

## CONFERENCE ABSTRACT

# Enhancing the Self Management of Type II Diabetes in Elderly Greeks Using m- and e - Health Facilitated Integrated Care Services and Policy Implications for Greece

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Chronic diseases are the leading cause of death and disability in Greece, a country suffering from a rapid deterioration of public health indicators during the years of the crisis. In the case of Type II Diabetes, the prevalence of the disease is estimated at more than 10% among Greek adults. The managements of Type II Diabetes has been so far mainly medical centred, specialists in special diabetic clinics providing secondary services to patients.

However, Type II Diabetes can be effectively managed in community settings if the patient is empowered to self - manage the condition. The presence of a multidisciplinary team of care professionals, that offers a holistic service, putting the needs and wishes of the patient and the caregiver at the centre of the care process, is of paramount importance in improving health related outcomes and decreasing the costs for management of the disease.

For the first time in Greece, a network of local government social and health providers, a Type II Diabetes advocacy group and an IT vendor planned and implement together an m - and e - health facilitated integrated care model in primary care settings within the framework of the EU co-funded project SmartCare.

This is a unique endeavor since currently, fragmentation of care services, lack of coordination, lack of appropriate IT systems to support co-decision making and medical - centred orientation of service provision are significant obstacles in planning and implementing integrated care services for the chronically ill.

Hence, the ATTICA pilot aims at supporting a shift towards vertical integration of chronic care and in this case Type II Diabetes, in an environment co-created by the main stakeholders and where the patient has a central role in defining the services appropriate to the individual needs in a community care pathway.

The objective of the pilot ATTICA is to apply integrated care services facilitated by m-health technologies in order to improve self - efficacy, patient activation and satisfaction measurements in adult T2DM patients (50+). Furthermore, to investigate whether after at least 6 months of such a service, clinical indicators of disease are improved (HbA1c) and whether the QoL of patients has increased compared to usual care.

The SmartCare Intervention consists of coordination of care carried out by trained care coordinators (nurses), supported by a multidisciplinary team of professionals (diabetes specialist, social worker, dietician) that apply e - care services and directed to adult T2DM patients based on individual needs.

Professionals assess the clinical, nutritional, psychological, social need status online in the vida24 platform and set out personal targets in discussion with patients and in terms of diet and basic parameter measurements such as blood glucose and pressure. QoL, Satisfaction with the service, Patient Activation, Self Efficacy, Perception of Integration are also assessed at the beginning, interim and at end of the project. Patient's compliance to targets is enhanced by automatic reminders and alerts generated by the platform and sent to an application in the patient's tablet (vidame). Messages to the app and Telcos are also means by which the multidisciplinary team encourages the patients to achieve targets set and to comply better.

ATTICA will present how the pilot planned activities related to: (1) user recruitment, (2) professional enrollment, (3) organizational changes, (4) IT and e-health technologies restructure, (4) Help - Desk Operation, (5) training of end users and (6) ethical and regulatory aspects.

The problems encountered in all the above topics, solutions put in place, risks encountered and lessons learned will also be presented, alongside interim outcomes from the pilot based on the MAST evaluation methodology for m-health technology facilitated integrated care as well as the preliminary results of the CBA conducted.

ATTICA will discuss sustainability and transferability issues in other care settings and moreover make proposals on how the service can be further developed in primary care settings for a more complex case - mix of patients and including more involvement of the social care sector.

Finally, Critical Success Factors for m-health facilitated Integrated Care service deployment will be discussed and the the results of the self assessment with respect to readiness and capacity for deployment of innovative solutions in the pilot, illustrating self-defined strengths and weaknesses, will be presented, based on the B3 Action Group Maturity Model of the EIP - AHA.

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**Keywords:** integrated care; type II diabetes; csf's; m - and e - health technologies; cba

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