EIP ON AHA

A3 Action Group Lifespan Health Promotion
&
Prevention of age related frailty and disease

Focus on prevention of functional decline and frailty

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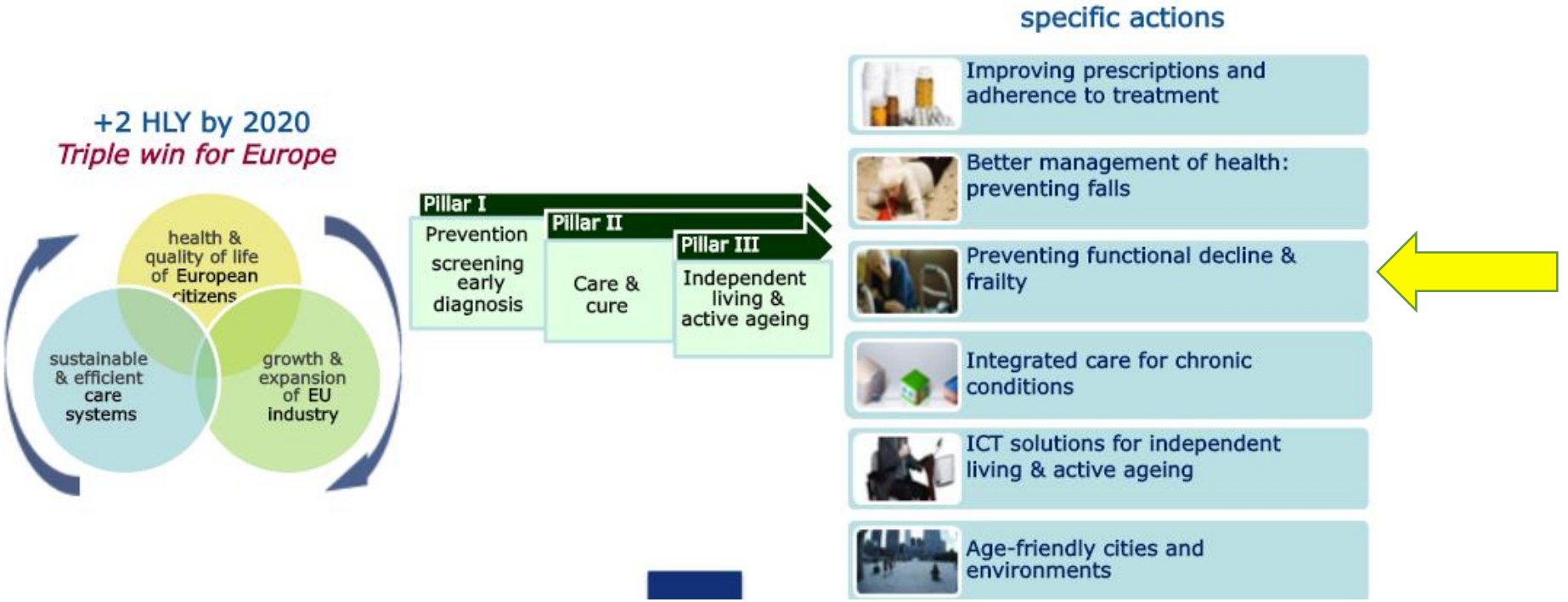
REGIONE CAMPANIA

EIP ON AHA
REFERENCE SITE
★★★★

EIP on AHA: Action Groups



A3 Action Group on Lifespan Health Promotion & Prevention of age related frailty and disease"

The Community

2018–2020

European Commission

Communication on digital transformation of health and care in the context of the Digital Single Market (DSM)

European Innovation Partnership on Active and Healthy Ageing

EIP ON AHA

ACTION GROUPS

Groups of stakeholders that work together on specific thematic areas, related to the overall objectives of the EIP on AHA focusing on scaling up innovation. Each Action Group has an action plan, and participants commit to running a number of activities contributing towards the headline targets of that action plan.

REFERENCE SITES

Ecosystems comprise different players that jointly implement a comprehensive, innovation-based approach to active and healthy ageing. The players involved include regional and/or local government authorities, cities, hospital/care organisations, industry, SMEs and/or start-ups, research and innovation organisations, and civil society.

HORIZONTAL INITIATIVES

Shared Policy Vision

BLUEPRINT

BLUEPRINT ON DIGITAL TRANSFORMATION OF HEALTH AND CARE

Policy vision developed and updated by partners that guides the main activities of the EIP actions groups and reference sites.

Market Implementation

I2M

INNOVATION TO MARKET (I2M)

Measures to promote scaling-up across borders of innovative digital solutions for active and healthy ageing. Targeting innovative EU companies (SMEs and Start-Ups) looking to expand across the EU.

Socio-economic Impacts

MAFEIP

MAFEIP

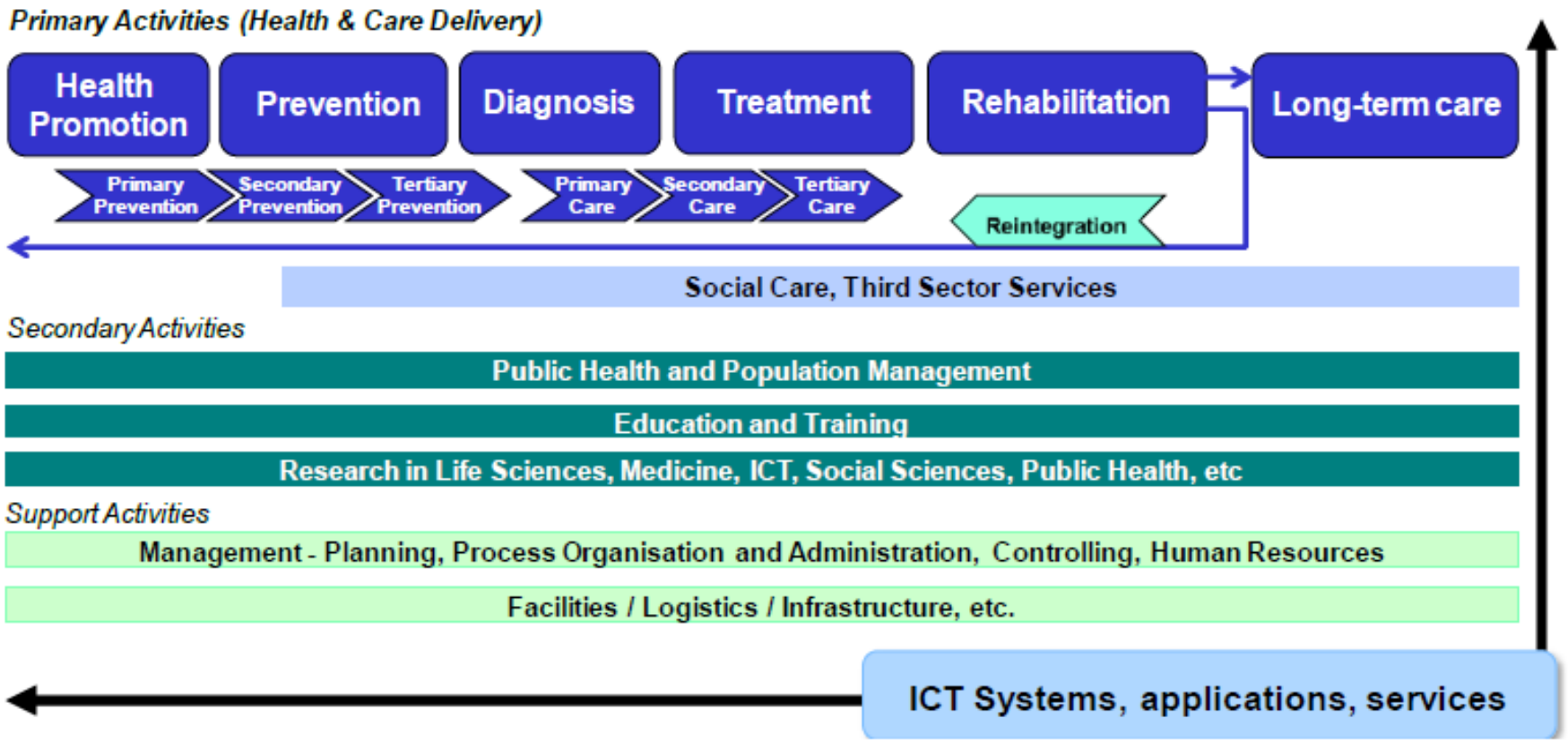
Common methodology for measuring impact of digital innovation for health and care.

TIMELINE

- Action Groups Commitments update — OCTOBER 2017
- New release of the MAFEIP tool — NOVEMBER 2017
- Blueprint Open call for engagement — NOVEMBER 2017
- Conference of Partners 27-28.02.2018 — FEBRUARY 2018
- Innovation to Market (I2M) map of investments and gap analysis — FEBRUARY 2018
- Action Group consultation for the renovation of the Action Plans — AUGUST 2018
- Blueprint update — SEPTEMBER 2018
- I2M Plan — SEPTEMBER 2018
- Action Plans 2018-2020 — FEBRUARY 2019
- Open call for Commitments — MARCH 2019
- Open call for Reference sites — JUNE 2019
- Call for Reference Sites twinning pairs — DECEMBER 2019

2017 · 2018 · 2019 · 2020

Scaling up a health and care value chain



Source: © empirica, WE4AHA 2018

Figure 2. Draft of a health and care value chain

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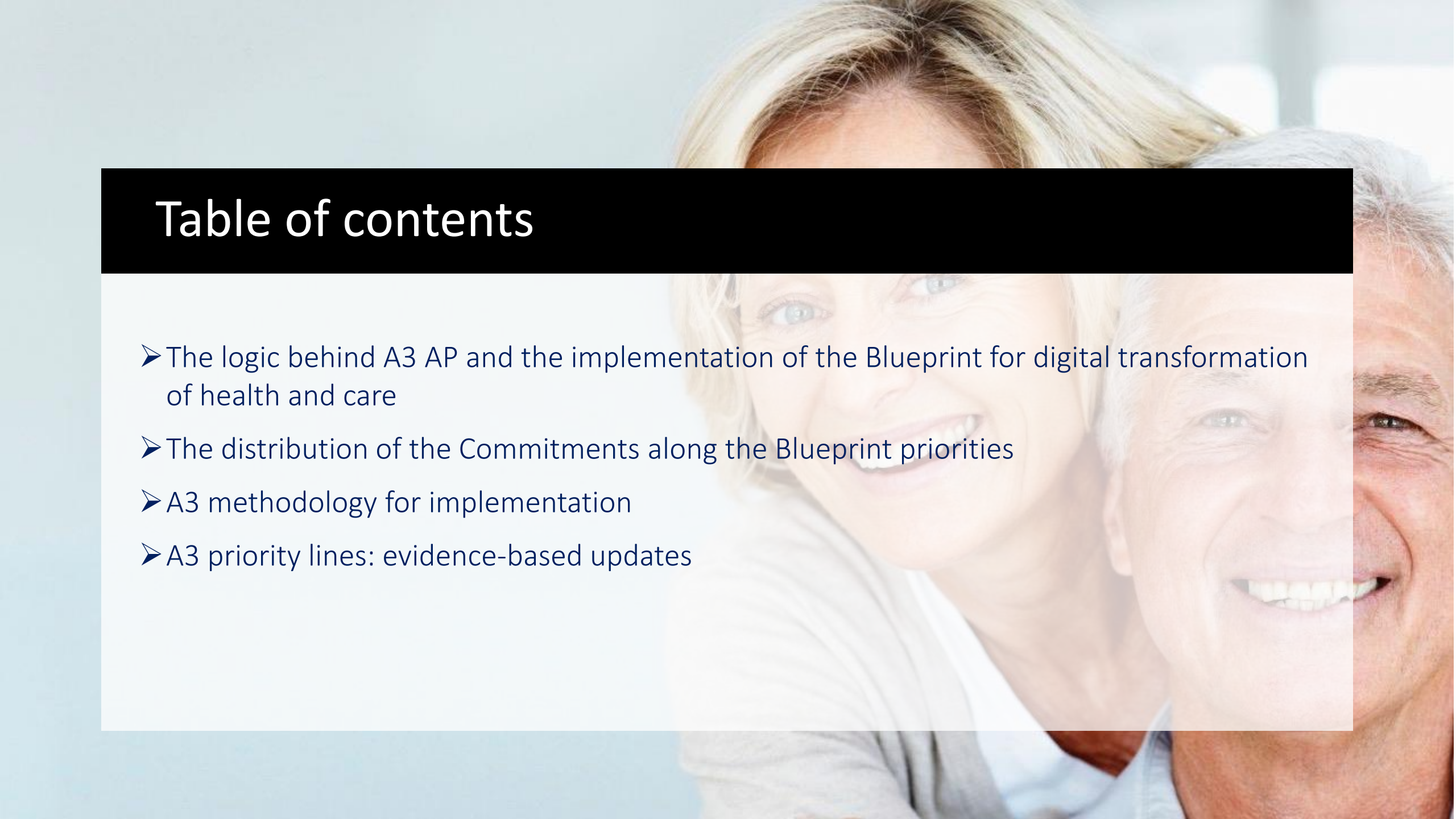

- The logic behind A3 AP and the implementation of the Blueprint for digital transformation of health and care
- The distribution of the Commitments along the Blueprint priorities
- A3 methodology for implementation
- A3 priority lines: evidence-based updates

A3 Coordination Team

Action Area	CAREGIVERS	COGNITIVE DECLINE	FRAILTY	FOOD and NUTRITION	PHISICAL ACTIVITY
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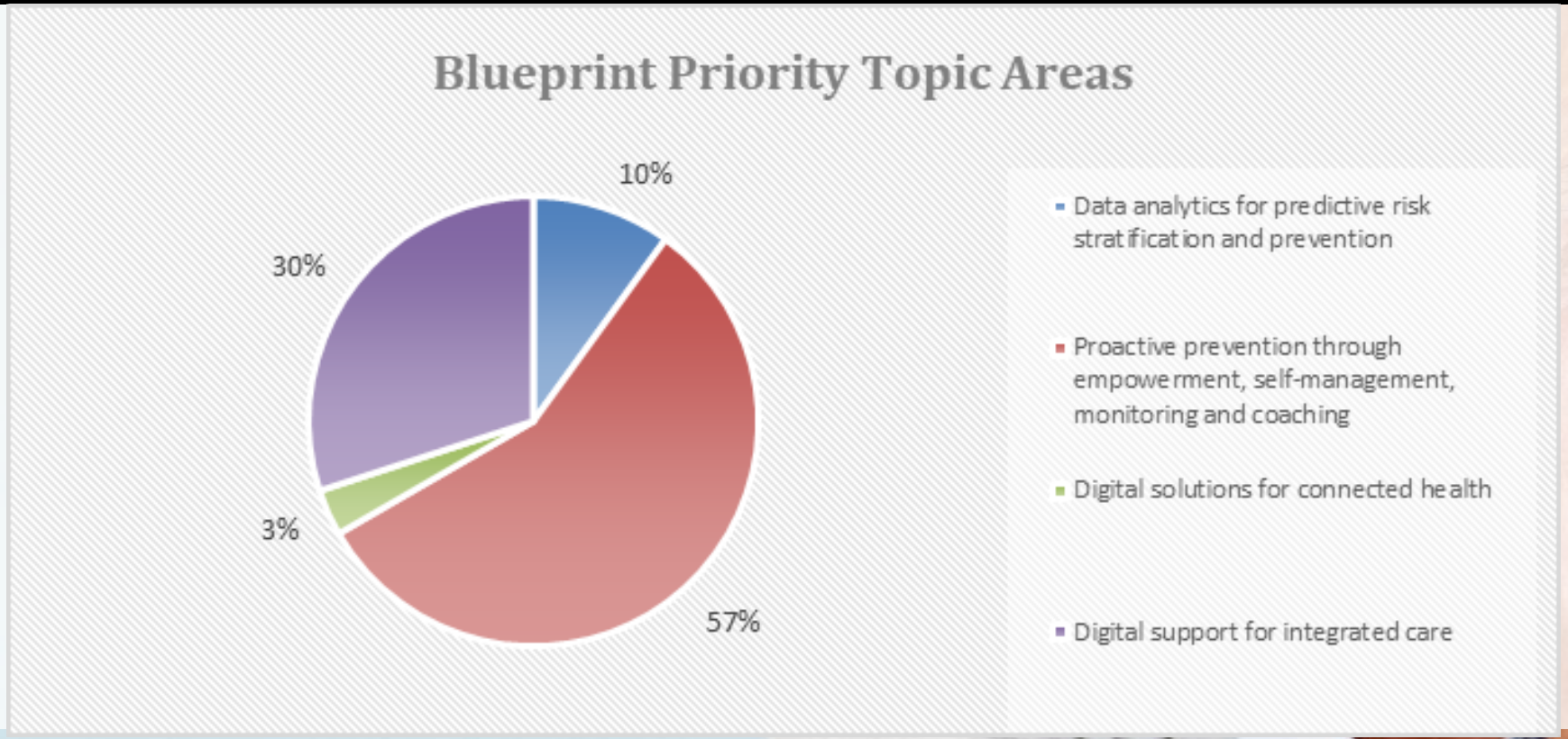
Co-coordinator	Joao Apostolo apostolo@esenfc.pt				Ana Maria Teixeira ateixeira@fcdef.uc.pt
Co-coordinator					

Prevalence of Collaborative Works on Blueprint pillars activities



Collaborative Results so far

- The **bio-psycho-social approach to frailty**, thanks to the **SUNFRAIL** proposal, that developed and validated a user-friendly, 9-items tool for the screening of frailty targeting community-dwelling older adults. It is being piloted with the objective of being integrated with risk stratification tools and connected care systems. Results from this project have been included into the work of the A3 action group with the intention to scale-up and make results from an EU-funded project accessible to a broad public community (transfer to Spain ongoing) – further pilots are foreseen in different partner countries in a Twinning approach (Austria).
- **A common understanding and shared vision** between European Health Systems for the prevention and management of frailty in older adults, in the **ADVANTAGE Joint Action**, that embeds digital solutions and is being translated into national roadmaps; Furthermore, results from the project Sunfrail have been crosslinked with activities in the Joint Action on Frailty Prevention (Advantage).
- Identification of gaps in education and **life-long-learning** to implement innovative approaches to AHA, implementing dedicated PhD programs on the feasability of measures to manage taste disturbance in cancer patients and on the Social Return on Investment when implementing primary food care for cancer patients. (ex. Murcia and Salerno Universities, Center for Gastrology Leuven has been twinning with Campania focusing on the set-up a new curriculum, with the support of the European Social Fund, to educate chefs in healthcare). This Belgian-Italian initiative aims to implement Primary Food Care and raise awareness and adaptation of professionals and enterprises within European healthcare; with the support of the Center for Gastrology; Karel de Grote University College, Antwerp (Belgium) initiated in 2018 a research unit “Primary Food Care”.
- Scale-up of the **Algorythm for health risk stratification**, such as the Emilia Romagna and Campania joint commitment supported by the CCM instrument of the Italian Ministry of Health.
- Management of cognitive decline: Defining, testing and implementing sustainable management of Parkinson’s disease. The **i-PROGNOSIS** Personalised Game Suite approach.
- The implementation of a number of **twinning programmes** between Reference Sites. These permitted the setting-up of large scale deployment of innovative solutions for telerehabilitation, early identification of mild cognitive impairment using the **Quick Mild Cognitive Impairment** (**QMCI**) screen, prevention and integrated management of asthma, Gastrological approach to malnutrition.
- Involvement (as organisers as well as participants) in many **workshops and conferences** at the locoregional, national and international level that facilitated the dissemination of the EIP on AHA opportunities and results.
- International collaborations such as **EP – INTERREG V A España Portugal** (POCTEP); Project: CIE - Centro Internacional sobre el Envejecimento.
- **Aicare platform** (designed and developed during the European project "**Adrihealthmob**" (IPA Adriatic - 2013-2016) proposing integrated, person-centric solutions that are accessible remotely to the user living at home, but assisted by the weekly visit of a trained nurse.

Collaborative Results so far

- Identification of **a list of indicators to improve assessment of frailty** elaborated by collaborative work of the University of Lancaster, the Mario Negri Institute, the University of Wroclaw, the University of Aveiro, Policlinico Milan and the University of Valencia, as a result of work with focus groups including patients, carers, and health professionals, as well as structured interviews with policymakers and expert scientists.
- **Guidelines** prepared through the collaboration between the Mario Negri Institute and the Policlinico Milan in the context of the **FOCUS project**. The guidelines were produced with the use of a validated approach that included both the GRADE and the PICO methodologies, and subsequently tested in a multi-centric feasibility study (described as a series of 5 pilot studies).
- **Platform for Knowledge exchange (PKE) and scaling up (PSU)** in the context of the **FOCUS project**. They aim at facilitating the awareness and the use of validated tools in strategies to tackle, prevent and manage frailty. The Request clinimetrics software provides an easy-to-use instrument to facilitate screening or the implementation of useful strategies or interventions for the prevention of frailty.
- Kick off of collaborative activities addressing **health tourism**.
- Building on digitalisation as **hub to share knowledge**.
- Building **synergies with the B3 action group** implementing the models elaborated by the B3 in group activities from A3 (VIGOUR project).
- **Building bridges** to well established training institutions such as the European Academy of Medicine of Ageing (**EAMA**) and the European Interdisciplinary council on Ageing (EICA), promoting the goals of the A3 group on a broad international level among experts to build leadership capacity for the A3 action group beyond EIP/AHA.
- Translating educational comittments to the work of **scientific societies** (such as the European Geriatric Medicine Society (**EuGMS**).
- **Crosslinking and building synergies with reference sites**.

Collaborative Results so far

National level

- The Italian ProMIS project evolved into a structured Programme supported by the Italian Ministry of Health, that stimulates and supports the adoption of innovative good practices by the regional health systems. The programme embeds a dedicated line of action for the EIP on AHA, ensuring adequate support to Italian Reference Sites and Regions willing to become involved through their stakeholders in the thematic Action Group, such as A3, where many Italian partners are involved. The programme ensures the availability of a structured communication plan, coherently developed and updated with the contributions of all regions, as well as a database of good practices and learning tools. The programme also provides a synthesis of relevant international documents in Italian to facilitate dissemination to broad audiences of the regional health systems. ProMIS has been ensuring that innovative approaches would be considered when designing national plans for prevention and for chronic diseases.

Collaborative Results so far

Regional level

1. The MACVIA integrated care pathways for airway diseases, that can be used as a model also for other chronic, non-communicable diseases. One of the tools made available by the twinning is the Allergy Diary, freely available in many languages. Next generation care pathways are the topic where the RSCN is involved now through the MACVIA ARIA initiative. This tool to manage allergic rhinitis and prevent asthma is being scaled up in 23 Countries and has more than 14500 users.
2. The Barcelona Brain Health Initiative, is developing a longitudinal study of cohorts to characterise, quantify, monitor and optimise biomedical markers, psycho-social and environmental markers relating to brain health, that envolve so far more than 4,500 citizens. In its third phase, the initiative aims at evaluating a multimodal and personalised intervention programme based on mobile technologies and advanced monitoring to suport remote health coaching strategies.
3. The Campania Strategy for Health Promotion targets the 5.8 million residents in the region, with an approach that is tailored by target and setting. Such a lifecourse approach embeds community living labs to ensure that validated good practices are scaled up throughout the region, also stimulating education, life long learning and new job opportunities. Agreements with regional school networks support the adoption of healthy lifestyles by Campania students;
4. The REducing FragiLity and increasing partiCipaTion and socIal incusion (REFLECTION), INTERREG Project, Lead by the Lombardy Region.
5. The CONSENSO model for community nurses, being scaled up by Liguria and Piemonte regions.
6. The Lyngby programme in Northern Denmark providing guided dance, to older adults, that proved quite engaging for older adults aged >85.
7. Veneto Region MuoverSI programme, aimed at promoting physical activity in the urban context.
8. The Community-Based Programme on Prevention and Mitigation of Frailty (ICP - PMF) in Community-Dwelling Older adults. Being implemented by the Biomedicine and Prevention Dept – university of Rome Tor Vergata, in the framework of Lazio Region.

Collaborative Results so far

Regional level

1. The Emilia Romagna region scale-up of the SUNFRAIL tool to screen community dwelling older adults for frailty based on an experimental phase conducted in two Health houses in Parma Community.
2. The Tuscany region AFA (Attività Fisica Adattata: adapted physical activity) programme, available throughout the entire region. Frail people can access gyms throughout the territory where specific physical exercise programmes are provided. A specific exercise programme based on the Otago methodology is being scaled up for people at higher risk of fall.
3. The Tuscany risk stratification system, using simple administrative data to stratify older patients with complex medical problems among those who access the emergency department (ED), providing prognostic information on risk of hospital re-admission and long-term mortality. The Dinamic Silver Code allows stratification of the elderly population that reaches the ED in quartiles (classes), using a specific computer software, activated on-demand. Frail subjects are assigned to the geriatric unit.
4. The Andalusia Public Health Department strategy for AHA, that embeds many initiatives targeting the primary care level. 1.2M older adults of 9M residents live in Andalusia.
5. The Coimbra programme for AHA. This ongoing program targets multiple dimensions: food/nutrition, cognitive functioning and physical activity. This approach works very well for community dwelling older adults, at home and at community centers. Simple, user friendly tools are embedded in the interventions, also including training endusers in the use of such tools (family and caregivers, etc). Education is also incorporated through the engagement of university students.
6. A collection of good practices in the Center Region of Portugal through the implementation of the "Award on Good Practices for Active and Healthy Ageing – Categories: Knowledge+, Live + and Health+" by the CCDRC – Coordination Council for the Central Regional of Portugal.
7. The Styria programme for nutrition and health for active and healthy ageing implemented into funding programme to support regional innovation and crosslinking regional stakeholders with the aim to reach the triple win also for the province of Styria (Acronym: ErGes).
8. The Twente region, being a reference site called Vitaal Twente, works in an ongoing programme to improve the vitality of their citizens by using technology. Projects focus on developing and testing independent living solutions like home sensors for older adults and personalised eHealth systems and strategies to prevent chronic diseases like diabetes.
9. Lombardy Region is leading standardised processes for integrated multi-specialty care models at community level. This includes systems receiving payment for treatment based on the quality of their transparently reported outcomes. Patient-centered medical homes, accountable care organisations, and integrated delivery systems have been designed specifically to support the process.

A3 Matrix of pillars & activities

	Screening, Monitoring and Early Diagnosis	Prevention	Care and Cure	Research And Education
A	Harmonization of Data			
B	Identification of Good Practices			
C	Scaling-up of Good Practices			
D	Models of care for integrated management			
E	Identify and implement Enabling Technologies			
F	Dissemination and active involvement of the stakeholders			
G	Synergies to other Action Groups and Reference Sites			

Blueprint Priority Topic Areas

European Innovation Partnership on Active and Healthy Ageing

Blueprint Priority Topic Area	A3 Action Area	
Data analytics for predictive risk stratification and prevention	1. Screening, monitoring and early diagnosis	5. Research, Education and citizen empowerment
Proactive prevention through empowerment, self-management, monitoring and coaching	2. Prevention & Health Promotion	
Digital solutions for connected health	3. The health value chain: from health promotion to disease prevention and integrated care (***new***)	
Digital support for integrated care	4. Care and Cure	

Blueprint Priority Topic Area	A3 Action Area
Data analytics for predictive risk stratification and prevention	1. Screening, monitoring and early diagnosis 1.1 Integrated assessment to improve nutrition 1.2 Identification of people at increased risk of frailty and functional decline 1.3 Screen for cognitive decline 1.4 Identification of risk strata based on administrative dataflows
Proactive prevention through empowerment, self-management, monitoring and coaching	2. Prevention & Health Promotion 2.1 Involve all stakeholders in raising awareness and advocacy about the need to adopt healthy lifestyles throughout the lifecourse to prevent age related diseases and frailty 2.2 Empower older people to stay connected and participate as active citizens: ICT culturally adopted tools to enable social inclusion and self-management 2.3 Promote physical activity at all ages to maintain physical and cognitive function through digitally supported creative arts and movement networks 2.4 Establish psychosocial tools and networks that built and promote caregivers' resilience and prevention of stress related diseases. 2.5 Intervention to imptovr food uptake 2.6 Intervention to improve cognitive functioning
Digital solutions for connected health	3. The health value chain: from health promotion to disease prevention and integrated care (***new***) 3.1 Embed disease prevention and health promotion in integrated management for age-related diseases
Digital support for integrated care	4. Care and Cure 4.1 Implement digitally enhanced early detection, assessment and rehabilitation;
	5. Research, Education and citizen empowerment 5.1 Raise awareness about the urgency to change education pathways including new skills and competencies to sustainably address health needs, according to the new models for health/social care; strengthen workforce planning and development along new roles, new functions, knowledge, skills and competences; support an approach grounded on shared responsibility, teamwork, information sharing and knowledge transfer to patients and their carers. 5.2 Build workforce capability through multidisciplinary education and training, that can support the implementation of new approaches to disease prevention, health promotion and integrated care 5.3 Invest in innovation, research, evaluation and knowledge transfer on age-related disease and frailty

Enabling factors emerged

Other networks (international, national, local)	Strategic approaches (International, national, locoregional)	Collaborative instruments
➢ RSCN ➢ EHTEL ➢ SHAFE ➢ ECHALLIANCE ➢ ProMIS	➢ Blueprint for the digital transformation of health and care ➢ Italian National Plan for Prevention ➢ Italian National Plan for Chronic Disease ➢ Campania Strategy for Health Promotion ➢ Guidelines prepared in the context of he FOCUS project ➢ Andalusia Public Health Department strategy for AHA ➢ Coimbra program for AHA ➢ Collection of good practices in the Center Region of Portugal	➢ Twinning experiences between Reference Sites ➢ INTERREG V A España Portugal (POCTEP); Project: CIE - Centro Internacional sobre el Envejecimento ➢ INTERREG MD.net ➢ SHAFE Interreg

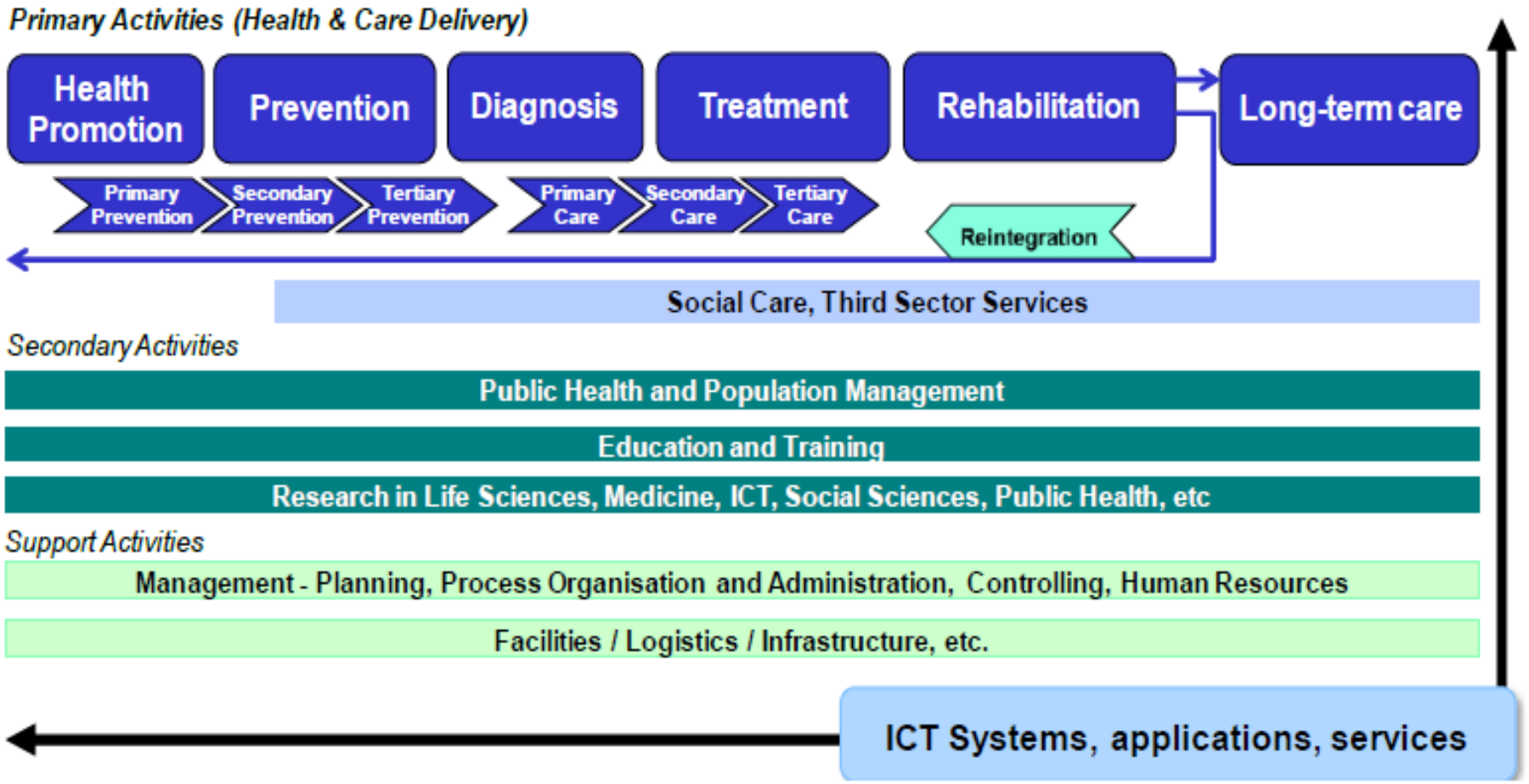
A3 methodology for implementation (*examples*)

	Screening, monitoring and early diagnosis	**Prevention & Health Promotion**	**Care and Cure** The health value chain: from health promotion to disease prevention and integrated care	**Research, education and citizen empowerment**
Harmonization of data	Algorythms for risk strata			
Identification of Good Practices	Risker algorythm	CARDIO 50		
Scaling up of Good Practices	Transfer of Risker through twinnings	YOUNG 50		Training of worksforce
Models for integrated care management		Cardiovascolar prevention	Innnovative diagnostic-therapeutic partners	
Identify and implement enabling technologies			Telemonitoring, coaching, management of politherapy and home care services	
Dissemination and active involvement of the stakeholders		ADVANTAGE campaign: face up to frailty		Empowerment for digital and health literacy
Synergies to other Ags and RS			Health Tourism	

Supporting RSCN synergies with the AGs A1, A2, A3, B3, C2 and D4 of the EIP on AHA

- Joint Commitment between RSCN & AGs
- Common challenge
- Implementation approach
- Measuring impact

A Health & Care Value Chain



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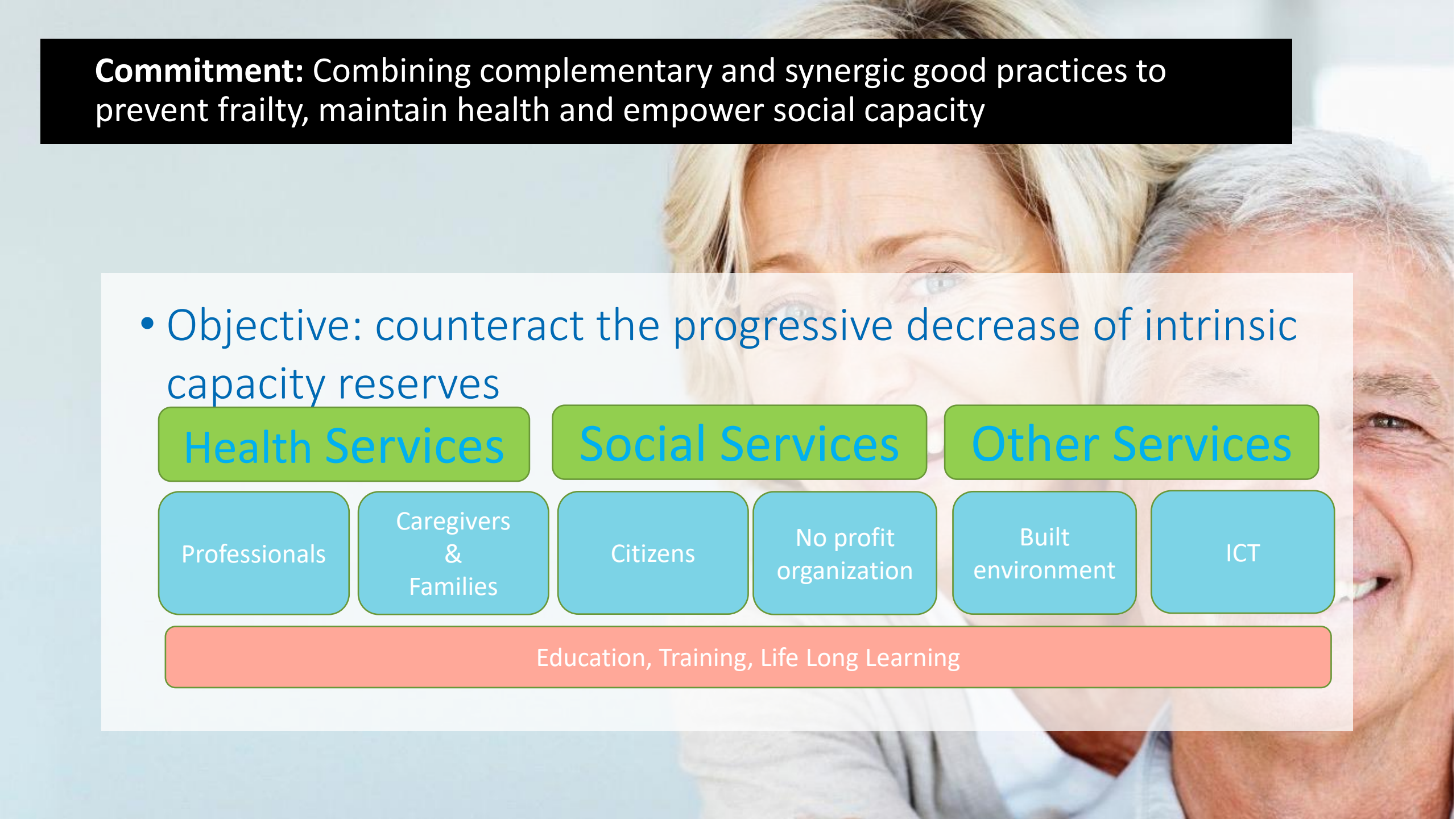
Commitment: Combining complementary and synergic good practices to prevent frailty, maintain health and empower social capacity



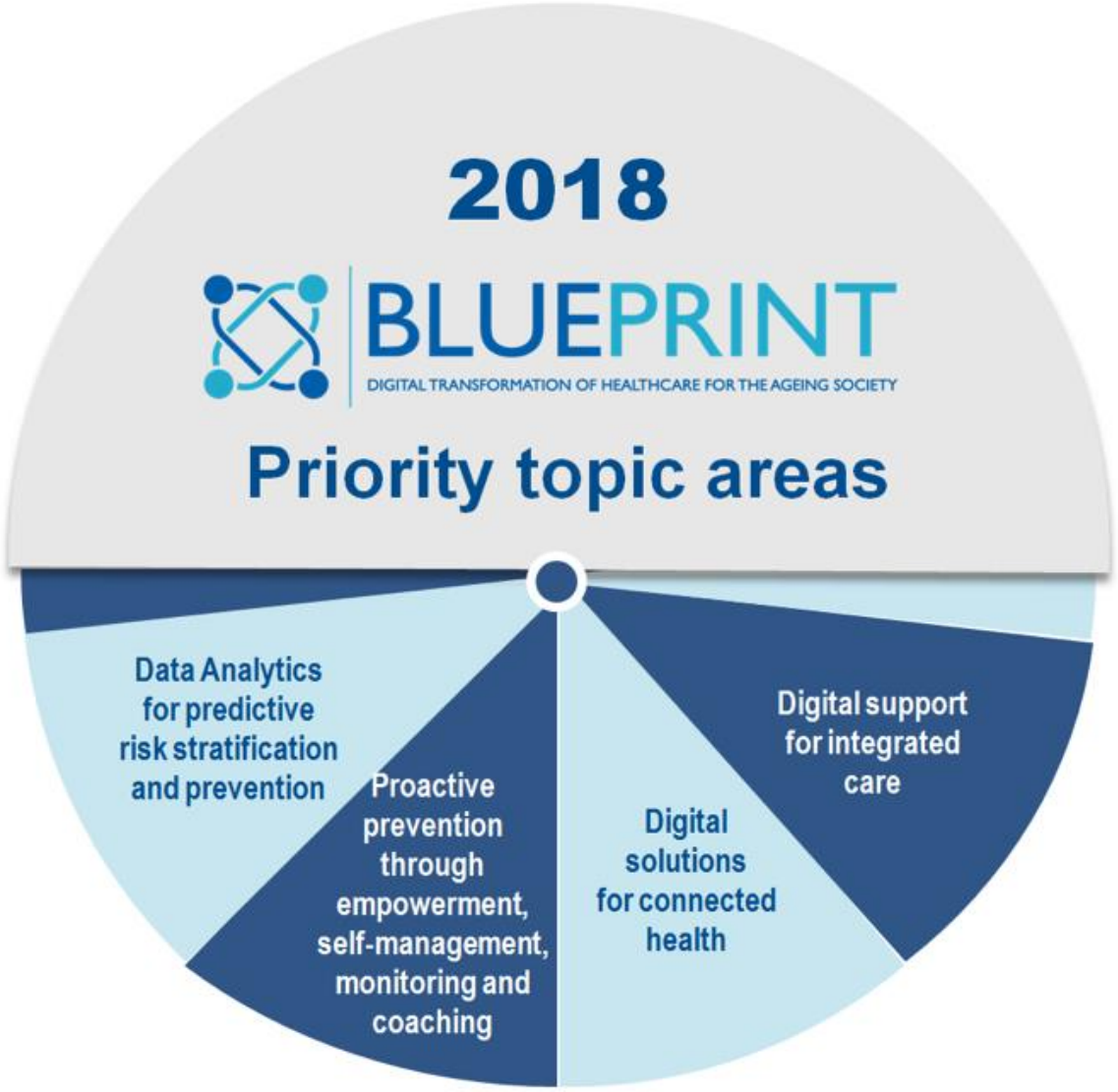
- Objective: counteract the progressive decrease of intrinsic capacity reserves

Health Services | **Social Services** | **Other Services**

Professionals | Caregivers & Families | Citizens | No profit organization | Built environment | ICT

Education, Training, Life Long Learning

The shared vision

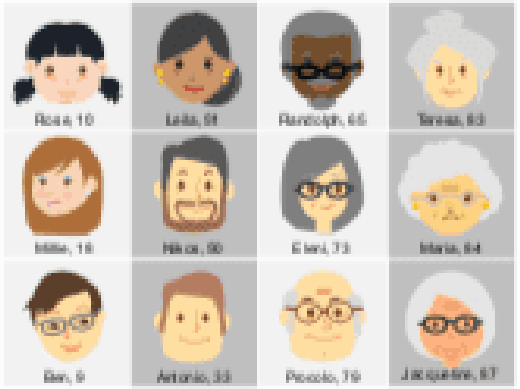


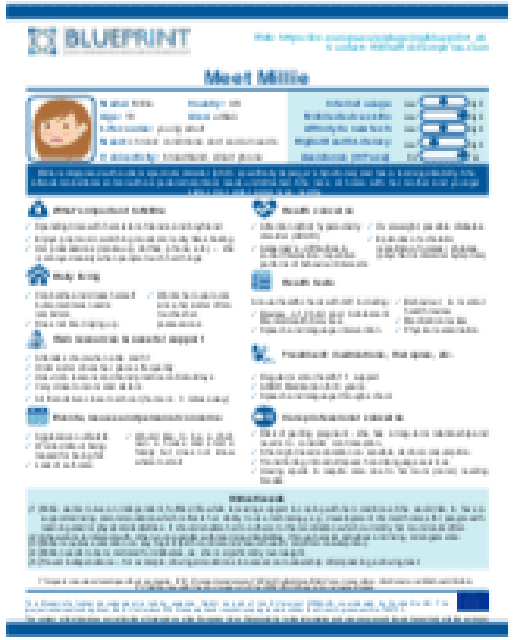
- Address health inequalities
- Reduce hospitalization
- Strengthen integrated home care services
- Deploy health promotion
- Align education and training

Implementing the Blueprint

Personas and unmet needs

- Person-oriented approach to identify specific unmet needs
- Allows stakeholders to relate to the identified unmet needs and situation of the persona
- Identified needs are based on current reality





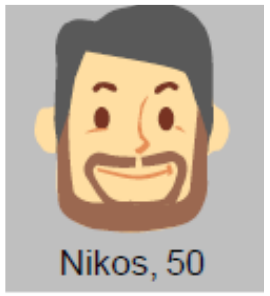
ICT solutions, technologies, trends, services, best practices

Mapping (persona needs, ICT solutions, possible interrelationships)

Chronic conditions

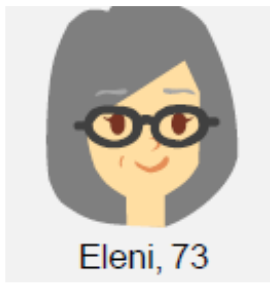
Millie, 18

Pre-diabetes, Attention deficit hyperactivity disorder (ADHD), Aggressive outbursts, Obesity, Worried about being teased due to obesity, wants an independent, fulfilled life while being supported with her conditions, Asperger's syndrome, echolalia



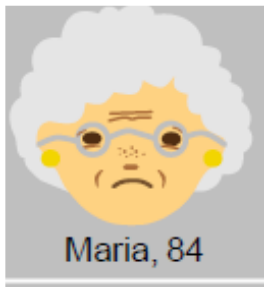
Nikos, 50

Metabolic syndrome (diabetes, hyper-tension), mild chronic obstructive pulmonary disease (COPD), Unable to afford professional lifestyle support services, work routine goes against healthy lifestyle intervention, Trying to stop smoking Stressed due to economic and health issues



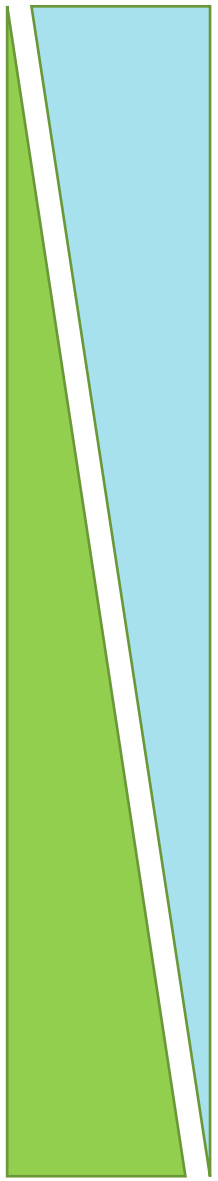
Eleni, 73

Hypertension, Poor medication adherence, Lives alone, lack of nearby family members, Stressed due to challenges of dementia and worried about having accidents alone at home Early stage dementia

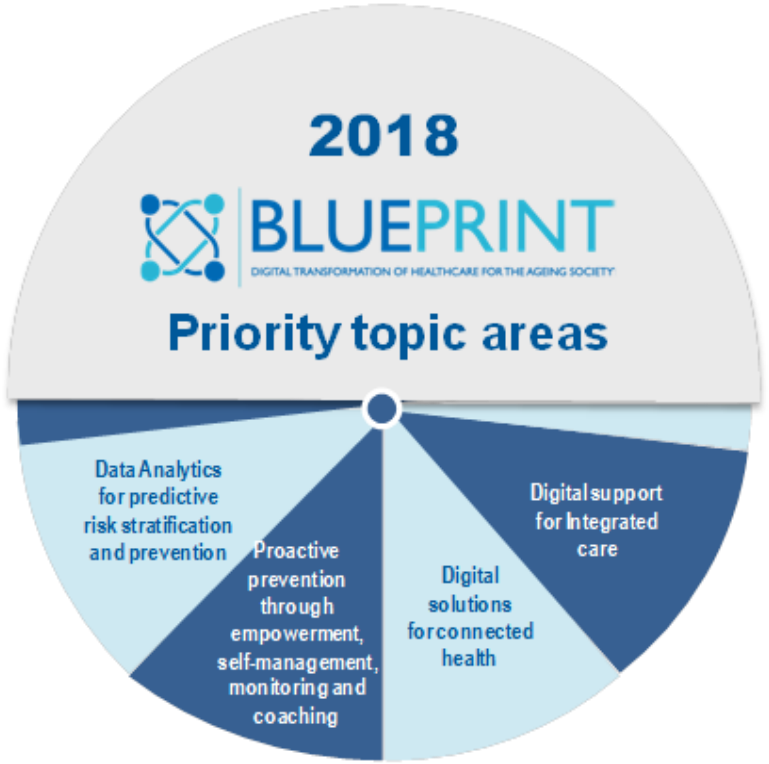


Maria, 84

Diabetes, retinopathy, heart failure, atrial fibrillation, chronic kidney disease (CKD), osteoarthritis: currently under control, occasional relapses. Feels isolated (no friends), huge financial struggles, poor adherence & hygiene, fear of being sent to nursing home, leaving family unprotected



- Find them on time
- Manage age related care transition
- Strengthen services at home
- Interaction among peers
- Secondary prevention
- Education and health literacy
- Support independence (ex. Transoprtation, driving assisting devices etc)



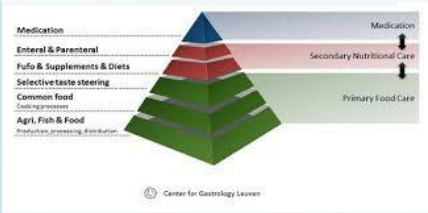
Common approach to AHA for AGs

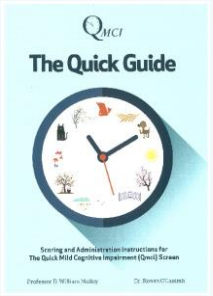
- early detection of frailty and its risk factors,
- multidimensional approaches to intervene and prevent frailty onset/progression (.i.e. targeting diet, physical functioning, cognitive functioning, social engagement) that include falls prevention initiatives and the increase of physical activity levels.
- polypharmacy management for those with multimorbidity;
- building digital open solutions that promote health awareness and personalised social and health care among ageing populations;
- research based on secondary use of health and care data;
- consideration of privacy and ethical issues involved

Building blocks for implementation

Multidimensional approach to frailty prevention

- Adequate Food intake
- Improve physical activity
- Stimulate cognitive functioning
- Stimulate socialization
- Prevent falls
- Prescription adherence
- Strengthen digital and health literacy





FOCUS ProFouND Prevention of Falls Network for Dissemination SIMPATHY PERSSILAA

What’s up next: strengthening ties with RSCN

- First joint commitment
- First joint Webinar
- New personas topics: eye diseases, dermathological diseases, orthodontics & dental functioning

EIP ON AHA

Thank you