERPA, European Pension Funds Associations, Deloitte, FORTH, CONTINUA, etc. Partners represent 14 Countries.		