

# ICT PSP – Health, Ageing and Inclusion Programme



## Health monitoring and sOcial integration environMent for Supporting Wide ExTension of independent life at HOME

(Grant Agreement No 250449)

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#### Abstract

This internal deliverable presents the final feedback received by the Advisory Group during the last visit to the Irish Pilot site, presents a summary of the qualitative analysis which took place under the guidance of the Advisory Group, and a synthesised list of lessons learned and recommendations arising from the Advisory Group activities throughout the project.

#### Key Word List

Advisory Group, Usability, Acceptance, Equipment, Patients, Pilot Site, Qualitative Study, Lessons Learned, Recommendations

## Change History

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### Version History:

- 0.1 30<sup>th</sup> January 2014
- 0.2 4<sup>th</sup> February 2014
- 1.0 26<sup>th</sup> February 2014

### Version Changes

- 0.1 Initial draft
- 0.2 Consolidated draft, including aspects of qualitative study and final recommendations
- 1.0 Minor changes prior to issue

### Outstanding Issues

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# 1. Introduction

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## 1.1 Purpose of this document

This document is the final feedback report from the Advisory Board.

It contains details of the site visit to the Louth pilot site, and some information about the qualitative analysis that the Board carried out.

## 2. Group visit to the Irish Pilot Site

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The visit to the pilot site in Louth offered an opportunity to witness the deployment of HSH services in the Irish context, but also a chance to provide a final feedback on the project activities.

### 2.1 Introduction

The pilot site was organised by AGE Platform Europe on the 18<sup>th</sup> November 2013 in close cooperation with the Irish partners running the pilot site. The meeting included an introductory session and first exchange of views, and a pilot site visit when experts had the opportunity to witness the technology in two users' flats.

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Mr Stuart QUINN	Netwell Centre
Ms Joanne FINNEGAN	Netwell Centre
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Ms Ophélie DURAND	AGE Platform Europe
Ms Nena GEORGANTZI	AGE Platform Europe

### 2.2 Introductory meeting with Irish Partners

Joanne Finnegan and Stuart Quinn from the Netwell Centre welcomed the participants and provided them with an overview of the Irish context. The Louth County has been the first one to launch an "ageing strategy" with various facets, including the use of ICT (along with transport, security and safety, health promotion/physical activities, care institutions, information and communication, older persons' forum, etc.).

They selected participants using contacts from the Dundalk Institute of Technology, Ireland's Health services and from the local authority. From 260-270 pre-selected people, they chose 60 participants to deploy HSH services.

Smart home devices such as badges to open doors and windows, light adjusters and climate control have not been installed due to unsuitability with participants' houses. The call centre used was provided by a private company and was not based in Dundalk.



Contacts with GPs have been very limited; no one helped to set up limits for blood pressure and glucose. The instruction for the participants was then to refer to their GPs. Joanne Finnegan explained that GPs did not want older persons to take their measurements themselves and that reimbursement of interventions linked to HSH-like services was still the big problem.

Alarms have been set up if no measurements were recorded in a week.

Technical issues encompassed low duration of batteries, unstable connections, difficulties linked to power cuts / devices rebooting, devices update. Netwell Centre staff had to travel each time to each participant to fix these problems.

Stuart Quinn acknowledged that the concept of ICT to live longer was the way forward and that we need to invest in open platforms rather than in devices. Tablets and smartphones would be much more effective thanks to apps.

Each month, participants were required to reply to a set of questions to assess how they were feeling towards the technology. 65% were neutral, 17% did not feel anxious and 17% did not feel anxious at all.

### 2.3 Overview of the visit

The group split in two groups to visit two participants.

The first user, a man suffering from diabetes, used the InTouch with ease, passing from one reading to another with competence and being able to interpret the graphics of his health records. He found no difficulty either using the vital parameters monitors. However, he experienced problems regarding the reliability of the glucometer's reading and continued to take his glucose reading according to the method prescribed by his GP (who did not have any interest in the HSH project).



The participant said that HSH services were not vital to him and that he would continue living as before when the technology is taken away. Nevertheless, he appreciated the contact with the call centre, the discreet feeling of being cared for and knowing that someone would be in touch if there is anything unusual in his home or his health. He also very much enjoyed the visits from the Netwell centre. Participating in HSH has opened up his curiosity vis-à-vis technology and he will start internet classes and buy a laptop.

The second user was also a man, living with his wife in a house. He was very enthusiastic about the project and the great support it brought to him. Thanks to the devices he felt much more secure and slowly dared to get out again, to take part in social activities or just to move about. These activities allowed him to lose weight and to improve his health. He was thus very concerned about the end of the project, asking what would happen with the devices and the monitoring and arguing that it would be a waste of money to stop everything after three years. Many older persons would not be able to pay for the devices, he added.

### 2.4 Feedback from the pilot site visits

Expectations were rather high from the AB members, well aware of the Netwell Centre reputation and activities, notably as age-friendly County. They appreciated the commitment of the team to the project and to the general improvement of the quality of life of the county's older inhabitants.

Experts took note of the repetitive problems linked to the devices (low duration of batteries, difficulties with the connection, bad design of switch on/off button of the InTouch, high number of false alerts, different readings of the glucometer) and acknowledged that some of them were outdated (Mambo, Ello). Moreover, some devices could not be installed due to houses' settings. They underlined the lack of involvement of GPs due to issues related to payment, as in Belgium, as a barrier for effective implementation of the technology.

While one participant visited recognised that he will not miss the devices, but only the human contact provided along with the feeling of being cared of, experts emphasised the great impact of technology on the second user's life. This questions the exit strategy to be implemented once the project ends as users may have become accustomed to the service for their security, social life and health. Moreover, the first user mentioned that thanks to the project, he was now willing to start internet courses in the near future.

After the visit, experts underlined the need to combine technical interventions with social support and stressed on the importance of exit strategies as a challenge and an ethical consideration. Health monitoring via technology without involvement from health professionals and in broader terms without a patient-doctor relationship, does not seem a realistic approach to better care. Obstacles to involvement of GPs, such as payment systems, overlapping services, fear of losing contact with patient must be further investigated.

Experts also raised the target population of such services: do we only target persons suffering from chronic conditions, i.e. chronic heart failure, diabetes and COPD. Depression and frailty were set up as exclusion criteria for the project but one expert highlighted the support smoke detector could offer to persons suffering from early

stage of dementia. However the same expert underlined the need to recognise that there is a section of the population that is not interested and that we should not underestimate the resistance among older people against digitalisation of services. Technology implies new skills and constant update of the devices, and both issues create difficulties for many people.

Experts took note of the great role social networks played in the Irish context, both as source of motivation and as obstacles to the use of HSH services. This shows the importance of the family and social networks in the acceptance of technology. However, users participating in the HSH project do so on a voluntary basis, which raises the issue of involvement of vulnerable, i.e. socially isolated groups of the population, one expert said. Further investigation is needed to assess the benefits of such services for all groups.

Moreover, experts recognised that the project has been too small and had not lasted long enough to provide with tangible assessment of the preventive effects of the use of ICT and of consecutive cost reductions. Witnessed benefits seemed to be rather linked to users' greater well-being, self-esteem and stimulus to adopt healthier lifestyles.

## 2.5 Lessons learned and recommendations for next steps

Experts recommended embedding such technologies into a holistic support system, including training and a regular social care network. Joint efforts of service providers, technology providers and political stakeholders, as shown in the Italian pilot site of the DREAMING project (Trieste), are essential to ensure good health and care services. This is also linked with the need to better integrate such services with healthcare services as a way to better involve GPs and maximise the returns on investment for eHealth. However, the need to take into account the impact of ICT on the medical profession must be acknowledged, family doctors may have less visits, specialists see their consultations modified while nurses will have a new role, i.e. accompany the patient to feel comfortable in taking one's measurements. One expert believes that older users' acceptance is not the main barrier; the most important is to convince GPs about the usefulness of the combined technical/service system and to gratify them when using the system.

Training should be provided to older users via community centres, universities of the third age or libraries, at no or very little cost to ensure that they remain up to date with ICT. Such training and support could also be provided by a contact person in the community, acting as a "digital concierge". This was the case in the Danish pilot site of DREAMING project (Langeland).

Moreover, experts underlined the necessity not to introduce too many devices at the same time. Users should be able to learn to use one device after the other; doing so, users would have more time to get acquainted with the devices, more confident when using them, and have less chances to feel stressed or overburdened with too many devices. This has been demonstrated by the example of the Corrèze region in France, where a first set of wires and plugs has been introduced to measure the cost benefit brought on by the feeling of well-being. Users get used to interacting with the call centre before the installation of medical devices.

Another important recommendation relates to the user-friendliness of the technology. Devices and systems should be as easy to use as possible, and be mainstream, i.e. the ones used by the general public. Relevance of newer technologies, i.e. which did not exist at the beginning of the project, must be assessed to see whether they would better fit users' needs (tablets or skype for instance). One expert underlined the need to have reliable and affordable technology and broadband coverage to ensure we can alleviate the pressures and cost of existing healthcare and social care models.

A key issue relates also to the costs of ICT, including maintenance, training of users – older persons, family, providers – and to the question of who pays for the devices, batteries, and the access to internet. New ways of financing and remunerating for monitoring of chronic diseases must be looked at. One expert also underlined the need not to focus on economic benefits and rather on better quality of care and more security and autonomy of older persons when evaluating such technology.

The issue of data protection has also been mentioned, along with the prior permission by the patient as to whom he/she permits the data to be sent to.

Last but not least, one expert strongly called on the European Commission to gather the results of the most successful HSH-like projects to decide which are the most promising services and devices, and test them on a very large scale and over a longer time to be able to gather statistically relevant figures on the impact of ICT.

Recommendations:

- Better integrate the provision of technology-based services with healthcare services, doing so better link with GPs.
- Provide opportunities of training for older persons.
- Progressively install devices in users' homes.
- Chose mainstream and easy-to-use devices, and use existing devices and software such as tablets and Skype.
- Assess the costs linked to the use of technologies and define new financing models.
- Collate results from HSH-like projects and launch large scale and long term projects to test the most promising devices and services.

### 3. Qualitative Analysis

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The Advisory Group suggested that qualitative analysis would be very interesting in a project like HSH as a way to enrich the statistical data and get a better insight into the personal factors that have affected the users' appreciation of the devices that were used in the pilots before implementing on a larger scale. The objective of this initiative is to harvest experiences and histories of end users in order to strengthen HSH deliverables and results and implementation experiences. This analysis was planned to complement the statistical data, shedding light on the background and context in which different users interact with the HSH services, which could be used to extract a list of barriers and/or of facilitators to the take up of technology.

This idea was discussed and planned in several meetings as presented in D4.4 (Advisory Group Intermediate Feedback) as well as during the project review in 2013, where it was agreed that although such an activity was not originally foreseen by the project, reasonable efforts should be made to do such qualitative analysis.

#### 3.1 The process

After consulting all Advisory Group members to gather some initial questions, Heidrun Mollenkopf and Marja Pijl, from the HSH Advisory Group worked on a voluntary basis on a first draft of the questionnaire for the qualitative interviews. Then a small working group was established comprised of the two Advisory Group members and Nena Georgantzi and Ophélie Durand from AGE Platform Europe, in order to guide the study and deliver the expected results. Wouter Keisjer and Raniero Chelli from the HSH management team oversaw the work on the qualitative study, and were in charge of communication with the pilot sites.

On the 16<sup>th</sup> August 2013 pilot sites received a pre-final version of the questionnaire, and were asked to give comments or ask questions by the 26<sup>th</sup> August 2013. After this time, pilot leaders were asked to select between 5-10 participants to take part in the study, and assign staff members to lead the interviews. In order to gather variable but also comparable data, pilot sites were requested to select users with diverse characteristics, in terms of e.g. health and social condition, professional background, familiarity with technology, and acceptance of devices.

In the first two weeks of September, the questionnaire was finalised based on input received from the pilot sites and the management team; on 22<sup>nd</sup> September 2013 pilot sites were contacted to officially start the interviews based on the final version of the questionnaire. Pilot sites were also provided with a list of guidelines explaining how the interviews should take place, and clarifying the questions and the next steps, including milestones and deadlines. The final version of the questionnaire and the guidelines are available in the separate deliverable on the Qualitative Study Appendix.

A first exchange of views on the evolution of the interviews took place during the PSC meeting in Treviso on 1<sup>st</sup> October 2013, where all pilots reported that they had selected users for the interviews: Latina, Louth and Antwerp were planning to involve five participants, whereas Badalona planned to interview all nine participants in the intervention group. Pilot sites were asked to fill in the templates in English, although longer transcriptions should be available in the original languages of the

interview. In all cases, a hard copy of each completed questionnaire (per participant) should be stored for future reference until the end of the project.

Mid-October 2013, the management team contacted the pilot sites for an intermediate report on the process; at the end of October 2013, AGE Platform Europe contacted them again to ensure that there were no problems or questions on the final steps.

Interviews took place between 27<sup>th</sup> September and 7<sup>th</sup> November 2013. The Belgian, Irish and Spanish pilot sites delivered the results by the set deadline (15<sup>th</sup> November 2013). After several reminders to the Italian pilot site finishing on the 12<sup>th</sup> December 2013, the management team decided that it was no longer possible to wait for the Italian interviews. The working group therefore proceeded with the analysis of the received questionnaires from the three pilot sites.

During the Advisory Group meeting in Dundalk on the 18<sup>th</sup> November 2013, a short exchange on the qualitative study took place. First, Nena Georgantzi from AGE briefly presented the received answers from the three pilot sites, and then the Irish partners shared some of their insights and experiences from the qualitative interviews. During this meeting, it was decided to prepare a document presenting in a synthesised manner the answers from the three pilot sites which participated in the study alongside the previously agreed smaller number of case studies.

A first draft of the synthesised analysis was circulated on the 18<sup>th</sup> December 2013. In December and January, Heidrun Mollenkopf, Marja Pilj and Nena Georgantzi also worked on the identification and analysis of a smaller number of case studies. On the occasion of the PSC meeting in Badalona and the HSH Final Conference on the 17<sup>th</sup> January 2014 in Barcelona, the working group met to draft conclusions based on the qualitative study, harmonise the presentation of the case studies, and present some lessons learned and recommendations to project partners as well as the participants of the Final Conference.

During the last PSC in Badalona on the 16<sup>th</sup> January 2014, it was also decided that the outcomes of the qualitative analysis would be presented in a separate deliverable, and only a summary would be included in the Final Feedback of the Advisory Group. In addition, AGE was asked to explore whether a publication could be made based on this analysis, its outcomes, as well as the most important conclusions of the Advisory Group during the course of the project. AGE was also requested to prepare a one-page document with the most important recommendations for the future.

During the discussion with partners further ideas came up. First, the results of the qualitative analysis should be linked with the quantitative data. Although, the timeframe of the project does not allow for such a task to be undertaken, the management team will share the quantitative data with the working group of the qualitative study, to explore potential synergies.

Nevertheless, one of the recommendations from this analysis is about ensuring that future research projects foresee both quantitative and qualitative analysis, and that sufficient time and resources are allocated to make links between the two. For example, low-stress levels noted through the quantitative analysis could be interpreted through qualitative data, by referring for instance to the role of staff involved in the trials and the continued support the participants received. This is an

important finding for deployment in real-life situations, which quantitative data alone do not allow us to reach.

Another recommendation would be that expert groups should have an important role in future research projects about reading, reviewing and ensuring synergies between different deliverables, such as qualitative and quantitative analysis.

In addition, in future qualitative analysis it would also be interesting to interview the staff to gain insights on the challenges they face regarding the acceptance of technologies, and make links with answers provided by participants.

A first opportunity to share the lessons learned from this analysis would be the SmartCare project, where many HSH partners are involved and the two Advisory Group members and AGE will be invited to present the outcomes of this study to the SmartCare consortium.

### 3.2 The distribution of interviews and case studies per pilot site and gender

In total 18 people were interviewed for the qualitative study; five from Antwerp, eight from Badalona and five from Louth. As explained above, no interviews took place in Latina.

**Table 1: Distribution per sex per pilot site**

Site	Male	Female
Badalona	1	7
Louth	2	3
Antwerp	3	2
<b>Total</b>	<b>6</b>	<b>12</b>

In Badalona, the decision was taken to involve all nine participants of the study group in order to have a comprehensive view of the opinions of the users taking part in the trials. However, in the end only eight interviews took place, as one of the older users was sick during the period of the interviews. Moreover, in Badalona one interview was taken with the participant's daughter because the person is troubled with cognitive impairment.

In Antwerp, partners evaluated all 17 participants remaining in the intervention group for the interviews, and selected based upon the following criteria:

- Use of the devices: Some people used the devices often, others did not, so they tried to involve both in the interviews.
- Housing conditions: Most of participants live in a day centre, but some live in private homes, and they wanted to include both.
- Location: They tried to select people from as many different locations as possible, to have a location independent result.
- Sex: The goal was to represent both sexes equally.

- Ability to express themselves: Not every participant was able to express him/herself clearly.

Eventually they selected three men and three women. However, one of the three women lived in a private home, but she did not want to be interviewed, so they ended up with five people for the interviews.

In Louth partners put it to a cross selection of the participants (active and non-active users) if they were interested in being interviewed; those who were interested were interviewed. They specified a cut-off date for replies / decisions by participants, which, together with time constraints, narrowed the selection as well.

Out of the 18 cases, nine cases were analysed in depth, three from each pilot site. While the same structure was applied to all these case "stories", they were drafted by different people, which explains the different writing style: Heidrun Mollenkopf prepared the cases from Louth, Marja Pijl the ones from Antwerp and Nena Georgantzi those from Badalona.

**Table 2: Distribution per pilot site and sex**

Site	Male	Female	Total
Badalona	1	2	3
Louth	1	2	3
Antwerp	1	2	3
Total	3	6	9

For the selection of these cases, the working group identified the most interesting and the most characteristic cases, as well as participants with similar backgrounds but different reactions, and participants with different backgrounds and similar answers. Attention was also given to present cases from all pilot sites and to have a relevant gender balance.

### 3.3 Main conclusions from the Qualitative Analysis

The objective of this qualitative study was to collect feedback from participants on their acceptance of technology, impact on their well-being and daily life, and confront this information with their socio-economic context and personal background.

The small number of users involved in the HSH trials and the even smaller sample who took part in the qualitative study – although carefully selected - do not allow for generally applicable conclusions. Nevertheless, they provide an extremely useful and rich source of knowledge on user acceptance of technologies for ageing well.

If one thing is certain, it is that this study has reaffirmed the heterogeneity of the target group (i.e. older persons) and the fact that there is no one-fits-all solution. Older participants' reactions to the HSH services range from very positive to negative. When innovating and introducing new technologies, we should not only think of individuals but of systems: the living, social, political, legal and technological environment of the person have an impact on his/her attitudes. The context in which

the services are offered is extremely important. The opinion of family, friends and other people the individual is in contact with and trusts, such as doctors, social workers, or carers, can influence people's feelings towards technology. Personal experiences, like biographical background, health status, familiarity with technology, etc. are also important.

In fact, in this study we have seen technology act both as an enabler and as a bottleneck: for some people, engaging with it is difficult, whereas for others it is the main reason for accepting the solution in the first place (i.e. people who are interested in technical aspects of project). Even if future generations will be more technology literate, there will always be "tech freaks" ready to try anything new and people who have difficulties or do not want to adapt to new media and gadgets.

Whereas all the components of the HSH platform that were implemented proved to be relevant in some way, different aspects were useful for different participants. For example, many participants were not interested in the Mambo and preferred to use their own mobile phone. For others however, the Mambo was the most interesting aspect of the service and the one they would like to keep. This observation confirms the need to tailor the solutions to the specific needs, expectations, lifestyle, preferences and routines of the individual in order to avoid duplication and ensure that the offered services are used by the consumer.

It would therefore be safe to conclude that the study builds a strong case for a personalised set of services.

Detailed lessons learned, conclusions and recommendations are available in the relevant document.

## 4. Final recommendations from the Advisory Group

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The experience of the qualitative analysis in the framework of the Home Sweet Home project and the overall activities of the Advisory Board have generated the following conclusions and recommendations about the development and deployment of technological solutions for older persons.

### Regarding future research:

- Foresee both quantitative and qualitative analysis as both methodologies provide particular insights. Sufficient time and resources should be allocated to enable making links between the two.
- Expert groups (such as the Advisory Board of HSH) should have an important role in future research projects, to engage in reading, reviewing and ensuring synergies between different deliverables.
- Include interviews with the staff of the trials to gain insights on the challenges they face regarding their acceptance of technologies, and make links with answers provided by participants.
- Document in detail what has changed in the course of the project, how has user involvement, advice by experts or lessons learned changed the development of the technologies and services.
- Explore whether assistive technologies are imposing a medicalised lifestyle on participants.
- Research how (far) technology can help the most vulnerable older persons: those socially excluded, suffering from dementia or depression.

### Regarding technological innovation

- Develop sets of solutions that can be tailored to the needs, expectations, lifestyle, preferences and routines of the individual.
- Observe how and where people live to avoid developing solutions that cannot be used in real-life situations.
- Ensure that solutions are reliable before exposing them to users.
- Make solutions robust, attractive and practical, taking due account of energy provision and challenges related to change of batteries.
- Opt for mainstream solutions, integrated – as far as possible – to a single device.
- For health and safety-related devices, a back-up should be available in case technology fails.
- Affordability should be at the centre of technological innovation for older persons.

### Regarding financing

- Although many of these technologies were conceived to reduce the need for personal contact with carers and health professionals, the study has shown

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that users highly appreciate the contact with the staff involved in the trials. Perhaps these technologies would be more acceptable as a tool to improve the work of health professionals and the quality of life of older persons, rather than a way to save on resources. Further analysis is needed.

- The quite low willingness to pay shows that an individualization of the cost is probably not the way forward. Different financing models should be explored.
- Costs for training, technical support and maintenance should be part of the package.

## Appendix A: Agenda of Dundalk Pilot Site Visit

Venue: Netwell Centre, PJ Carroll's Building,  
Dundalk Institute of Technology, Ireland

Home Sweet Home (HSH) Advisory Group visit in Dundalk – November 18 <sup>th</sup> 2013		
Time	Item	Person responsible
13.00 – 14.30	Arrival of experts and lunch	All
14.30 – 14.40	Welcome and roundtable	John Oates (HSH Management team)
14.30 – 15.30	Presentations by Irish partners and discussion	Joanne Finnegan & Stuart Quinn (Netwell Centre)
15.30 – 17.00	Transfer and visit of two HSH users (split in 2 groups)	Joanne Finnegan & Stuart Quinn (Netwell Centre)
17.00 – 17.45	Exchange of views on visits	Ophélie Durand & Nena Georgantzi (AGE)
17.45 – 18.20	Updates and discussion on qualitative analysis	Nena Georgantzi & John Oates
18.10 – 18.30	Wrap-up and goodbye	All

### Participants

1. Blandine Cassou – Mounat (AIM)
2. Angela Cluzel (EDE)
3. Ophélie Durand (AGE Platform Europe)
4. Nena Georgantzi (AGE Platform Europe)
5. Joanne Finnegan (Netwell Centre)
6. Stuart Quinn (Netwell Centre)
7. Shauna McGee (Netwell Centre)
8. Heidrun Mollenkopf (BAGSO)
9. John Oates (HSH Management team)
10. Marja Pijl (Eurocarers)

## Appendix B: Template for Collection of Feedback after Dundalk Pilot Site Visit

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### Home Sweet Home Advisory Group meeting 18<sup>th</sup> November 2013

#### Dundalk – Ireland

The aim of the Advisory Group (AG) visit in Dundalk is to:

- enable experts to have an overview of the Irish pilot site;
- comment on the successes and failures of technology components;
- experience the use of HSH technology by older people and professionals in order to give evaluate its acceptance, added value and impact;
- provide advice on specific issues of concern to the pilot site in Dundalk;
- provide long-term perspectives to its outcomes.

After the pilot site visit, experts are requested to write a one/two page report on their experience and views of the visit based on the following questions:

- 1- Expectations of the experts prior to the visit (positive/negative?, etc.)
- 2- Perceptions of experts during the visit (e.g. acceptance of technology?, etc.)  
*(Is the technology user-friendly and adapted to users' needs? Which are the challenges? Are there technical issues? How is it applied in this pilot site? Are there any particularities? Do the users react/ accept the technology differently than in other pilot sites? Do you have any thoughts about the reasons for this?)*
- 3- Perception of experts after the visit (e.g. added value for older people?, positive/negative?, etc.)  
*(Is there an added value by the use of technology for the users involved? Can you make a comparison with other settings? What are the challenges and lessons learned? Are there any ethical or other concerns?)*
- 4- Which are your recommendations concerning the provision of the technology-based services? How could we better use mainstream and recent technologies?
- 5- Which are your recommendations in case HSH results are negative, in particularly regarding economic benefits (due to the cost of the used technology, as discussed in Dundalk)?
- 6- Do you have specific recommendations, experience regarding the three questions raised by HSH Irish partners?
- 7- How, in your experiences, could you see this type of research and technology scaled into the wider reality healthcare sphere? Taking into account data protection/policy changes/costs/user acceptance etc.
- 8- With projects going mainstream how is it possible to develop knowledge further and alleviate the pressures on existing healthcare models? What are the barriers and how do they feel they can be overcome in the future?
- 9- Public/Private Funded projects. There are more examples of these type of projects working in the private sector, would you know of these and share your experiences of



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same and if you could see these working in the public sector. How could you see it working in the public domain with regards to policy changes/cost contributions/input from stakeholders etc.?

10- Do you have any suggestions on the dissemination of the project findings?

**THANK YOU!!!**

Please return your report by **December 15th 2013** to Ophelie Durand  
at [ophelie.durand@age-platform.eu](mailto:ophelie.durand@age-platform.eu)

## Appendix C: AG Members individual reports on Dundalk Pilot Site Visit

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### C.1 Report by Blandine Cassou Mounat (AIM)

The aim of the Advisory Group (AG) visit in Dundalk is to:

- enable experts to have an overview of the Irish pilot site;
- comment on the successes and failures of technology components;
- experience the use of HSH technology by older people and professionals in order to give evaluate its acceptance, added value and impact;
- provide advice on specific issues of concern to the pilot site in Dundalk;
- provide long-term perspectives to its outcomes.

After the pilot site visit, experts are requested to write a one/two page report on their experience and views of the visit based on the following questions:

#### 1- Expectations of the experts prior to the visit (positive/negative?, etc.)

Prior to the visit, I did have the expectation to understand better how we can find solutions to improve elder people's lives at home.

I had some experience with distance monitoring of patients suffering from chronic diseases in another European Project (Renewing Health) and I must say that compared to this other visit, the organisation of the visit of Home Sweet Home was a lot better.

The most important point for me which I did not necessarily expect was the concrete visit of the project at elder people's place, which really allowed me to think of some concrete problems encountered.

#### 2- Perceptions of experts during the visit (e.g. acceptance of technology?, etc.)

*(Is the technology user-friendly and adapted to users' needs? Which are the challenges? Are there technical issues? How is it applied in this pilot site? Are there any particularities? Do the users react/ accept the technology differently than in other pilot sites? Do you have any thoughts about the reasons for this? )*

The technology seems to be user-friendly indeed.

I rather see a problem in the fact that the technologies provided were not always required by elder people:

- Mambo was reported not be used
- Doubling the diabetes monitoring equipment of one of the users (why give him this equipment if he already has one? -> is it always the case for such diabetes patients in Ireland that they have this equipment? If this is the case, we should not provide them with the machine for a second time and just with the other appliances).

The technology was accepted very well and appreciated.

I wonder whether providing a teleconference system is really necessary (it is probably also linked with the time when the project started and the absence of other cheaper and easily accessible solutions). This means I do not doubt the usefulness of a

teleconference system, but I wonder if this is really the role of a European project to provide it.

The main issue really seems to be to have an internet connection paid for. People do need to have it (this was also funded by the project but will be lost now).

As for technical problems, the project manager team mentioned problems with battery, problems with some of the equipment that always has to be plugged in.

3. Perception of experts after the visit (e.g. added value for older people?, positive/negative?, etc.)

*(Is there an added value by the use of technology for the users involved? Can you make a comparison with other settings? What are the challenges and lessons learned? Are there any ethical or other concerns?)*

One of the challenges is the involvement of people in this type of project.

If I understood right, all participants are voluntary which raises the question: what would be the acceptance rate for a population at risk in general (voluntary and not voluntary users). Put in other words, it would be interesting to know if this project can be deployed at a larger scale and used for everybody if its added value is established.

Another issue outlined many times in all study cases is the relationship with the GP on the health monitoring part. For example in one of the visits where the patient suffered from Diabetes, it was said that his doctor did not approve of the second monitoring system provided by Home Sweet Home to measure the Blood pressure.

It would be interesting maybe to meet this doctor to better explain the Home Sweet Home project and see why exactly he was criticising the HSH equipment: is it because he thought it was overlapping or is it because he feared to lose the link with his patient?

In the first case, he would be right while in the second case, a training could be offered to doctors on this issue or a reform of the financing of doctors should be considered (towards a pay-for-performance system)

One of the questions that I asked was whether this introduction of all technologies at the same time was not perceived as an invasion for the participants. But I have been answered that except some technical problems at the beginning, patients rather enjoyed the safety that these new devices created. So this again, would be positive.

4. Which are your recommendations concerning the provision of the technology-based services? How could we better use mainstream and recent technologies?

Of course, the use of skype should be recommended for teleconferences.

Otherwise a linkage between all technologies used could be interesting (if this is technically possible). What I mean by this is that it should be evaluated whether newer technologies (that did not exist at the beginning of the project) could now be used with a higher user-friendliness. Eg. What solutions exist on an I-pad or I-phone that could cover more needs at the same time.. (replacing the mambo and the Intouch system by one of these technologies)

5. Which are your recommendations in case HSH results are negative, in particularly regarding economic benefits (due to the cost of the used technology, as discussed in Dundalk)?

As for exit strategies for the programme in case results are negative, I would advise to leave the equipment with the people who know how to use it (rather than taking it back) and trying to see if they could support the cost of the system (call centre).

If it is not the case, I would advise to get in touch with the Irish compulsory health insurance, with a strong evidence-based of added value.

Would there be a way to involve this actor earlier on (as a partner?).

The Dundalk city Council could also be asked whether they could fund this service.

6. Do you have specific recommendations, experience regarding the three questions raised by HSH Irish partners?

1. How, in your experiences, could you see this type of research and technology scaled into the wider reality healthcare sphere? Taking into account data protection/policy changes/costs/user acceptance etc.

The philosophy is to integrate the ICT for older people and chronic diseases within the existing health/LTC system (that should not be a specific project anymore - need of coordinating / integrating health and LTC systems)

Need to think about the acceptance of the devices, meaning that one should avoid to many devices, using simple and reliable devices easy to maintain (iPad instead of complicate devices)

Think on the change on the health system (need to involve and clarify the role of GP/homecare/ first line and hospitals, which role for healthcare providers, new jobs and task repartition)

The costs of ICT and its integration should be calculated (plus maintenance, training of patients and family and providers, who will pay for the devices, internet access, battery...) and also how to integrate it in a new way of financing and remunerating for chronic diseases (mix of capitation, lump sum and fee for services)

Think also about the integration of a unique health record for the patient including what is done a home level and by doctors (with the classical questions and measures about data protection)

Thus, need to mainstream all progressively (test first in an entire region)

2. With projects going mainstream how is it possible to develop knowledge further and alleviate the pressures on existing healthcare models? What are the barriers and how do they feel they can be overcome in the future?

We need to think about the acceptance of the devices, meaning that one should avoid to many devices, using simple and reliable devices easy to maintain (iPad instead of complicate devices)

We should also address the change on the health system (need to involve and clarify the role of GP/homecare/ first line and hospitals, which role for healthcare providers, new jobs and task repartition)

The costs of ICT and its integration should be calculated (plus maintenance, training of patients and family and providers, who will pay for the devices, internet access, battery...) and also how to integrate it in a new way of financing and remunerating for chronic diseases (mix of capitation, lump sum and fee for services)

*(see also answers to Questions 2 and 3)*

3. Public/Private Funded projects. There are more examples of these type of projects working in the private sector, would you know of these and share your experiences of same and if you could see these working in the public sector. How could you see it working in the public domain with regards to policy changes/cost contributions/input from stakeholders etc.?

-> Political will is essential to go from a private-funded project to a public-funded one. Evidence that the programme brings a real added value and saves money is also important and can trigger political will.

The healthcare sector as a whole has to back the change for it to happen.

Health carers therefore probably need to be convinced and some of them trained to make the change.

Regarding public and private funding in general:, the question also relates to the types of health system used, which has an influence on the reimbursement.

The question of public vs private depends mainly on the type of health system which is country dependent: in the Bismarckian system with providers in competition (BE, FR, NL, DE, CH) it is not a question; in the Beveridgian systems (IE, EN, SP, IT, Scandinavia) it is sometimes easier to implement the decision of integration, once decided (and financed) as the system is unique and the providers often are part of the systems.

### 7. Do you have any suggestions on the dissemination of the project findings?

I think AGE already has a big experience with dissemination of findings.

What I can suggest is:

- Presenting the results in more conferences (EIP Conferences ?)
- Preparing a Report that is short and readable with visuals if possible (schemes, photos)
- Sending it to all partners but also putting it on Twitter/ on your website/ asking partners of the project to put it on their website
- Get in touch with all local authorities/ associations that could be interested in the results of the project

## C.2 Report by Heidrun Mollenkopf (BAGSO)



The aim of the Advisory Group (AG) visit in Dundalk was to:

- enable experts to have an overview of the Irish pilot site;
- comment on the successes and failures of technology components;
- experience the use of HSH technology by older people and professionals in order to give evaluate its acceptance, added value and impact;
- provide advice on specific issues of concern to the pilot site in Dundalk;
- provide long-term perspectives to its outcomes.

### 1- *Expectations of the experts prior to the visit (positive/negative? etc.)*

My expectations concerning the meeting were rather high as I knew the Netwell Centre from earlier visits. Concerning the pilot sites I was looking forward to see and hear from users about their experiences after three years of participation in the HSH project.

### 2- *Perceptions of experts during the visit (e.g. acceptance of technology? etc.)*

My expectations concerning the Netwell Centre team were fully met: we were welcomed, informed and accompanied by an experienced and competent team. The staff's relations with the older persons – at least with those we visited together – seemed well

established.

The limitations were obvious on the part of the technologies. Some – e.g., the domotic devices – were not adaptable to the different types of houses/homes, others as e.g., the video-conferencing and cognitive training were obviously not of interest to the older study participants.

At the same time I saw for the first time how excited an older user was about the devices he used. The older gentleman we visited in his home greeted us with the question: "What happens when the project ends? Will it be possible to continue with the devices and services? If not, and if it would end after three years, it would have been a waste of money!" Supported by his wife he argued that for most of the older people it would not be possible to pay for it. And both of them confirmed how important the vital parameter monitors had been for him after he returned back home from hospital after a serious illness. Thanks to the devices he felt much more secure and slowly dared to get out again, to take part in social activities or just to move about. These activities resulted in a loss of weight and better general health.

3- *Perception of experts after the visit (e.g. added value for older people? positive/negative? etc.)*

This visit made obvious (1) how much older persons can benefit from technically supported services, (2) how important the combination of technical interventions with social support is, and (3) how important it is for projects to provide a transparent exit strategy. To some people (as we met them in other places) it does not seem to make any difference whether they can continue using the systems or they are even relieved when the study ends. However, in case they really got accustomed to the devices and services and relied on them, it is a great challenge and important ethical question how to deal with this situation.

4- *Which are your recommendations concerning the provision of the technology-based services? How could we better use mainstream and recent technologies?*

My impression (and experience from other studies and practices I know) is that the technologies should be embedded into a holistic support system, including training and a regular social care network. Trieste provided a good example of joint efforts of service providers, technology providers and political stakeholders to ensuring good health and care services in their municipality.

Moreover, it might be useful not to introduce too many devices at the same time. Instead, people should be able to learn to use one device after the other. Once they experienced the usefulness of one device they will be more declined to try the next and maybe more demanding one.

5- *Which are your recommendations in case HSH results are negative, in particularly regarding economic benefits (due to the cost of the used technology, as discussed in Dundalk)?*

I would not care about economic benefits. The aim of technology supported services should be better quality of care and more security and autonomy of older persons.

6- *Do you have specific recommendations, experience regarding the three questions raised by HSH Irish partners?*

After having visited several projects I think that user acceptance is not the main problem. More important is to convince general practitioners about the usefulness of the combined technical/service system and to gratify them when using the system (which is not the

case until now).

### 7- Do you have any suggestions on the dissemination of the project findings?

Try to address policy makers, health and care insurances, senior citizens' organisations etc. who can support the systems' implementation.

## C.3 Report by Marja Pijl (EUROCARERS)

### 1. Expectations

I expected to find similar results as for the other projects I have been involved in.

### 2. What I learned during the visit

It was interesting to first get a presentation of the region where the project takes place, a rural area with a high degree of social cohesion.

We were told that this project - contrary to other projects - was not primarily about health but about environment.

Problems that had been encountered seemed to have to do with the equipment, with the providers of telecom connections and with the organisation of the health care system.

Due to problems with the health care system, the project used a call centre on the other side of Ireland. This had worked well.

It was acknowledged that some of the devices were not good enough, like the mambo and that there were regular devices like the mobile phone that could serve the same purpose. This, of course, would be much more practical. However, the use of Skype turned out to be not feasible in this project for reasons of competition between telecom providers.

There had been problems with some equipment (like cords that turned out to be an obstacle) but these were remedied. Another problem that had been encountered was that after power cuts the system had to be rebooted with a button that was difficult to find.

There had been many health alerts with a rather high number of false alerts. This could have been caused by standards that were too high, faulty equipment or false reading of data.

According to the project officers two thirds of the participants said they were happy to be involved. There were 3 dropouts among the 30 participants in the experiment, as opposed to 10 in the control group.

We had the chance to talk to one patient. In my case this was Tom, who had diabetes. He lived by himself and he seemed to feel quite comfortable with the devices for taking the necessary measurements. He had participated because he was asked to join and saw no reason to say no. On the other hand, he would not mind going back to the way he used to do his measurements before, in fact he had continued to do so during the experiment, because his GP wanted this. No wonder he did not mind giving up the new devices: it would make life simpler for him: only using one method instead of two at the same time. Here one of the problems of the national health and social care policies became visible, which we had encountered in Belgium as well: because the GPs are paid with a fee for service they were not willing to invest any time in participation in the experiment. It seemed as if the Irish

project stood quite apart from the formal health care system and this was different than in some other projects. A strong compartmentalisation between primary and secondary health care contributed to this situation.

One of the project workers had helped Tom to install new batteries when he needed them and had also provided these batteries. We heard that the batteries were quite expensive, and after the project those who would like to continue with the electronic devices would have to pay for them themselves.

### 3. After the visit

A key question is, of course, for which categories of patients the technological devices will be useful. It had struck me that in all projects with which I am familiar and where technological devices are tried out they are always concerned with the same three diseases: Chronic heart failure, diabetes and COPD. Would technological devices also be applicable for other chronic health conditions? Of course in Dundalk this question could not be answered.

In the discussion we did touch on the question for which categories of patients these technical applications are useful and in which cases their use is not advisable. Depression and frailty are counter indications but nonetheless a smoke alarm would be good for people with beginning dementia. In this project dementia had been an exclusion criterion. It was mentioned that the use of ICT might be more beneficial for working people than for older people, but the older people are the ones who suffer more often from chronic diseases than younger people. The project staff thought that the way forward would be to use technology on a larger scale. It seemed to be well accepted by the users in Dundalk.

At the same time it was acknowledged that there is a section of the population that is not interested. Still I think that those who are protagonists of introducing more technology into health care services can easily underestimate the resistance among older people against the digitalising of services. When I look at my personal network I know of at least three persons who simply refuse to have anything whatsoever to do with computers. The others do use a computer, but their use is rather limited and so is mine (mostly e-mail, internet and for some Skype). Each new system or programme requires new skills and older people have to learn (be taught). In addition to these obstacles there is the fact that one needs to renew one's equipment after only relatively few years. Not to mention the rapid development of new programmes like facebook, twitter and all the apps. If a personal assistant has to be used to learn how to use the new systems and programmes, this adds to the already considerable costs involved with getting new equipment.

If policy makers count on implementing technology on a larger scale, they will have to take the resistance of some older people into account as well as the costs to be borne by the users.

It was remarkable that in this case it was not said to be difficult to recruit participants for the project. The reputation of the Dundalk Centre for Technology was one factor that explained this, as well as the closely knit community, where people know each other and it seems they encouraged each other. We learned that relatives had played an important role, both in a negative and a positive sense. I did not hear this in other countries. It should be taken into account that the family plays a large role in Irish society.

It could not be said that this project had prevented any adverse events which might otherwise have occurred. The project was too small and had lasted not long enough to be able to draw any statistically relevant conclusions. If the preventative effects of the use of ICT could be

demonstrated then this would be an important contribution to cost reduction. Positive effects of the project seemed to be that patients felt better because they knew they were monitored. The daily collection of data by the patients themselves turned out to be a stimulus for some to change their lifestyle.

It may be interesting to mention that I just came across a review of a dissertation to be defended this month at the University of Maastricht by Josiane Boyne. It is titled Effects of Telemonitoring in Patients with Heart Failure. She has found that telemonitoring increases the knowledge patients have of their disease and their self-care. There are positive effects on anxiety and depression and the task of the heart-failure nurse has been eased.

This points in the same direction as the outcomes in Dundalk.

### 4. Recommendations

Like in other projects it was emphasized in Dundalk that it is necessary to make the devices and systems as easy to use as is possible and to try to work with systems that are used by the general public.

I think that the more people have experience with ICT at a younger age the more they will be inclined to use it as they get older. For working people the workplace is the place where they learn about what is new in ICT. Older people do not have such a natural learning environment. I think it could be helpful if there were facilities (like community centre, libraries or the University of the Third Age) where older people could familiarise themselves with the innovations in the ICT sector and where they could practice new skills at no or very low cost, so that they remain up to date re ICT.

Why not have a “digital concierge” as a community service in each locality to help people who have problems with their ICT? People would be less frightened and feel reassured when something goes wrong with their equipment and the concierge would make the threshold to work with ICT lower. The DREAMING project in Langeland used such a person very effectively.

A more fundamental question is, that the more integrated the health care system is, the easier it will be to maximise the returns on implementing e-health. If some vital participants, like the GPs don't want to collaborate because they come under a different regime, this will reduce the benefits of implementing electronic systems a great deal. But integrating systems that are now apart is easier said than done.

### 5. What about economic benefits?

It is logical that in a small project like the one in Dundalk the costs are higher than the demonstrable economic advantages. On the one hand this may be a matter of scale. If the numbers are larger, probably the costs per participant would be lower. Another problem is the length of the project. In order to show that a project such as this has a preventative function, it should last much longer, maybe as long as 10+ years.

It is interesting that projects such as these take place in many countries, because it can show which national structures such as the organisation of health care system or the more public or private character of services are conducive or prohibitive to the introduction of ICT.

But if we try to find statistically relevant data, we will have to work with much larger samples under similar rather than dissimilar conditions. Testing new systems in several countries at the same time makes it more difficult to get statistically relevant figures.

There are very many European projects, a lot of them quite alike. Why doesn't Europe compare the results of the projects and call a meeting of the most successful projects. The partners of all these projects might then be able to decide on the systems and devices which seem most promising. These could then be tested out on a very large scale and over a longer time in a country with conditions that offer good possibilities for the introduction of ICT. By doing it in one country only one reduces the statistical problems that are caused by the different national contexts. Unfortunately such a procedure would take a very long time and the trend among policy makers and health care providers is to innovate rather sooner than later.

Still, it is important to consider very carefully which systems should be implemented and not to do this in a hurry. Investments in ICT are costly and if they have to be changed too soon and too often there will be no economic benefit.

The small projects like DREAMING and HSH can be considered as testing grounds to find out what the problems are and where the openings are for further development of e-health and what conditions might have to be changed in order to implement e-health successfully.

### **6. Questions from Irish partners.**

I find these questions very difficult to answer. It would be good if there were sufficient evidence about the effectiveness of various systems, before they are rolled out on a larger scale. Interoperability of systems is very important. I understood in Dundalk that there should be standards for open source ... Obviously, in order to discuss these problems one must have a better insight into how technology works than I do.

As for the question about public/private funded projects, my frame of reference is the Dutch Health Care system, which has gone private, but with heavy government regulation. All citizens have a mandatory health care insurance with a private insurance company. They pay part of the premium directly to the insurance company. About as large a part of the premium for this insurance is paid by the employer. For older people the premium is taken out of their pension together with taxes. A large part of all health care comes under this system, and for treatment that is not included in this basic insurance package one can conclude an additional insurance with one's company. One can say that we have a private health care system mostly paid for with public money, that is if we consider the mandatory premiums as public money, because they come under government rules and are obligatory. There are very few incentives to organise health care outside of this system, so I find it difficult to say anything about the public/private question. It all depends on how the health care system is organised, which is different from country to country.

### **7. Dissemination**

My recommendations would not be different here than for previous projects, with one exception. There are so many experiments everywhere, a few large scale, but many rather small scale, about which we can find reports everywhere. Readers may easily feel overfed with this kind of material. I think it would be much more beneficial to write some good overviews of a large number of similar projects and compare and contrast their outcomes. This may be a helpful tool in the course of further development of e-health.

### C.4 Report by Angela Cluzel (EDE)



EUROPEAN ASSOCIATION FOR DIRECTORS AND PROVIDERS OF LONG-TERM CARE SERVICES FOR THE ELDERLY A.S.B.L.

#### Advisory Board HOME SWEET HOME Pilot Site Visit DUNDALK

1. DUNDALK and the County of Louth have a strong reputation within the AGE platform for innovation in the use of technology enabling older persons to remain living at home. The experimentation for "smart homes" carried out at the Dundalk Institute of Technology, the Netwell Centre, has often been cited in Brussels. That Dundalk had been selected as a pilot site for the Home Sweet Home project was of no surprise. The question that I asked was more : who would be operating the project? Health services, social services or the local authorities?

The project in fact was coordinated by the Netwell Centre team ; a team who has already gathered much experience in collaborating with the Irish health services and the County Louth social services. In introduction to our visit a short film informed us of the pioneering efforts made by the County Louth to make the county the first "age-friendly county" in Ireland and that could be a model for others to follow. The efforts to integrate older persons into the community, neighbourhood visits, bus service "à la carte" to shops or doctors cabinet, numerous themes for getting together (Older People's Forum), only to quote a few of them, were set up. Already a lot was existing to keep older persons to live longer in their own homes.

The Home Sweet Home project was introduced into this context by providing technology to integrate care solutions combining social and health care. The Netwell Centre coordinate the project with conviction.

2. We learned that not all the technology envisaged by the HSH project was installed in the pilot homes: ex. cognitive training; video-conferencing; domotic system for opening windows and doors

What we saw installed in the home of Mr. T were vital parameter monitors: blood pressure meter, glucometer, and scale for body weight. The readings went to the portal installed in a discreet corner of the living room. The portal was in the form of a touch-screen interface, smaller than a television but larger than the portal we saw installed in Antwerp. *This touch-screen version seemed more user-friendly and Mr. T used it with ease* using a stick to activate the icons. He passed from one reading to another with competence. He was able to interpret the graphics of his health records. However Mr. T followed the instructions of the project coordinators carefully, as there was one technical difficulty to overcome: it was not recommended to "switch off" the screen at night as this "cut off" the device. Some users automatically "switched off" and the portal had to be re-initialised!

Mr T. found no difficulty using his vital parameter monitors. However he was uncertain of the reliability of the glucometer's reading and continued to take is glucose reading according to the method prescribed by his G.P. He did this *as his G.P. took no interest in the HSH monitoring*. We learned that most of the G.P.s took no concern in the HSH project (one GP accepted to be on an "alarm" chain). **This is certainly an area where**

### **a solution should be found in the event of wide deployment of vital parameter monitoring.**

Mr. T. said that his engagement in HSH was not "vital" to him and he would continue living as before when the technology was taken away but he did appreciate the contact from the call centre, *he had a discreet feeling of being cared for*, and if there was anything unusual in his home or his health he knew someone would be in touch with him from the call centre. To the question on batteries for the technical devices Mr. T said that recently he had to change the batteries of his blood pressure meter. They were 4 batteries placed in top-to-tail order. Luckily the project coordinators had batteries in their car and were able to change the batteries. It would certainly be unlikely that Mr. T would be able to change them himself. **The cost and hassle should be accounted for in future deployment.**

Concerning the broadband connection Mr T had had this installed by the HSH project as he had never needed broadband before entering the project. This was the case of many of the participants. The cost was supported by HSH for the duration of the project. However when asked would he continue to subscribe to a broadband connection Mr. T replied that he *was taking internet classes and was going to buy a laptop before the end of the project* and he would envisage the need for keeping on the connection. **We had the feeling that participating in the HSH project had opened up his curiosity for "getting connected".**

We asked him if the sensors were intrusive in his home and Mr. T. told us he was not aware of them. He knew that they would tell him if there were a fire, flooding, or heating alerts and that there would be an alarm if he was not moving around as usual.

Although Mr. T. was indifferent about the ending of the use of the technology it came through that *he would miss the personal contact he had had with the two coordinators of Netwell Centre*; **participating in the project had brought him the cheery visits to his home of Joanne and Shauna.**

3. To what extent did we find an added value for older persons? Concerning the *environmental monitors I certainly believe they bring security and reassurance* and contribute to living well longer at home. I would add a floor lighting from bed to bathroom too. The package would include of course the portal, touch-screen unit with "behind it" the call centre.

However to oblige vital health monitoring by technology *without compliance with, and a patient-doctor relationship, with the GP* and other health specialists does not seem a realistic approach to better care. The health monitoring we have seen in Trieste with the involvement of the district medical centre and a call centre seemed an optimum set up.

In all the pilot site visits we have remarked that the learning of the use of the technology can be a hurdle and that the selection of the participants naturally takes into consideration this parameter. However what brings evident pleasure to the participants is the "extra" visits they receive from nursing staff, coordinators, throughout the project duration. **Maybe one impact for added value could be that the participants are stimulated in their daily living, in receiving visitors and, can one say, enjoy "un meilleur image de soi".**

4. We had lively discussions with the Netwell Centre team, they held no secrets from us and presented from their point of view the flaws and the positive points of the HSH project. They informed us extensively of the Irish national health system: hospital health versus community health, which indeed left little place for the funding of "prevention". They like us shall be anxiously awaiting the statistical analysis of the 60 selected patients and the final



## D4.6 Advisory Group Final Feedback

results of the project.

Specific Recommendations :

The passage from a research project to wide-spread application in the healthcare system.

Wide deployment of domotic living is exactly what is happening in the département where I live: the Corrèze in the centre of France. On the one hand The local departmental authority, the Conseil Général (CG), co-funds the functioning of its nursing homes (35 homes) and on the other hand there is a need to adapt housing for older people to stay on living longer despite reduction of their autonomy. Therefore a priority of the housing policy is to enable people to live longer at home and help those who encounter difficulties to be aided by new technologies. After an experimental phase from 2009 to 2011 which proved that domotic technology can offer a pragmatic answer to the needs of older people, the CG decided to make a wide-spread offer to the inhabitants of the département.

<http://www.correze.fr/personnes-agees-et-handicapees/les-personnes-handicapees/tele-assistance-et-domotique-personnes-handicapees/>

The domotic technology installed was to assure the security, to prevent falls and to manage falls in an optimum manner. The cost of rental of the technology is shared by the user and the CG ( taken from the budget of the nursing homes.)

This example shows the effectiveness of social care and security. Before installing "medical devices" it allows the beneficiary to get used to interacting with the call centre, to a first set of wires and plugs and to measure the cost benefit brought on by the feeling of "well-being at home".

A second step would be the introduction of medical devices according to the participative inter-action of the local medical centre together with the CG -based call centre.

Concerning healthcare data protection there are now well experimented systems available (in Sweden in the Lulea district). The transfer of data from the portals, e-prescriptions, e-medical reports can all be done with protection and with prior permission by the patient to whom he permits the data to be sent to.

I would add a sub-heading "medical-staff changes" . The health authorities of the region deciding to install healthcare technology at home must take into account the impact on the medical profession - the family doctor will have less visits, specialists will have their consultations modified, ; patients with télé-medicine control will engender a reduction in sanitary transport to specialists, etc. Nurses will have a new role : to accompany the patient to feel comfortable in taking his/her measures.

Finally, in order that domotic projects become reality we must have RELIABLE and AFFORDABLE technology and RELIABLE and AFFORDABLE coverage of broadband and only with confidence in the material can we alleviate the pressures and cost of existing healthcare and social care models. (although the Corrèze model has proved that tele-assistance can function through the telephone and does not rely on broadband).

Angela Cluzel  
E.D.E.

## Appendix D: Letter sent to HSH pilot site coordinators on August 16<sup>th</sup> 2013 regarding the Qualitative Study

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Dear Colleague,

In line with agreements with the European Commission and to help us all to deliver our promises, over the last weeks members of the Advisory Group have been working hard on making our plans for an additional qualitative analysis concrete.

As you know this analysis will add to the statistical data of the HSH trial and subsequently will provide better insight into the personal factors that can affect users' appreciation. Gaining such knowledge from consortia like HSH is crucial and one of the primary aims of the European Commission to prepare 'the market' for implementation on a larger scale.

In the coming months all sites will put in the extra effort of harvesting from experiences and histories of our users. We (Advisory Board and management team) realize this entails our time and resources. To make things as easy and tailored to your situation as possible we issue the questionnaire (see in the accompanying attachment) and a few critical questions (see below). The questionnaire is the result of numerous discussions and e-mails from the last few months that was the preparatory work. The questions will help us identifying possible **pitfalls** or **blind spots** that make it possible, based on your input, to solve before the analysis will start (mid September). To do so it is important to:

- a. have an internal discussion in your team on the practicalities of the analysis
- b. **return** your remarks (see questions below) to us **before August 26<sup>th</sup>**.

In case you have any enquiry: please do not hesitate to contact us.

Kind regards,

On behalf of the Advisory Board and management team,

Raniero

### Critical Questions: input for final questionnaire

- *Who (one person from the HSH site team) will (a) be in charge of coordinating\* the analysis and (b) be the contact person for this analysis?*  
\*Planning of interviews; collecting and administration questionnaires.
- *Who will perform the interviews\*?*  
\*Typically this is the dedicated person in your team that the particular participant (that will interviewed) knows best.
- *Based on the questionnaire: do you have a (preselection\*) list of ID-numbers (approximately 10) of participants that you will ask to participate?*  
\*Based on you current knowledge of participants – not after asking them for collaboration.

On the Questionnaire:

- *Do you have questions, suggestions and/or additional questions for the final version of the questionnaire?*
- *Is the process of interviewing / collecting data clearly stated? (If not, please let us know). Do you have additional suggestions?*

## **Appendix E: Letter sent to HSH Pilot Site Coordinators on 22<sup>nd</sup> September 2013 regarding the interviews**

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Dear Pilot Coordinator,

As expected, attached you will find the final version for you and your team to use in the interviews that will provide the consortium with a additional qualitative analysis.

During the PSC in approximately 10 days from now, we trust your team will be able to report on (a) your preparations and (b) progress. To align all efforts, we request you to prepare such short report (see also: 'critical questions' - my letter on August 16th). Please note that such report will provide valuable practical information and suggestions to other members of the consortium. Also: by sharing our experiences we will be able to align the analysis across the consortium which will contribute to the validity of our approach.

In case you have any enquiry: please do not hesitate to contact us.

Kind regards,

Raniero Chelli

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On behalf of the Home Sweet Home Advisory Board and Management Team.