REQUEST FOR INFORMATION QUESTIONNAIRE

ABOUT THE CAREMATRIX PROJECT

CareMatrix is a European H2020 Pre-Commercial Procurement (PCP) project for integrated care solutions designed to challenge the health market to develop innovative technology for People with Multimorbidity (PMM), funded by GA 964370.

The project consortium, made up of 7 partners from 4 EU countries includes Innovation Skane AB as coordinator, the International Foundation for Integrated Care (IFIC), NorwayHealthTech, Vestre Viken HT, Skane Lans Landsting, BIOEF Fundación Vasca para la innovación e investigación sanitarias and Osakidetza-Servicio Vasco de Salud. The project is coordinated by Innovation Skane AB.

In Europe, over 50 million people suffer from multimorbidity. Recent reviews find that people with multimorbidity experience a range of system and professional-related issues with care delivery. In part, this is because current investments in process-based provision means delivering healthcare within single diagnoses tracks or silos.

The CareMatrix project aims to close the gap between supply and demand for innovative integrated care solutions that enables the specific care, treatment, administration and support needed for people with multimorbidity. The objective is to bring radical improvements to the quality and efficiency of public services and service delivery by encouraging the development and validation of breakthrough solutions. This needs to be developed in close dialogue between people with multimorbidity, care providers and industry sectors.

ABOUT THE PCP PROCESS

Currently no existing solutions adequately meet the needs of PMM. Successful procurement requires involving technology companies and consortia at the earliest possible stage.

Pre-Commercial Procurement (PCP) is a useful approach to the public procurement of R&D services where no near-to-the-market solutions exist yet. The PCP can compare the pros and cons of alternative competing solutions, and de-risk the most promising innovations step-by-step via solution design, prototyping, development and first product testing.

The Open Market Consultation (OMC), as a first stage of the PCP process, aims at actively approaching the market to discover the state of the art. The OMC consists of an in-depth dialogue and provides an overview on the procurement objectives, the PCP process and the main clauses of contracts. Information sharing will follow established procurement principles of fairness, transparency, and accessibility to information.

Norway Health Tech

VESTRE VIKEN

INNOVATION SKANE

REGION SKANE

bioef basque foundation for health innovation and research

Osakidetza

IFIC

REQUEST FOR INFORMATION QUESTIONNAIRE

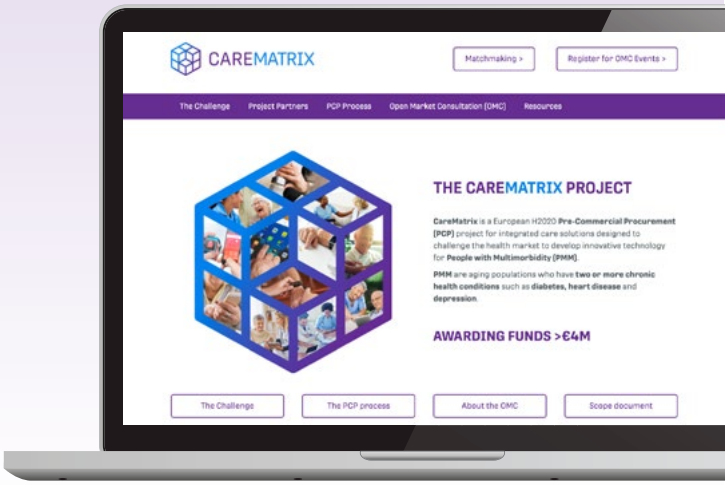
This Request for Information Questionnaire is part of the OMC and aims to gather information about the state-of-the-art and existing solutions to address the **challenges/needs in care for PMM** identified in the **Scope Document** and initially proposed **Use Cases**.

Through this questionnaire the CareMatrix consortium aims at receiving feedback from potential suppliers as well as other relevant stakeholders (including medtech experts, research organisations, patients' associations, care professionals' associations, health care providers and public agencies).

Completion of this questionnaire is voluntary and does not constitute a prerequisite or advantage of any kind for participation in the CareMatrix tender.

Thanks in advance for sharing your knowledge and thoughts through this questionnaire. Your responses will be valuable for CareMatrix to refine its approach, as part of the OMC process, and will be used for the project's purposes only.

You can exert your rights or ask any question at **suppliers@carematrix.eu**.



Complete the questionnaire inside Acrobat Reader by clicking and filling in the form fields below. You can save as you go. When finished you can email it by pressing the 'Submit Form' button on the last page or email it to suppliers@carematrix.eu

1. ORGANISATION'S DETAILS

Organisation name:

Headquarters Country:

Website:

Organisation type: Please select

Other:

Organisation size: Please select:

A brief intro for organisation:

Main contact's details

First name:

Last name:

Position:

E-mail:

2. CAREMATRIX SCOPE

A. Stakeholders

The pivotal target population of the CareMatrix project are People with Multimorbidity (PMM). For the purpose of this project, Multimorbidity is understood as the co-occurrence of two or more chronic conditions in a single person. Other relevant groups considered primary stakeholders of the project are health and care practitioners, eHealth Industry or SMEs or procurers at different levels, among others (see section 3. CareMatrix Stakeholders of the Report on insights, needs and key challenges scope document).

Do you think it is feasible to target this population with the CareMatrix approach?

☐ Yes ☐ No ☐ Don't know ☐ No answer

Please explain your choice:

Would you add any other stakeholder that could be relevant for the CareMatrix project?

☐ Yes ☐ No ☐ Don't know ☐ No answer

If yes, which one :

B. Building blocks

The insights, needs and key challenges identified at the initial stage of the CareMatrix project have been classified in five Building Blocks:

1. Early and comprehensive assessment with a preventive approach

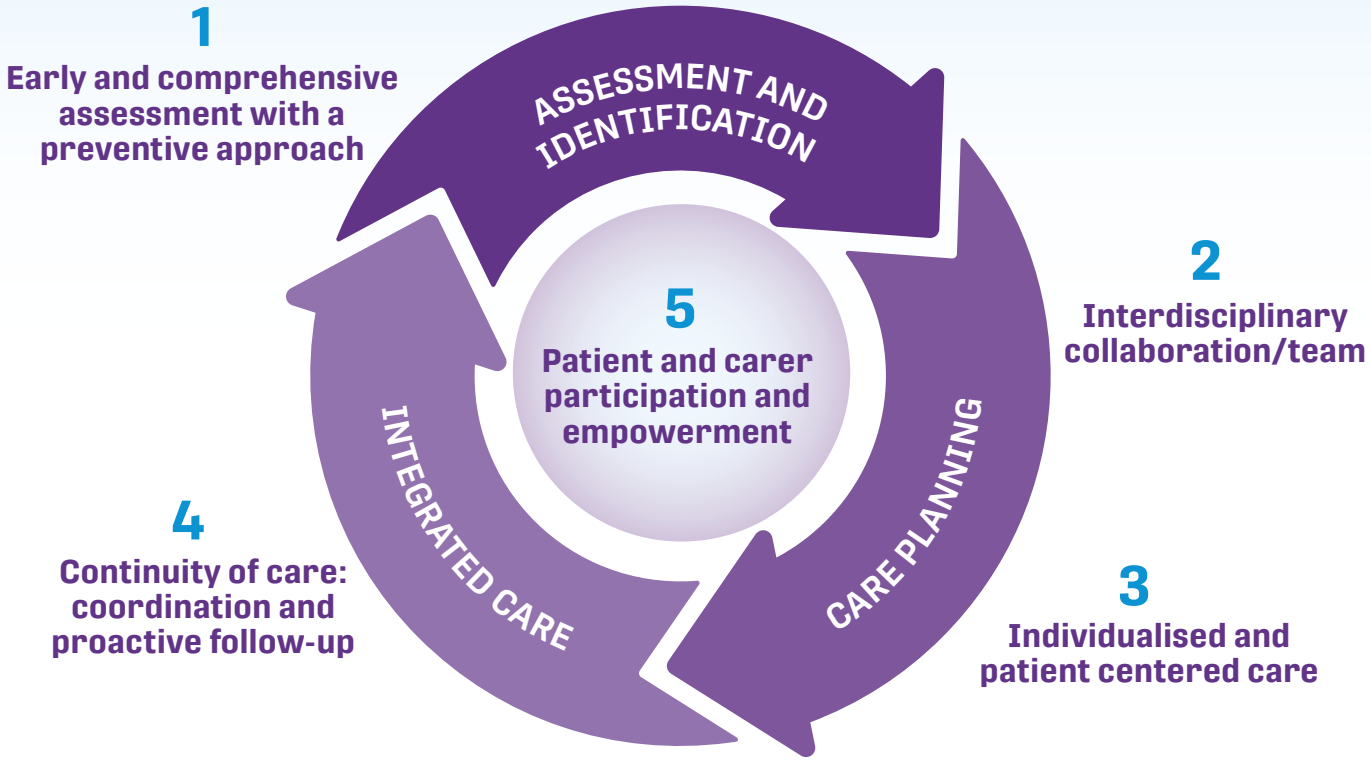
2. Interdisciplinary collaboration/Interdisciplinary team

3. Individualized and patient centered care

4. Continuity of care: communication, coordination and proactive follow-up

5. Patient and carer participation and empowerment

These Building Blocks have been ordered along a theoretical care pathway in the Scope Document.
Have a look and then answer the following questions:



Are the CareMatrix building blocks and concept description clear?

☐ Yes ☐ No ☐ Don't know ☐ No answer

Please explain your choice:

Which would be the biggest challenges to address in your view?

C. Use-cases

The previous Building Blocks have been elaborated in five Use Cases and described in the Use Cases document.

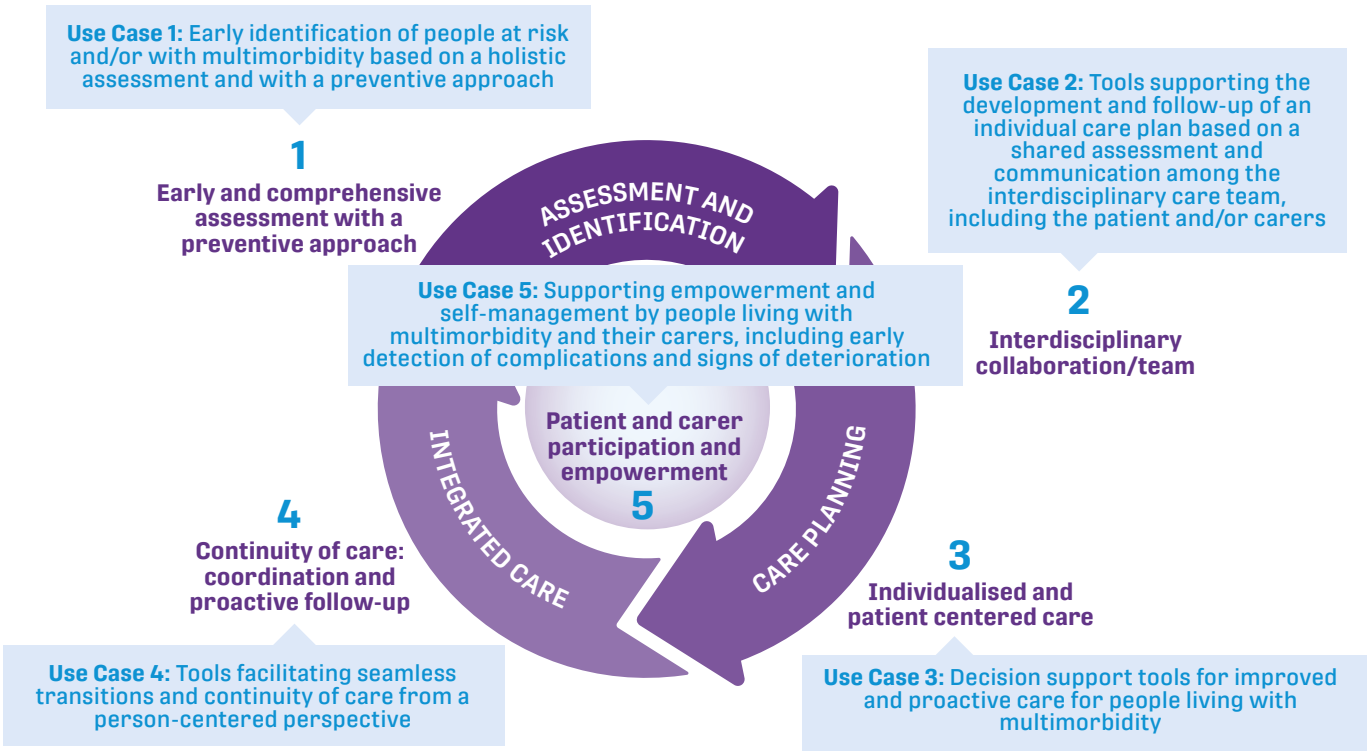
Use case 1. Early identification of people at risk and/or with multimorbidity based on a holistic assessment and with a preventive approach

Use case 2. Tools supporting the development and follow-up of an individual care plan based on a shared assessment and communication among the interdisciplinary care team, including the patient and/or carers

Use case 3. Decision support tools for improved and proactive care for people living with multimorbidity

Use case 4. Tools facilitating seamless transitions and continuity of care from a person-centered perspective

Use case 5. Supporting empowerment and self-management by people living with multimorbidity and their carers, including early detection of complications and signs of deterioration



Please have a look at them and then answer the following questions:

Are the CareMatrix use cases and concept description clear?

☐ Yes ☐ No ☐ Don't know ☐ No answer

Please explain your choice:

Could you indicate the complexity of the use cases by ordering them from higher to lower complexity?

Which would be the biggest challenges to address in your view?

D. Preliminary IT and legal/regulatory requirements

The CareMatrix approach requires interoperability between healthcare givers within 3 different countries, which is a challenge. How can procurers support suppliers to accomplish this objective?

The solution and necessary supporting materials should be available in the procurers' local languages and in English. Explain how this is to be achieved:

Privacy and data protection

The solution should be designed in line with the current Data Protection Regulation. Which privacy-by-design strategies do you consider important, and how do you incorporate them? And also considering the recent Schrems II-judgment?

Phase 3 – evaluation, support

The CareMatrix solution provider will comprehensively evaluate the solution at the premises of one of the three procurers in Phase 3, with a team available physically and/or remotely to resolve any issues and problems that prevent the system from working as desired. How will it be achieved?

Commercialisation

Solution developers will retain Intellectual Property Rights, and they are expected to commercialise the solution after the project end beyond the CareMatrix buyers' group. Why would CareMatrix be an opportunity for your organisation and which kind of measures would you put in place to commercialise the solution?

Describe in general how your company would ensure the delivery of SaaS in a way that the solution/product is aligned with applicable confidentiality/privacy regulations, and that data is securely managed.

3. ASSESSMENT OF EXISTING TECHNOLOGIES

A. On your own solutions

Do you have a solution covering all CareMatrix requirements in FULL that is already available in the market?

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

Do you have a solution related to one or more CareMatrix use cases?

Use case 1. Early identification of people at risk and/or with multimorbidity based on a holistic assessment and with a preventive approach

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

Use case 2. Tools supporting the development and follow-up of an individual care plan based on a shared assessment and communication among the interdisciplinary care team, including the patient and/or carers

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

Use case 3. Decision support tools for improved and proactive care for people living with multimorbidity

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

Use case 4. Tools facilitating seamless transitions and continuity of care from a person-centered perspective

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

Use case 5. Supporting empowerment and self-management by people living with multimorbidity and their carers, including early detection of complications and signs of deterioration

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

Briefly describe your solution, and name

If you have a solution, at which stage is your solution?

☐ Concept level ☐ Prototye level ☐ Market Releasd ☐ Don't know ☐ No answer

Has the solution been tested in real-world conditions or in a controlled environment?

☐ Yes ☐ No ☐ Partially ☐ Don't know ☐ No answer

If so, please indicate indicators of performance

Inside each use case, please select what your solution currently covers

USE CASE 1. Early identification of people at risk and/or with multimorbidity based on a holistic assessment and with a preventive approach

- ☐ Use of comprehensive data (electronic health data, social data, ad hoc assessment questionnaires, data/information provided by the patient or carer)
- ☐ Interoperability to access comprehensive information on a person from different available care services (primary care, hospital care, mental health care, elderly, social and community care)
- ☐ Access by general practitioners and by staff in charge of patients' segmentation to information on risk factors in a regular and timely manner
- ☐ Comprehensive assessment visualisation
- ☐ Alert/advice functionalities
- ☐ Case detection (of people at higher risk of becoming multmorbid, and/or of PMM and/or of PMM at higher risk of health deterioration)
- ☐ Storage of comprehensive data and assessment under the legal and regulatory requirements on security, privacy protection and ethics in place

USE CASE 2. Tools supporting the development and follow-up of an individual care plan based on a shared assessment and communication among the interdisciplinary care team, including the patient and/or carers

- ☐ Tools for the creation and update of individual care plans for PMMs
- ☐ Tools allowing for collaborative work between different healthcare professionals and healthcare providers)
- ☐ Tools enabling the communication and comprehensive dialogue between healthcare professionals and the patient and/or informal carers on the individual care plan
- ☐ Tools enabling the communication among the whole interdisciplinary care team (which in some countries/health systems could include social care and/or community pharmacies)
- ☐ Interoperability between data and information systems from different care providers (including also, if feasible, social care information systems)
- ☐ Enabling shared information on the individual care plan, including the medication plan and self-care advice
- ☐ Enabling shared information on patient's appointments, consultations, tests, scales
- ☐ Enabling shared information and assessment of the patient (among areas which could be addressed: individual's health status, functional status, mental health status, pain level, values and preferences, social and family resources, capacity to self-care and/or digital skills)
- ☐ Enabling shared information on support received by the patient from the social care system, when relevant

USE CASE 3. Decision support tools for improved and proactive care for people living with multimorbidity

- [ ] Access to clinical information/data, including on mental health.
- [ ] Access to information registered by the patient on symptoms, evolution of parameters, measures and others
- [ ] Access to the individual care plan
- [ ] In health systems/countries with not available IT-based solution already in place or planned for: solution allowing for an automatic detection of possible interactions between medications and treatments for different conditions that converge in a patient
- [ ] System allowing for alerts to care professionals on necessary interventions - including necessary reviews of the individual care plan - by the interdisciplinary care team, according to up-to-date evidence, protocols and care pathways in place
- [ ] Tool allowing to extract personalised recommendations for end users, including training materials, to be provided by healthcare professionals
- [ ] Platform allowing for a repository of resources that provide information and knowledge (including, if available, training resources) on up-to-date evidence and clinical practice guidelines on care for people with multimorbidity, as well as other practical tools for a better management of care for people with multimorbidity (such as individualised care plan templates, contact persons for consultation in other sectors/organisations, and/or information on available resources in the community, among others).
- [ ] Access to data on PROMs and PREMs
- [ ] Tools allowing for the extraction of data by health care professionals for a defined population or group of patients under their care, as well as to elaborate scorecards for the self-assessment of their practice
- [ ] Tools allowing for the extraction of data and scoreboards by healthcare managers for the evaluation of the performance regarding care for people with multimorbidity

USE CASE 4. Tools facilitating seamless transitions and continuity of care from a person-centered perspective

- [ ] Solution that supports the visualisation of the individual care plan by care professionals and by the patient
- [ ] Access to interoperable or shared relevant health data and information on the patient registered by different care sectors, levels, settings and care professionals providing care to the patient
- [ ] Access to data and information registered by the patient and/or carers (formal or informal) at home
- [ ] Tools allowing for timely and automatic transfer of information and communication between care professionals, levels and settings, particularly at times of care transitions such as hospital admission, hospital discharge, emergency visit, stay in a medium/long-term care institution, move to an institution or activation of other relevant social support or community support resources
- [ ] System allowing for alerts/reminders to relevant healthcare professionals for the review of the individual care plan, when relevant, in care transitions
- [ ] System facilitating clear and understandable information to be provided to patients and carers at key transition points (areas that could be addressed: next steps in the care pathway, updates to the individual care plan)
- [ ] Solutions enabling an easier access by the PMM to the healthcare system, particularly at times of health crisis, acuteness or when having a doubt about his/her health by care professionals
- [ ] If there is an identified care coordinator for the patient: contact information and communication channel with the patient's care coordinator

USE CASE 5. Supporting empowerment and self-management by people living with multimorbidity and their carers, including early detection of complications and signs of deterioration

- [ ] In health systems/countries where the law allows for it but it is not in place: development of a solution where the patient and/or his/her authorised carers can consult health-related information from the health system (such as tests, diagnostics, therapeutic goals) as well as include information themselves (such as a personal diary). In health systems/regions where a solution (such as a Personal Electronic Health Folder) already exists, to include a gateway to the existing Personal Electronic Health Folder.
- [ ] Platform allowing for a repository of information materials and tools for patients and carers to support them in a better management of their conditions (for example on monitoring, interpretation of symptoms, adherence to treatments)
- [ ] Tool providing access to personalised recommendations for end users, including training materials
- [ ] Platform allowing for the telemonitoring of a patient's clinical and emotional situation, as well as his/her adherence to treatment and possible complications
- [ ] Interoperable platform of existing home-care devices
- [ ] Tool for a better self-management of polypharmacy in patients who could benefit from it
- [ ] Platform providing information on resources available in the community that can support patients and their informal carers in a better management of their conditions
- [ ] Platform allowing for data and information on self-care activities as well as on the evolution of a patient's health conditions, parameters and symptoms to be registered by the patient and/or carers at home
- [ ] Platform enabling meetings, forums and communication between patients and informal carers to share experiences of living with multimorbidity
- [ ] Platform allowing for the collection of data on PROMs and PREMs

B. On other solutions in the market

Which other solutions do you know of are currently on the market, covering all or most of the use cases described in CareMatrix?

What is your understanding of available solutions on the market, supporting multiple processes/ treatment and/or tracks?

C. On current trends

Describe (in your view) the most significant current trends within the challenge area over the next 5 years.

How do you perceive these trends will affect customers, and how will you address this?

How will this affect your company, and product/service portfolio?

4. ANY OTHER QUESTIONS, COMMENTS OR FEEDBACK?

If you feel you have completed this form to the best of your current knowledge, please click the submit button to email it to suppliers@carematrix.eu

SUBMIT FORM >