Table Of Content

Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries

JA2015 - GPSD [705038]

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Project abstract

General Objective The proposal is promoted by a network of EIP-AHA Italian Reference Sites with the intent to validate and standardize approaches on frailty and multimorbidity by building on the instruments developed with the European Commission Innovation Partnership on Active and Healthy Ageing. Key-partners of the project are mainly EIP-AHA Reference Sites (and AG Coordinators: A1, A3, B3), representing countries from the northern, southern and eastern part of Europe. Methods and Means Proposed actions will support the development, validation and experimentation of a model to improve the detection, prevention and care of frailty and management of multimorbidity in EU countries, providing partners with different approaches to care from which to adopt/adapt their own systems/services. The model will be experimented in selected RS. It will support the development of innovative tools for the prediction of frailty and multimorbidity by level of care, focussing on community based prevention and avoidable hospitalization. It will offer the EC and the MS with instruments for the potential replication of the model/good practices through the EIP-AHA initiative. The involvement of European networks (EUREGHA), and of the International Scientific Research Networks in the field of frailty and disability (IAGG-GARN), will grant necessary scientific support and advocacy for a real EU and international value.Project's Main Outcomes• A shared model of references on frailty and multimorbidity.• A tool kit for the prediction of frailty and multimorbidity by level of care: Primary care: easy to use tool to assess risks of frailty through the physical function (slow gait speed, others); tools to support the design of information systems and care pathways for the management of chronic diseases. Secondary-tertiary level: identification of methods and instruments to predict multimorbidity. Other tools: instruments for professional's skills improvement and analysis of costs.

Summary of context, overal objectives,strategic, relevance and contribution of the action

Sunfrail was a 30 - months European project funded by the EU Health Programme 2014-2020. The consortium, coordinated by Emilia-Romagna Region, brings together 11 partners of the European Commission Innovation Partnership on Active and Healthy Ageing from 6 EU Member States of the northern, southern and eastern part of Europe.

The project's main objective was to develop and experiment a model, good practices and tools to improve the identification, prevention and care of frailty and management of multimorbidity in community dwelling persons (over 65) of EU countries.

After a process of literature review and in-depth discussions with major

stakeholders, frailty has been defined as a condition characterized by increased vulnerability and sensitivity to physical, psychological and social stressors, according to the bio-psycho social paradigm. Being frailty a reversible condition, the project focused especially on early detection and prevention, especially in primary care and community settings, in order to avoid disability and adverse outcomes.

Assessments conducted on Reference Sites Health and Social Systems and Services and related good practices allowed for the development of the Sunfrail Model on frailty and multimorbidity. At the same time, a specific appraisal indicated the necessity to consider older adults perceptions on frailty in order to bridge the gap between their needs and services available.
The review also pointed out also that a systematic assessment of frailty risk factors as well as the availability of specific tools for its early identification were missing; especially in primary care and community settings, leading to the design of the Sunfrail Conceptual Frame and of the Sunfrail tool.

The Sunfrail Tool is a nine-question, easy to use tool designed to identify frailty and multimorbidity according to the bio (physical), psycho (cognitive and psychological) and social domains. Based on the Sunfrail Conceptual Frame, the Sunfrail Tool can be administered by professionals and community actors, generating an initial "alert" for further investigations or activation of pathways within the health, social and community systems.

In order to facilitate the understanding and utilization of the Sunfrail Tool by social and health care professionals, the project has also designed the Sunfrail Tool for Human Resources Development; a short, multidisciplinary training programme on frailty and multimorbidity according to the bio-psychosocial model.

Within the Model experimental phase, the Sunfrail project conducted a further appraisal of identified good practices on population risk stratification (e.g.: Risk-ER), to measure how they could fit and enrich the designed Sunfrail Model of Care. The main outcomes were reduced hospital and emergency admissions for ambulatory care sensitive conditions. At the same time, the adaptability, usability and adoption of the Sunfrail Tool into Reference Sites current professional practice was tested, to verify the potential for replicability in EU countries.

The experimentation of the Sunfrail Tool involved 651 older adults over 65 years of age. The main results confirmed the capacity of the Tool to identify frailty and related risks in the population over 65, especially in primary care and community settings. The Tool appears particularly suitable to identify frailty risks in a population without clear signs of disability or not known by services and therefore is appropriate to orient the selection of preventive care pathways.

An assessment conducted on beneficiaries and professional opinions highlighted that the Sunfrail Tool is understandable, easy to use in every day

practice, facilitating access and linking health, social and community services.

It proved to be effective in raising older adults awareness on frailty risk factors and on services available; in strengthening professional's knowledge and approach to frailty; in facilitating the connections among existe

Methods and means

Coordination and management tools had been created by RER-ASSR, in collaboration with ASTER and EUREGHA, namely:
• Operational Plan
• Sharing of local, regional, stakeholders' contacts and mailing list
• Internal project repository
• Financial reporting manual
• Meeting minutes
• Set of teleconference and update of to do list
• Activity memo and reminder
• Continuous risk assessment analysis and contingency plan definition
• Management of all the communication with the Project Officer and the REA
• Preparation of budget amendment

Specific support was given to partner for the technical and scientific coordination of the
Project through ad hoc communications and feed back to task/WP leaders on methodological
aspects and on deliverables produced.

Work performed during the reportingperiod

Recent developments – Technical Aspects

Development of the Model - WP4

From August 2015 the project has started the first step of the operational plan, meaning the literature review, the assessment of Reference Sites health and social systems and services, the appraisal of EIP-AHA good practices on frailty and multimorbidity and the assessment of patients/beneficiaries perceptions of frailty and barriers to care. The review provided indications on the gaps existent in terms of early identification, prevention and management of these conditions, especially in community dwelling settings, and allowed the design of a tool for the early identification of these conditions. This phase was

complemented by the assessment of the human resources programmes and development of a specific model and tools.

Literature Review (WP4.1.2)
MACVIA French reference site of the EIP-AHA performed an international literature review, from July to October 2015.
A PubMed review was done on frailty and multimorbidity, reaching toward the general objective of Sunfrail project to improve the identification, prevention and management of frailty and the general care of multimorbidity in community-dwelling persons (over 65 years old). An Excel file was generated to extract the data. Four dimensions of frailty were identified: biophysical, psychological, social and environmental. Emphasis was put on the overlapping factors of the multidimensional perspectives of frailty. Frailty, although considered to be a distinct geriatric concept, shares close links with other concepts like multimorbidity or sarcopenia, as well as common psychological, social and environmental determinants.

Assessment of good practices (WP4.2.1)
Based on the work on good practices (GPs) conducted through the EIP-AHA initiative, the Sunfrail project has initially designed a set of criteria aimed to assess Sunfrail Reference Sites GPs on Frailty and Multimorbidity.
The applicability of these criteria was tested during the assessment of the good practices from the EIP-AHA initiative, conducted from December 2015 to March 2016, through 2 phases. During the first phase, an inventory of the existing repositories A3 (Prevention and early diagnosis of frailty and functional decline, both physical and cognitive, in older people) and B3 (Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level) was made with data from 2013. Two Excel tables were created, based on the criteria agreed among partner: one table for A3 Good practices, one for B3 Good Practices. All GPs were referenced within the tables. 98 GPs were listed in the A3 compilation. 86 GPs were listed in the B3 compilation. Out of 98 A3 GPs, 45 were selected, divided into 5 main topics (screening frailty, ICT tools, management of frailty, nutrition, statistical & observational research around frailty). Out of the 86 GP from action group B3, 41 were selected, corresponding to 3 main themes (ICT, management, integrated approach/New health models, training workforce). A set of criteria was selected to enable the identification of services good practices. The results of the assessment of GPs indicates that the criteria initially designed for the identification of good practices needed to be revised, as GPs from the EIP-AHA initiative (A3 and B3) could not fulfil entirely these criteria. In particular, on the repository EIP-AHA there was a lack of information concerning multimorbidity and frailty or insufficient information concerning the practical applicability of the practice. Based on these aspects the criteria for the assessment of GPs were then revised.

The assessment followed with a second phase in which Sunfrail Reference Sites Good Practices on Frailty and Multimorbidity were assessed and a report produced. This step has been performed as part of the Deliverable 5.4 (Survey of RS service delivery).

Assessment of partners Health and Social Systems (WP 4.2.2)

From September 2015

The main output achieved so far and their potential impact and use by target group (including benefits)

Among the project main outputs are: the Operational definition of Frailty, the Sunfrail Model and Tool for the early identification of frailty and multimorbidity. The project has also developed a Model and a Tool for human resources development: a short educational programme, for frailty detection, prevention and management with a multidisciplinary approach.

The assessment conducted on Reference Sites Health Systems and Health and Social Services, on the beneficiaries perceptions and barriers to care, and on the identification of human programmes and needs related to frailty and multimorbidity, gave an overall view of the models of care available at Reference Sites participating to the Sunfrail project and contributed to design the Sunfrail Pre-Model for the identification, prevention, management and care of multimorbidity.

The results of the assessments indicates that there is an important need to "bridge the gap" between services provision and utilization, especially considering beneficiaries perception of frailty versus their expressed need to maintain independence, that influences their health seeking behaviour.
It is therefore important to focus on older people awareness on risk factors and preventive measures, and on improving professional's knowledge and capacity to detect, prevent, manage and communicate frailty within a multidisciplinary effort.

The Potential for Innovation, Replicability and Sustainability

The proposed innovative Model and tools has allowed the assessment of the dimensions of frailty and multimorbidity, in different EU countries, following a multimodal scheme. It has provided to partner with a scenario of different approaches to care and good practices from which to adopt/adapt and complement their own schemes of care. It has supported the development of innovative tools for the early identification of frailty and prediction of multimorbidity according to the different level/entry point of care and with a tool for human resources development.

Replicability and sustainability has been ensured by the participation of all relevant actors (EU stakeholders, scientific community, services planning and delivery, decision makers and final beneficiaries), to all project's design and

implementation phases, including the main dissemination events (transnational workshops).
Particularly, the active involvement of EUREGHA (the European Regional and Local Health Authorities), of the European Union Geriatric Medicine Society (EUGMS) - working group on "Frailty in older persons", and of internationally recognized experts in the field of frailty and multimorbidity (AB members), has supported the project development with necessary strength in terms of scientific knowledge, technical input and potential for dissemination and replication, thus ensuring a real added EU and international value.

The active involvement of relevant EIP-AHA networks (A3 and B3 action groups), in the assessment and dissemination phases, has ensured full complementarity with the actions already implemented within the EIP-AHA initiative and the sustainability of proposed actions.

Achieved outcomes compared to the expected outcomes

The impact of the action is intended as the changes in thinking, attitudes and processes enhancing Reference Sites capacity to sustain the activities beyond the project life (sustainability). It is reflected by the adoption of policies and strategies, the involvement and empowerment of key stakeholders and beneficiaries, the allocation of funding and resources, organizational changes and requests for replications and adoptions of the designed model and tools. The impact reported by each Reference Site is summarized below:

Emilia-Romagna Region

Institutional: describe if there was an involvement of key institutions at the sub national and national level and the related effects in terms of strategies, policies regarding the project's objectives and expected results.

SUNFRAIL project achievements fit within Emilia-Romagna Regional Social and Health planning. Since 2007 Emilia-Romagna Region has been deeply involved in planning and organizing services addressing Population Ageing challenges with a particular focus on frailty and multimorbidity. The Regional commitment is demonstrated by the new 2015-2018 Regional Plan for prevention and the 2017-2019 Regional Social and Health Plan; by a number of policy actions ranging from prevention and management of frailty, chronic diseases, multimorbidity and falls, as well as health researches focused on aging. Furthermore, since 2013 Emilia-Romagna is participating as Reference Site to the European Innovation

Partnership on Active and Healthy Ageing.

Intersectoral collaboration: describe the involvement of relevant sectors (health, social, community, others).
The 2017-2019 Regional Social and Health Plan, that has been recently approved, foresees to support the development of territorial and community health-care services, strengthening the role of primary health care facilities as a strategic hub for health and social integration.
Among the objectives of the Plan are listed: to establish policies to strengthen home care and community care settings; to encourage the autonomy of people within their life contexts; to improve the quality of health services and health expertise (including the skills needed to work in multiprofessional teams).
The Sunfrail model and tools are coherent with these purposes, and are raising a progressive interest and requests for replications by local stakeholders.

Allocation of Resources: describe if, as effect of the project activities, funding and resources were allocated to continue the activities beyond the project life.

The recently approved Regional Social and Health Plan indicate some national and regional resources allocated coherenty with SUNFRAIL purposes and results. Among them:
- the National Fund for Non-Self-Sufficiency (FNNA), established in 2006 (law n.296, 27th December 2006), with the aim of providing support to people with disabilities and to non self-sufficient older adults. The Fund promotes home-care, avoiding the risk of institutionalization and ensuring the implementation of the essential levels of welfare services.
- the Regional Fund for Non Self-Sufficiency (FRNA), to promote the development and qualification of the network of services for non self-sufficiency, and to support families and home-care of non self-sufficient people.

Multiplier effect: describe the changes in terms of replication and extension of good practices, model and tools.
Among the innovative instruments identified with the project, Risk ER good practice of Emilia Romagna has contributed to enrich the Sunfrail designed Model of Care due to its capacity to predict, identify and manage patients at high risk of hospitalisation and disability in primary care settings. The experimentation took place in 6 Community Health Centres (Case della Salute) where nearly 6000 people were identified through the risk profile algorithm (very high-high risk of hospitalization). The main outcomes were improved pathways for identification, prevention and care of f

Dissemination and evaluation activitiescarried out so far and their major results

Communication – Dissemination WP2
The dissemination plan was finalized in October 2015. It has the purpose to establish a structured and clear way to communicate and disseminate project results, both internally to partners and to external stakeholders and the general public. The strategy outlines communication and dissemination objectives, target groups, visual identity and promotional tools, online and social media, and networking events and tools.

Dissemination tools
In parallel with finalising the dissemination strategy, the visual identity of SUNFRAIL was developed. The project logo was finalised and has been shared with all partners. A Visual Identity Manual explaining how to use the logo was shared in September 2015.
The Project Website is available since early November 2015 at www.sunfrail.eu. The website contains information about the project, the partners and work packages, the concepts of frailty and multimorbidity, a news section, a document section, an events calendar, a built in Twitter flow, link to the LinkedIn account and a contact form. The website is continuously updated with project news.

The website also has a built-in fully operational partner section with the function of an "intranet" where partners can upload documents and deliverables for mutual review.
A project brochure has been developed, which includes basic information about the project, with the aim of showcasing the project to stakeholders during relevant events. To facilitate local dissemination, all partners were asked whether they would like the brochure translated from English. After consulting the partners, French and Italian versions were produced. The project final brochure was developed to provide information about the project, the EU synergies, the main outcomes, the results of the experimentation and recommendations for future adoption and replications of the Sunfrail Model and tools.
The dissemination strategy foresees four newsletters, containing information about the project and related news and events. The newsletters were circulated to the stakeholders identified in the stakeholder mapping, and to EUREGHA members – regional and local health authorities across the EU.

Twitter and LinkedIn accounts for the project were created to raise awareness about the project in social media. Twitter has especially been used during project events and the LinkedIn group aims at gathering project partners and other interested stakeholders.

A stakeholder mapping document was created during the early phases of the project, to identify professionals and organisations that would be able to provide input to project activities as well as benefitting from project results.

Stakeholders were mapped at European, national and sub national level. The stakeholder mapping has been continuously updated with contributions from partners and remains a living document identifying stakeholders which will receive updates on the project progress through newsletters.

To market the two SUNFRAIL Transnational Workshops in Bologna, Naples and the Final Conference in Bologna, a poster and an agenda were designed with the aim of marketing the events. Sunfrail shoppers with logos of the consortium were produced and distributed during the Final conference. A Layman version of the Final Report was also produced.

A PowerPoint template and a letterhead, following the project's visual identity, were developed and are available for download on the SUNFRAIL website. Also a standard presentation was developed, including basic information about the project for partners to use to promote the project at external events. Apart from these tools, developed for external use, a template for deliverables was also produced for project partners.

Business cards were also developed and distributed to project partners, containing the project logo and contact information.

Sunfrail and related results have been presented to important project's dissemination events such as:

Work package

Work Package 1: Coordination of the project

Start month: 1
End month: 30
Work Package Leader: RER-ASSR

The Leader will set up an organizational structure that will ensure the smooth implementation and quality of the project process and outputs. A Steering Committee (SC) made up of one representative of each of the project partner, will be set up. Representatives will have to be delegated or be able to represent their organizations: in other terms they will have take binding decisions on behalf of the entity they are representing. Decisions will be taken by the SC based on voting: one member, one vote. When needed, to unlock situations and decisions, the vote of the Lead Partner will count twice.
The role of the SC is to provide general oversight functions of the project progress and take over the responsibility for adjusting the project during the implementation phase. The SC will be coordinated by the LP, which will be responsible for acting as the intermediary for all communications between the beneficiaries and the Agency, requesting and reviewing any documents or information required by the Agency and verify their completeness and correctness before passing them on to the Agency, submitting reports to the Agency, ensure that all payments are made to the other beneficiaries without unjustified delay, inform the Agency of the amounts paid to each beneficiary, when required in the MGA or requested by the Agency. The SC will meet 5 times during project implementation. Ongoing communication will occur through streaming channels, Skype, emails as well as telephone

While all these activities will not be delegated or subcontracted, the LP will be supported by the linked Third Party to RER-ASSR, ASTER (TP1). Specifically, ASTER (TP1) will provide technical support in management procedures and will be in charge of running the Transnational Secretariat (TS) thus contributing to make daily action running in a smooth and effective way.
Apart from the above listed activities, the LP will lead Internal Communication and Decision Making (maintaining continuous and constructive communication between all partners, addressing any difficult or conflict situations that may arise, regular teleconferences); Administrative Co-ordination (the correct handling of contractual documents and the proper communication with CHAFEA); Financial Management (monitoring of the correct budget use through the web-based management tool); Reporting (reporting to the CHAFEA in accordance with requirements as per Grant Agreement).
The Transnational Secretariat (TS) will: a) support preparatory activities of transnational meetings: i) send reminders 1 month before each meeting, ii) ask hosting partner to provide info pack to facilitate partners in their travel and accommodation arrangements, iii) circulate agenda; b) be responsible for project document management: i) collect official documents, ii) store them on accessible and secure online web storage platforms; c) support project scheduling: i) open

and update an online Project Calendar, ii) remind milestones deadlines to Activity Leading Organizations, iii) support Lead Partner in collecting evidences of Multiplying events and dissemination activities.
At scientific level, an Advisory Board (AB), coordinated by the Lead Partner, will be set up by the SC during the kick off meeting in Luxembourg. Subject to agreement of the SC, representatives from other stakeholders may also be invited to sit on the board. The role of the AB is to provide scientific guidance for project implementation and to support the SC at critical stages of the project and on any key challenging issues. The Advisory Board will meet 4 times during project implementation. Ongoing communication will occur through streaming channels, Skype, emails as well as telephone.
Project Partners will have to a) Keep information stored in the Beneficiary Registry up to date, b) Inform the coordinator immediately of any events or circumstances likely to affect significantly or delay the implementation of the action, c) Submit to the coordinator in good tim

Work Package 2: Dissemination of the project

Start month: 1
End month: 30
Work Package Leader: EUREGHA

During the kick-off meeting a Dissemination Strategy (DS) and its related Dissemination Action Plan (DAP) will be discussed by all partners. The DS will address the issue of sustainability and will include a stakeholder analysis and the definition of channels of communication.
The principles of the DS will be:
A) To guarantee a relevant impact at Eu level through an intensive Eu networking and "project alliance building" activity which will be targeted at least at the following organizations: a) European Innovation Partnership on Active and Healthy Ageing (EIP-AHA); b) WHO's Regions for Health Network (RHN); c) Community Of Regions for Assisted Living (CORAL); ENGAGED – Community for Active and Healthy Living; Age Platform Europe; European Regions Research and Innovations Network (ERRIN) and specifically their Health Working Group: http://errin.eu/; Assembly of European Regions (AER); European Public Health Alliance (EPHA). Existing partners' connections with other EU based organizations will also be used to extend the benefits of the project to other EU countries.
B) To extend and settle project dissemination and impact at local, regional and national levels. During the preparatory phase, project partners have already performed a first check of feasible and sustainable dissemination activities which should be implemented at local, regional and national levels and which could be the main actors to involve from the very beginning. These kind of dissemination actions will be guided by strong educational principles (especially on the professionals' side), commitment to increase research capacities of local, regional and national research units focused on the project topic
C) To use the most appropriate dissemination "tools and means" according to the project phase: a) Electronic versions of project deliverables will be disseminated through surface mail, institutional websites and presented at relevant events: one

official project brochure will be published when the project will be launched while an updated version will be introduced whenever key milestones will be reached.
D) To include evaluation as a key issue in the dissemination plan, to best try and assure that we are reaching the expecting target groups, and that the dissemination is well implemented.
E) To include evaluation of the efficiency of the dissemination by the project partners on a regular basis so that the dissemination plan can be revised and updated throughout the project if needed, to assure the efficiency of the dissemination
F) Interlinking with partners, such as making sure that the project's website is interlinked with all the partners' websites for increased visibility, but also with other relevant EU initiatives such as the website of the EIP-AHA
G) Overall, to not focus the main dissemination work on the final conference; i.e. to include for instance one workshop per year where the development of the project is discussed, workshops to where external stakeholders can be invited
H) To create an ongoing relationship between the AB and the most important external stakeholders that can provide feedback on a regular basis, for instance in meetings with said stakeholders

WP Leader, in cooperation with the LP, will
2.1 Conduct a detailed stakeholder analysis, including stakeholders at EU, national, regional and local level, at the very start of the programme so that the communication and dissemination can target all stakeholders from an early stage;
2.2 Adapt the method of dissemination after the different stakeholders, have a strategic "plan" of which communication channels that will work best for the different stakeholders, in order to improve the effects of the dissemination;
2.2 Develop a dissemination plan with the aim to raising awareness of the expected project results, promoting project results, and "translate" the project results to the different stakeholders that are targeted. The first version of the diss

Work Package 3: Monitoring and Evaluation of the project

Start month: 1
End month: 30
Work Package Leader: DEUSTO UNIVERSITY

Monitoring is the regular and systematic collection of information (including those which relate to agreed indicators) that can then be measured against baselines and forecasts. Evaluation, however, has a wider scope and is important for assessing (and understanding) the achievements of the project. It addresses questions such as
i) To what extent and in what ways have the objectives of the project been met or exceeded;
ii) How effectively were the outputs achieved; and
iii) To what extent and in what way have the outputs contributed to appropriate outcomes (impacts).

The importance of the monitoring and evaluation WP cannot be easily overstated in view of the potential outcomes (impacts) that will affect the well-being of frail (mainly older) people and both their formal and informal carers. Linked with such outcomes (impacts) are the potential for the model developed to help facilitate a delay in the onset of frailty; greater equalization in access to health and social support services; and a reduction in the costs to formal health and social care services. Such matters are included in the range of performance measures to be refined and adopted within the project (see below).
At the outset a Monitoring and Evaluation Plan will be developed with clear terms of reference. The Plan will include a summary description of the context; the background requirement; the approach being adopted; and timetables for the same. It will identify the indicators for which monitoring information will be required and arrangements for reporting. Some of the indicators may be designated as carrying especial importance and, therefore, carrying 'priority' status. The Plan will, furthermore, set out what evaluation activity will take place throughout the life of the project. For both monitoring and evaluation, the responsibility of all partners to gather necessary information (including that which is provided by the stakeholders with whom they have contact) and feed it into the monitoring and evaluation process will be emphasized. More than this it will clearly state the nature and extent of detail required for such information. That information will be available for scrutiny by the Project Coordinator and by the Advisory Board.
To help partners in planning the way they feed into the monitoring and evaluation process the Monitoring and Evaluation Plan will incorporate a 'Delivery Profile' that will be updated throughout the project – both facilitating and prompting the necessary inputs. It will also provide a guideline, as appropriate, in relation to the way that partners utilize what, in some cases, will be personal data (e.g. from their involvement in 'Reference Sites' (per the EIP-AHA) or 'Validation Sites) in accordance with data protection requirements (and any new guidance).
A comprehensive (Excel) spreadsheet will be maintained in relation to the monitoring and evaluation tasks – and will be available to all project partners.
Interim Monitoring and Evaluation reports will be produced – also giving information on issues that have been encountered and lessons learnt. The Interim reports will support the Lead Partner in its reporting to CHAFEA.
Performance measures (PIs) that will be put in place for the project will cover the following areas.
They will endeavour, at all times, to reflect the holistic perspective taken by the project. This, of course, broadens out from any 'narrow' biomedical or physical perceptions of frailty and encompasses the position of people aged over 65 who are frail in community settings.

• The range and authority of sources of information drawn upon (from within the EIP AHA network and beyond) that provide a meaningful context for fulfillment of the project's objectives; with account taken of their attention to
o frailty in community settings
o integrated approaches involving health and social care
o environmental contexts (housing accessibility, assistive technologi

Work Package 4: Design a model for frailty identification, prevention and care and management of multimorbidity

Start month: 1
End month: 15
Work Package Leader: RER-ASSR

Main methods and means:
- Desk Analysis (incl. analysis of secondary data)
- Analysis of EIP-AHA action groups (A3, B3), initiatives outcomes and tools
- Workshops with stakeholders at regional and national level
- Group Discussions
- Other

TASKS
4.1 Opening: Organizing a transnational Workshop (M1-M2)
4.1.0. Collect necessary evidence to be shared during the transnational workshop
4.1.1. Organize a transnational workshop with PPs, relevant institutions and collaborating stakeholders, to share the objectives of the project and to involve them through key moment of the implementation.
4.1.2 Identification of a shared definition of domains approaching frailty through their health, socio-economical and environmental aspects, by participating institutions and stakeholders.

4.2 Modelling – Phase I (M2-M6):
4.2.1 Analysis of the tools, findings and recommendations resulting from the EIP-AHA initiatives on frailty and multimorbidity (Action Groups A3 and B3) and of constraints to effective implementation. (M1-M2)
4.2.2 Assessment of partner's social and health systems (international literature review, scientific evidences) (M3)
4.2.3 Develop the pre-model and adapt tools (with its social, health, economic and educational dimension): all dimensions of PPs running models are put together (M2-M4)
4.2.4 Develop innovative tools for predicting frailty and multimorbidity and to assess their costs (M2-M6).

4.3 Modelling Phase II (M11-M15)
4.3.0 International literature review to assess effectiveness of RS practices (M11-M12)
4.3.1 Review and validate the model based on the results of the WP5 (M11-M14)

4.4 Organize a transnational workshop to share the model (M15)

Work Package 5: Validating the model

Start month: 1
End month: 10
Work Package Leader: GERONTOPOLE

Main methods and means:
- Qualitative investigations (Focus Groups, others)
- Analysis of secondary data (services delivery, results of EIP-AHA assessment)
- Quantitative investigations (if needed)

TASKS
5.1 Analyse the results of EIP-AHA initiatives on the assessment of patients/final beneficiaries on perception on frailty and multimorbidity and expectations for care and quality of life (M1);

5.2 Prepare and conduct complementary investigations (qualitative research methods) (M2-M3);

5.3 Develop/adapt instruments and tools for the assessment of RS service delivery (M3-M6)

5.4 Survey of service delivery: identification of good practices and usual care (M7-M10):
5.4.0 Data collection and analysis:
5.4.1 Secondary data collection: data sources (AGs A1, A3, B3, services delivery and information systems HIS).
5.4.2 If necessary, conduct complementary quantitative investigations
5.4.3 Data analysis and reporting

5.5 Assessment of the human resources development programmes and tools (see details in WP 7) (M3-6)
5.5.0 Elaborate tools
5.5.1 Perform the assessment
5.5.2 Review and adapt the tools

Work Package 6: Experimenting the model

Start month: 16
End month: 30
Work Package Leader: HSCB

Main methods and means:
- SUNFRAIL will experiment the application of the frailty model through a number of operational structures including existing frailty units, Living Labs, and other structures available in each participating region
- The experimentation will apply the outputs from WP5 which will include(frailty and

multimorbidity predicting tools, guidelines for professional performance improvement, ways of multi-disciplinary working and integration
- Explore an analysis of costs

TASKS
6.1 Identify the operational structures supporting experimentation (frailty units, living Labs, others), most applicable at Regional/local level (M16). Each partner will select the operational structure more suitable to own specific context.

6.2 Experiment the model, through specific units, living labs or other operational structures (pilot); partners will decide whether to adopt/adapt the elements emerging from the model according to their specific needs. (M16-M27)
6.2.1 Selection of "pieces of the full model" to be tested or further analyzed
6.2.2 Identify system/services good practices and weaknesses
6.2.3 Develop an operational plan
6.2.4 Experimentthe tools for frailty and multimorbidity early detection (slow gate speed, multimorbidity predicting tool, others). (M16-M27)

6.3 Improve knowledge and challenge human resources to produce new working methods (M16-27)

6.4 Review and adapt the Model and the application of the tools
(frailty and multimorbidity predicting tools, educational tools, analysis of costs, data sets, pathways of care, etc.).

6.5 Assess and ensure its sustainability, replicability and transferability at EU level. Ensure institutional, operational and economic sustainability of the Model through the involvement of relevant institutions, policy makers and patients (accompanying measures) (M16-M30)

6.6 Monitor how experimentations can produce better results/evidences:
Testing
- Services
- Economic dimension
- Educational dimension
- Health dimension

WP2 RELATED ACTIVITY
- Organization of a transnational event to disseminate the results of the sperimentation (M30)
- Planning for local/national advocacy initiatives – M30/M31

Work Package 7: Healthcare staff innovative education

Start month: 1
End month: 30
Work Package Leader: REGIONE PIEMONTE

Professionals are falling short on appropriate competencies for effective team work' (The Lancet Commission on health professionals' education). In almost all countries the education of health professionals has failed to solve the dysfunctions and inequities in health systems due to, among other things, curricular rigidities and professional silos. By interprofessional education we mean learning 'from and about each other' in order to improve collaboration. Of course, shared learning on common topics can be a first step to real integrated team-based education.

See 5.4 Assessment of the existing human resources and their respective training and educational background

The work will be carried out in close cooperation with the European Innovation Partnership Action Group B3, Activity Area 3: 'Workforce Development'.
Building upon the AA3 mapping of good practices at EU level, regarding the existing training and academic programmes for healthcare professionals in the different countries, a synthesis of the best experiences and training models coming out from the mapping will be carried out.
This workpackage will be cross-sectional throughout all the different areas and domains considered in the project planning.

Along with the overview and analysis of existing care models in the specific context of frailty and pre-frailty, together with the experts involved in the project WPs, specific features regarding the training of healthcare students/staff will be designed. Healthcare staff training design would have to follow the best and most effective care models' needs. The project experts involved will develop an innovative experimental educational model, in coherence with the experimental innovative care model developed in WP 4.
Medicine students, psychologists, pharmacists and nursing students' existing curricular contents will be analyzed, in order to identify the gaps existing with the staff training needs working in the context of a possible 'ideal' care model, focused on prevention, identification and care of frailty.
Focus on polypharmacy/multitherapy: The physiological age-related decline, through the gradual reduction of functioning of the body, causes the onset of progressive frailty together with multimorbidity. For this reason, polypharmacy plays a crucial role in the life of the elderly, affecting the perceived QoL and the degree of frailty.

Among the different methods proposed to implement rationalization of polypharmacy, the strategy of optimizing the use of drugs by increasing in the healthcare staff the knowledge of such valuable tools as medicinal products are , is currently surprisingly underestimated. In fact, despite scientific research increases continuously information about properties of drugs, too often the training of the healthcare team (GPs, nurses, pharmacists) and of students from different health education degree courses is docked to traditional patterns with limited application contents

GOAL: Focusing attention to the development of innovative training methods can be translated into an effective tool for preventing frailty and for improving perceived QoLin the elderly, through the reduction of polypharmacy-induced critical issues. Overcoming the limitations of traditional education models, our objective is the implementation of a continuous, experiential, measurable and productive training system:

Continuous: for undergraduates (students from different graduation courses), postgraduates (internship, master degrees), and professionals (healthcare staff);

Experiential: learning will be based on experience, through the application of acquired skills and the continuous revision of previously acquired concepts according to what is experienced;

Quantifiable: the IT tools used by different healthcare professionals (prescribing and dispensing data collection, medical records) will allow a direct assessment of the implementation of good practices in prescrib

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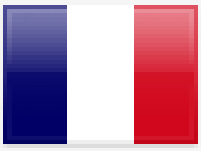

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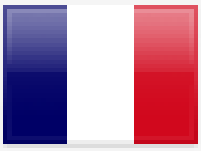

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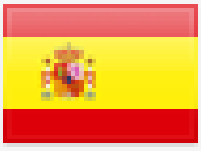

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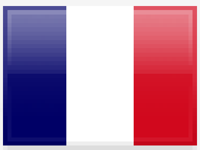

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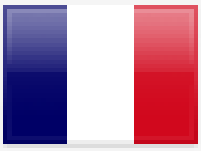

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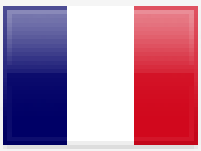

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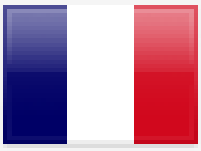

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OUTPUTS

Final Conference

RER-ASSR
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 18/07/2018
Organization of a final conference to share the results of the project and planning for future initiatives

Final M&E Report

DEUSTO UNIVERSITY
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 18/07/2018
Report to Final Conference and presentation on the conduct of the project, issues confronted and lessons

A report on the model of care on frailty and multimorbidity

RER-ASSR
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 18/07/2018
A shared multi-modular model of care on frailty and multimorbidity

A report on experimentation of the model, its transferability and sustainability

HSCB
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 19/02/2018
A report on the experimentation of the model, the tools developed, its sustainability and transferability

Educational model for healthcare staff and related tools

REGIONE PIEMONTE
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 19/02/2018
A revised educational model for healthcare staff, including the guidelines for training healthcare staff on frailty and multimorbidity

A report on the tools developed to predict and manage frailty and multimorbidity

GERONTOPOLE
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 19/02/2018
-A description of frailty and multimorbidity predicting tools (at primary, secondary and tertiary care); educational tools, data sets, pathways of care, etc. -A cost analysis of the tools of the tool kit

A pre-model of care developed

RER-ASSR
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 02/03/2017
An outline of the pre-model of reference for the prevention and management of frailty and care of multimorbidity Being the development of the model a process involving the three core WP, through the design, validation, experimentation and revision, the output related to this deliverables will be ready to be make public at the end of the WP6, along with deliverable D6.3 (a report on the model of care on frailty and multimorbidity).

Identified tools to predict frailty and multimorbidity

GERONTOPOLE
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 02/03/2017
Identified tools to predict frailty and multimorbidity (and related costs) Being the development of the tools to predict frailty and multimorbidity a process

involving the two core WP (WP4-6), through the identification, experimentation and revision, the output related to this deliverables will be ready to be make public at the end of the WP6, along with deliverable D6.2 (a report on the tools to predict and manage frailty and multimorbidity).

Interim Report

RER-ASSR
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 02/03/2017
The report describes the activities carried out, milestones and results achieved in the first half of the project. Deliverables can be attached as annexes.

Report on RS Services Delivery

CHRU
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 02/03/2017
Analysis of service delivery provision in different RS/geographic areas (good practices and usual care)

Report on patients/final beneficiaries on perception on frailty and multimorbidity and expectations

HSCB
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 07/10/2016
Assessment of patients/final beneficiaries perception on frailty and multimorbidity and expectations for care and quality of life

Project WebSite

RER-ASSR
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 04/01/2016
Develop a Project web site, in collaboration with EUREGHA

Monitoring and Evaluation Plan

DEUSTO UNIVERSITY
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 15/12/2015
Detailed Monitoring and Evaluation Plan with clear terms of reference, initial benchmark PIs and a 'Delivery Profile'

Dissemination Strategy, Action Plan, Map and Tools

EUREGHA
Reference Sites Network for Prevention and Care of Frailty and Chronic Conditions in community dwelling persons of EU Countries (SUNFRAIL)
Published on: 23/10/2015
Develop a dissemination plan to raising awareness and promoting project results. Provide a dissemination map, including tools (brochures, website, workshop).