1. **Next Adopter name: A.S.L. Napoli 2 Nord – Public Health organization**

2. **Next Adopter Working Group:**
(Structures of the ASL Napoli 2 Nord identified with Deliberative Act no. 364 of 24.02.2021)

Organization	Level of involvement
Direzione Sanitaria	Consultation
Dipartimento farmaceutico	Full Participation
U.O.C. Integrazione Socio-Sanitaria e Cure Domiciliari	Full Participation
U.O.S.D. Anziani e Demenze del Dipartimento Cure Territoriali	Full Participation
U.O.C. Tecnologie Informatiche ed Ingegneria Clinica	Full Participation
U.O.C. Gestione Risorse Economiche Finanziarie	Information

3. **Analysis of Next Adopter's needs:**

Block	Needs (brainstorming)
Block 3: Vertical and Horizontal integration experiences adopted in Catalonia	Reduce inappropriate days of hospitalization for frail elderly people in need of protected discharge
	Avoid hospitalization for elderly people who do not need this treatment regime
	Completion of regional accreditation procedures for private health and social services, for transformation of (PL) hospital-bed
	Increase the residential and semi-residential (PL) hospital-bed of a social type
	Network hospitals and territorial health and social services for the management of protected resignations
	Facilitating access routes to integrated home care through better specification of access criteria
Block 5: Digital support of integrated care services	Remote monitoring of fragile patients using information technology
	Project digital platform to support integrated home care to manage the care of patients with simple and complex needs
	Define dashboard to identify the criteria for the stratification of fragilities and social vulnerabilities, also with the Municipalities
	Create dashboard to define objectives and quality indicators in the management of the fragile patient in home care

Block	Needs (grouped)
Block 3: Vertical and Horizontal integration experiences adopted in Catalonia	Reduction of inappropriate hospital admissions
	Strengthening/qualification of the territorial network of accredited social and social, semi-residential and residential, public and private services
	Strengthen the link between the points of the network of services, hospital and territorial
	Improve the qualification of service access policies
Block 5: Digital support of integrated care services	Implementation of information technologies to support the home care of interventions
	Platform for patient management at home, for remote monitoring
	Platform to support the integrated management of frail elderly patients

Block	Needs (prioritized)
Block 3: Vertical and Horizontal integration experiences adopted in Catalonia	Strengthen the link between the points of the network of services, hospital and territorial, also to reduce inappropriate hospital admissions
	Strengthening/qualification of the territorial network of accredited social and social, semi-residential and residential, public and private services
Block 5: Digital support of integrated care services	Implementation of information technologies to support the home care of interventions
	Platform to support the integrated management of frail elderly patients

4. Asses and select the Core Features

B3- Vertical and Horizontal integration experiences adopted in Catalonia

Block 3	CF 3.1 Programme for chronic and frail patients	CF 3.2 Support for complex case management including home hospitalization, transitional care and vertical & horizontal integration supported by digital tools	CF 3.4 Integrated Care for admission avoidance of subacute and frail patients
Strengthening of the network of semi-residential and residential socio-sanitary and social services	X		X
Reduction of inappropriate hospital admissions		X	X

B5- Digital support of integrated care services

Block 5	CF 5.1 Regional information exchange platform (HC3)	CF 5.2 Primary Care electronic Medical Record (eCAP) and Electronic Prescription	CF 5.4 ICT tools supporting adaptive case management & collaborative work
Implementation of information technologies to support the home care of interventions	X		X
Platform to support the integrated management of frail elderly patients	X	X	X

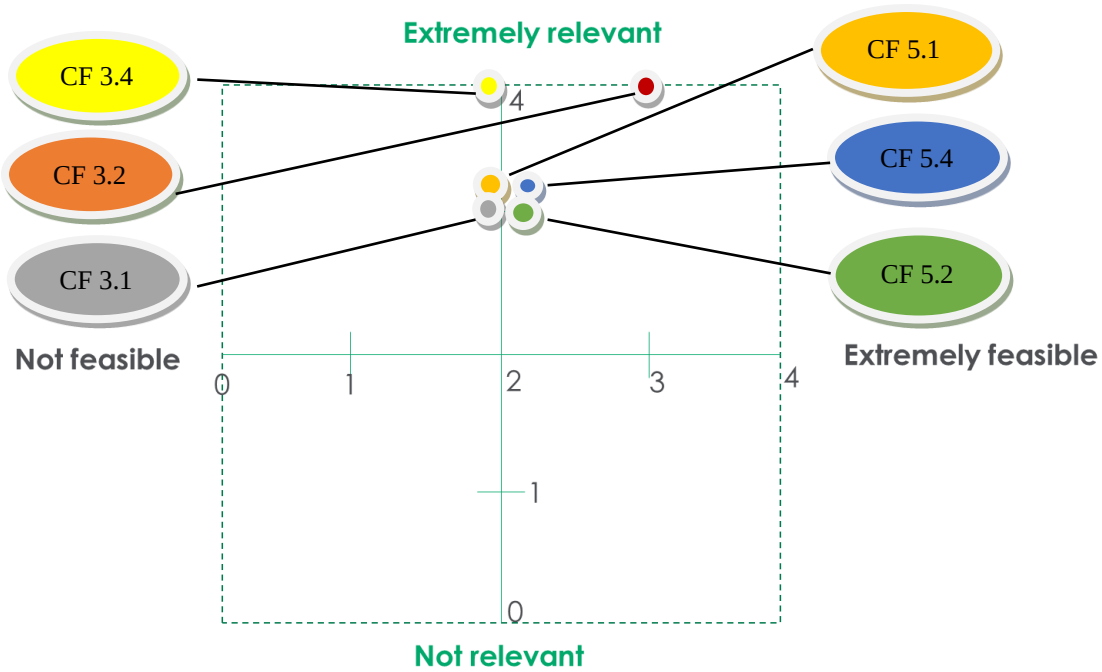
Original Good Practice Name: [WP6-CATALAN OPEN INNOVATION HUB ON ICT-SUPPORTED INTEGRATED CARE SERVICES FOR CHRONIC PATIENTS]

Scirocco Model	Block 3 CF1	Block 3 CF2	Block 3 CF4
D1 Readiness to Change	3	4	3
D2: Structure & Governance	3	3	3
D3: Digital infrastructure	2	3	1
D4 :Process Coordination	3	3	3
D5: Funding	1	1	1
D6: Removal of inhibitors	1	2	2
D7: Population Approach	1	1	1
D8: Citizen Empowerment	2	2	2
D9: Evaluation Methods	2	2	2
D 10: Breadth of Ambition	3	2	2
D 11: Innovation Management	2	2	2
D 12: Capacity Building	2	2	2

Scirocco Model	Block 5 CF1	Block 5 CF2	Block 5 CF4
D1 Readiness to Change	2	2	2
D2: Structure & Governance	2	2	1
D3: Digital infrastructure	3	3	1
D4 :Process Coordination	3	3	3
D5: Funding	1	1	1
D6: Removal of inhibitors	2	2	2
D7: Population Approach	2	2	2
D8: Citizen Empowerment	2	2	2
D9: Evaluation Methods	2	2	2
D 10: Breadth of Ambition	1	1	1
D 11: Innovation Management	2	2	2
D 12: Capacity Building	2	2	2

Core Feature	Relevance	Feasibility
CF 3.1 Programme for chronic and frail patients	3	2
CF 3.2 Support for complex case management including home hospitalization, transitional care and vertical & horizontal integration supported by digital tools	4	3
CF 3.4 Integrated Care for admission avoidance of subacute and frail patients	4	2
CF 5.1 Regional information exchange platform (HC3)	3	2
CF 5.2 Primary Care electronic Medical Record (eCAP) and Electronic Prescription	3	2
CF 5.4 ICT tools supporting adaptive case management & collaborative work	3	2

Scores: Not at all; Slightly; 2= Moderately; 3= Very and 4= Extremely]



Final Core Features
Core Feature 3.2: Support for complex case management including home hospitalization, transitional care and vertical&horizontal integration supported by digital tools
Core Feature 3.4: Integrated Care for admission avoidance of subacute and frail patients
Core Feature 5.1: Regional information exchange platform (HC3)
Core Feature 5.4: ICT tools supporting adaptive case management & collaborative work