Eubie Blake (he lived up to 96)

“If I had knew how long I would live for, I would have taken more care of myself.”

Toulouse
10th September 2013

L. Rodríguez Mañas
Hospital Universitario de Getafe
Madrid (Spain)
1. Patient-Centered Health Systems: Our Target

2. Potential pathways of care: Main criteria

3. Strategies to face frailty in Europe: the EIP-AHA

4. IAGG actions to tackle the challenge of frailty

5. Final remarks
LONGEVITY

Graph 6 - Projection of life expectancy at birth in EUROPOP2008, men (in years)

Source: Commission services.

Graph 7 - Projection of life expectancy at birth in EUROPOP2008, women (in years)

Source: Commission services.
Frailty
Disability
"Failure to thrive"
Death

Functional Capacity

Source: Commission services.
Few older patients with 2 or more chronic diseases are frail/disabled

However, some older people without disease (or mild disease) are frail!
Co-morbidities, frailty and mortality

Comorbidity decreases its predictive accuracy as the age of the population increases

- Frailty contribution increases from 4.3% to 8.8%
- Chronic disease contribution decreases from 11.4% to 0.7%

With permission from H. Bergmann
Public spending (in euros) per 1000 persons older than 75 yrs.

<table>
<thead>
<tr>
<th></th>
<th>Time of informal care (million hours)</th>
<th>Cost (million of euros)</th>
<th>% GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SPAIN</strong></td>
<td>3,249</td>
<td>24,917-41,291</td>
<td>2.3-3.6</td>
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<td><strong>MADRID</strong></td>
<td>251</td>
<td>1,927-3,528</td>
<td>1.0-1.8</td>
</tr>
</tbody>
</table>

The social value of informal care provided to elderly dependent people in Spain
Characteristics of the Patient

“CLASSIC” PATIENT (XXth Century)

- One acute/chronic disease
- Without functional impact
- Without functional sequelae

MODERN PATIENT (XXIth Century)

- Several chronic diseases, with usual acute episodes
- With functional impact
- With functional sequelae

Characteristics of the Health Systems

FOCUS ON DISEASE

FOCUS ON FUNCTION

Rodríguez-Mañas; 2001
A3 Action Group Prevention and early diagnosis of frailty and functional decline

TOPICS

1. Patient-Centered Health Systems: Our Target

2. Potential pathways of care: Main criteria

3. Strategies to face frailty in Europe: the EIP-AHA

4. IAGG actions to tackle the challenge of frailty

5. Final remarks
WHY WE SHOULD NOT WAIT FOR THE APPEARANCE OF DISABILITY?
Frailty: a Complex Syndrome of Increased Vulnerability

Prevent/Delay Frailty
Health Promotion and Prevention

Delay Onset

Delay/Prevent adverse outcomes, care

FRAILTY

Appropriate Time

Life-course Determinants:
Biological (including genetic)
Psychological
Social, Societal Environment

Chronic Disease
Decline in physiologic reserve

Candidate markers
• Nutrition
• Mobility
• Activity
• Strength
• Endurance
• Cognition
• Mood

Adverse outcomes
• Disability
• Morbidity
• Hospitalization
• Institutionalization
• Death

Biological, Psychological, Social, societal modifiers/assets and deficits, Health and Care systems

Modified from Bergman H, 2008
Prolong the management of failure...

...or aim for success?
1. Patient-Centered Health Systems: Our Target

2. Potential pathways of care: Main criteria

3. Strategies to face frailty in Europe: the EIP-AHA

4. IAGG actions to tackle the challenge of frailty

5. Final remarks
European Innovation Partnership on Active and Healthy Ageing

Background and components
EIP on Active & Healthy Ageing

objectives, targets, scope & focus

specific actions

+2 HLY by 2020

Triple win for Europe

Pillar I
Prevention
screening
early
diagnosis

Pillar II
Care & cure

Pillar III
Independent living & active ageing

Prescription and adherence to medical plans (A1)

Better management of health: preventing falls (A2)

Preventing functional decline and frailty (A3)

Integrated care for chronic conditions, inc. telecare (B3)

ICT solutions for independent living & active ageing (C2)

Age-friendly cities and environments (D4)
EIP on Active & Healthy Ageing
Innovative Collaboration

The **EIP on AHA** does not lead to new legislative changes, but instead focuses on:

- **Joining up resources & expertise**
  Input to policy making, collection of experience, evidence

- **Bridging gaps & connecting**
  Direct collaboration with regions and local communities
  Speed up the innovation process

- **Facilitating scaling up & multiplying**
  Bottom up process based on evidence & real-life tested ideas
  Focus on feasibility & scalability of innovative solutions

- **Fostering synergies**
  Coordinating efforts towards a common objective
  EC as facilitator and guarantor of delivery of main objectives
Building up EIP scale and critical mass

1,000 regions & municipalities

1 billion euro mobilised

30 mio citizens, >2 mio patients

>500 commitments

3,000 partners & 300 leading organisations

Marketplace
>30,000 visits >650 registered users
The **EIP on AHA** is not a financial instrument but provides information on potential funding opportunities for Active & Healthy Ageing managed by other DGs.

- **7th Framework Programme (FP7):** More than €4 billion available in the last calls (July 2012) potentially relevant for societal challenge such as ageing and/or EIP priorities.

- **Competitiveness and Innovation Framework Programme (CIP):** ICT part of CIP allocated €24 Million in the Work Programme 2012 for actions directly relevant for the EIP. In 2013 Call, €39 million.

- **Second Health Programmes:** In 2012 call, €4 million supporting the EIP on AHA. In 2013 Call €6 Million and a Joint Action on Chronic Diseases and promoting Healthy Ageing (€5 Million).

**TODAY**

- Structural Funds (2007-2013)
  - e.g. PROGRESS (DG EMPL)
  - €743 million

- **European Investment Bank**
  - Risk-sharing Finance-Facility (RSFF) €2 billion 2007-2013

- **€ 700 million (2008-2013)**

**FUTURE**

- **COSME Program for the Competitiveness of Enterprises and SMEs (2014-2020)**
  - €446 million (2014-2020)

- **Health Programme**
  - €9 billion (original proposal) for Health, Demographic Change and Well Being

- **European Union Cohesion Policy (2014-2020)**
  - e.g. European Programme for Social Innovation €98 Million
EU Health Programme
Call for Proposals 2013

CALL 2: 4.2.1.1 ADDRESSING CHRONIC DISEASES AND PROMOTING HEALTHY AGEING ACROSS THE LIFE CYCLE

• In support of the joint action

• Will focus on the promotion of healthy lifestyles among the 65+ age group through the prevention of specific risks.

• Unhealthy lifestyles and social isolation are key risk factors for chronic diseases and have an adverse impact on the health of older people.

• Should promote targeted innovative cost-effective health promotion approaches in older age groups.

[Project grants] Indicative amount: EUR 1,000,000
Call 3: 4.2.1.2 Supporting the priorities of the European Innovation Partnership on Active and Healthy Ageing

- In support of the practical implementation of innovative solutions responding to the priorities of the European Innovation Partnership on Active and Healthy Ageing

- will foster pilot actions at local and regional level focusing on the management of multimorbidity among elderly people through integrated care pathways as well as on improving adherence to treatment and prevention of falls and frailty

- will group existing and planned public and private activities of excellence in order to create innovative, practical, feasible and measurable projects centred around:
  1. interventions for early identification and diagnosis of physical frailty in older persons
  2. interventions to address polypharmacy

*Project grants*  
Indicative amount: EUR 6 000 000

**Deadline: 22 March 2013**

Executive Agency for Health and Consumers:  
http://ec.europa.eu/eahc/health/projects.html
Objective 3.1b: Wide deployment of integrated care

**Funding Instrument:** Pilot B – several pilots for up to 7M€ in total

**Deadline:** 14 May 2013

**Focus and outcomes:**
- ICT services and applications in integrated care programmes (either vertically within healthcare or horizontal integration of healthcare, social care, long-term and self-care)
- Unlock innovative services and value chains
- Involve new actors (e.g. insurers)
- Deploy novel organisational models and care pathways
- Target primarily national and/or regional authorities deploying integrated care programmes for the first time

Work programme 2014 – 2015

Informal draft discussion document
(August 2013)
Health, demographic change and wellbeing

Understanding health, ageing and disease
PHC 1 - 2014) Understanding health, ageing and disease: determinants, risk factors and pathways
PHC 2 - 2015) Understanding health, ageing and disease: systems medicine

Innovative treatments and technologies
PHC 16 – 2014) Comparing the effectiveness of existing healthcare interventions in the elderly

Advancing active and healthy ageing
PHC 18 – 2014) Advancing active and healthy ageing with ICT: Service robotics within assisted living environments; and ICT solutions for independent living with cognitive impairment
PHC 19 – 2015) Advancing active and healthy ageing with ICT: Early risk detection and intervention
PHC 20 – 2015) Promoting mental wellbeing: in the ageing population

Call – Co-ordination activities
HCO 1 – 2014) Innovation Partnership: Support for the European Innovation Partnership on Active and Healthy Ageing
EIP Monitoring Framework

+2 Healthy Life Years

Outcome indicators e.g.:
- Less hospitalisation
- Less depressed people

Process indicators
Input indicators e.g.:
- Time
- Money
- Number of organisations

Output indicators e.g.:
- Number of regions involved
- Number of patients involved
- New services: 24/7-telephone

Establish the link

JRC: Theory & Modelling

Action Groups

Individual Actions

HLY At birth

Triple Win

Quality of Life

Sustainability of Care

Innovation-based Competitiveness

Outcome indicators e.g.:
- Less hospitalisation
- Less depressed people

Process indicators
Input indicators e.g.:
- Time
- Money
- Number of organisations

Output indicators e.g.:
- Number of regions involved
- Number of patients involved
- New services: 24/7-telephone

Individual Actions
EIP on AHA Commitments for specific actions

- **Total**: Increase of commitments in 2013
  - **2013**: 310
  - **2012**: 261

- **D4 Age Friendly Environments**
  - **2013**: 34
  - **2012**: 35

- **C2 Independent living**
  - **2013**: 25
  - **2012**: 45

- **B3 Integrated Care**
  - **2013**: 68
  - **2012**: 68

- **A3 Frailty**
  - **2013**: 107

- **A2 Falls**
  - **2013**: 39
  - **2012**: 30

- **A1 Adherence to treatment**
  - **2013**: 37
  - **2012**: 32

- **Increase of commitments in 2013**
The commitments

1st Invitation for commitments

261 Commitments

2nd Invitation for commitments

310 Commitments

involvement of:

• all 27 EU MS
• health providers in 271 commitments
• public authorities from all levels in 170 commitments
• SMEs in 130 commitments
• large industry in 79 commitments

national, regional and local level
bottom-up approach
creating critical mass and scale
mobilisation of efforts, resources
leveraging funding opportunities
tangible outcomes – benefits for citizens, care systems and economy and society
The Action Group A3
Which type of organisation is a partner of A3?

128 Commitments in total

<table>
<thead>
<tr>
<th>Type of Organisation</th>
<th>2nd call</th>
<th>1st call</th>
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<td>Advocacy organisations</td>
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<tr>
<td>Large Industry</td>
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<tr>
<td>SME</td>
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<tr>
<td>Public University Hospital</td>
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<tr>
<td>Public Health Provider</td>
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<td>Private Health Provider</td>
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<td>Regional administration</td>
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<td>Research/academia</td>
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<td>26</td>
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<tr>
<td>Other</td>
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<td><strong>TOTAL</strong></td>
<td><strong>87</strong></td>
<td><strong>41</strong></td>
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</table>
Where do members of A3 come from?
A3 Action Group 1st year of work

- Developing work group & A3 dynamics
- Progressing on contents
- Giving visibility & sharing information
- 2nd Call for commitments & reference sites self-assessment
- Elements to align EC funding instruments
Work Elements

Visibility and information sharing

- Participation in Horizon 2020 strategy preparatory work
- Setting priorities related to healthy ageing & financing CIP, FP7, PROGRESS in 2012 EC calls

A3 work development and dynamics

- Meetings in Brussels with partners
- Conference of partners, November 2012
- Phone meetings with A3 coordinators
- Over desk tasks:
  - CIRCAIB platform
  - Governance structure & coordinators

Alignment with EC funding

- Elaboration of A3 Action Plan
- Conference on Frailty in old age, 18 April 2013
- Workshops during frailty conference
- Collaboration WHO frailty conference
- Publication on frailty (in progress)
- Initiate policy lines at EC level
- Monitoring

Progress on contents

- Meetings in Brussels with partners
- Conference of partners, November 2012
- Phone meetings with A3 coordinators
- Over desk tasks:
  - CIRCAIB platform
  - Governance structure & coordinators

- Participation in Horizon 2020 strategy preparatory work
- Setting priorities related to healthy ageing & financing CIP, FP7, PROGRESS in 2012 EC calls

- Participation in Gastein Forum 2012
- Participation in e-health week 2012 & 2013
- Press releases, intracom, EC website

- Participation in e-health week 2012 & 2013
- Press releases, intracom, EC website
- Participation in Horizon 2020 strategy preparatory work
- Setting priorities related to healthy ageing & financing CIP, FP7, PROGRESS in 2012 EC calls
A3 Action Group story

- Early 2012 1st call for commitments
- 6th November 2012 1st conference of Partners A3 Action Plan
- Early 2013 2nd call for commitments
- 18th April Conference Frailty in old age
- August 2013 A3 Good Practices Repository
- November 2013 2nd conference of Partners Action Plan Annex I

1st deliverable
2nd deliverables
6th deliverable
7th deliverable
A3 Action Group Prevention and early diagnosis of frailty and functional decline

A3 Action Plan

Rationale for prevention of frailty and functional decline

✓ Frail older adults require a proactive, multimodal, coordinated multi-disciplinary and multi-agency approach, preferable delivered in an integrated health and care system.

✓ Innovative organisational approaches and technical solutions that target frail older people for evidence based interventions could achieve a more efficient use of resources, increasing the sustainability of health and care systems.

✓ Applying ICT and e-health to services is expected to be effective in the prevention and treatment of frailty and functional/cognitive decline. This may result in better quality of life and a reduction in the use of health care services due to increased independent living.
A3 Action Group Prevention and early diagnosis of frailty and functional decline

ACTIONS TO BE LAUNCHED IN THE A3 ACTION PLAN

Shift the approach from reactive disease management to screening, triage, anticipatory care and prevention of functional decline. This shift is to be brought about through innovative, coordinated and comprehensive community based prevention, assessment and integrated case management systems delivered within an integrated health and care system.
### A3 Activities

<table>
<thead>
<tr>
<th>Category</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions</strong></td>
<td>- social sector /health sector/community/scaling up</td>
</tr>
<tr>
<td><strong>Empowerment</strong></td>
<td>- empowerment/health literacy/patients information/caregivers information</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>- prevention/screening/monitoring performance</td>
</tr>
<tr>
<td><strong>Integration of care</strong></td>
<td>- coordinated interventions between social and health carers</td>
</tr>
<tr>
<td><strong>Research</strong></td>
<td>- research/ basic research/knowledge generation</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>- training professionals/capacity building patients/capacity building care-givers</td>
</tr>
<tr>
<td><strong>Advocacy/communication/cooperation</strong></td>
<td>- raise awareness/dissemination results/dissemination evidence/communication/translational research</td>
</tr>
</tbody>
</table>
Settings

- Community places (houses, pharmacies, social-networks)
- Hospitals
- Primary care centres
- Long term institutions
- Social facilities
- Research institutions
- Academia institutions
- Enterprises
**Target population**

**Robust Old people**
- Healthy and independent old people
- Old people in risk of frailty (malnutrition, cognitive impairment, chronic diseases...)

**High-risk Independent Patients**
- Polimedicated patients
- Multi-morbidity patients
- Very old people (centenaries)
  - Pre-Frail patients
  - People with specific symptoms
  - Vascular disease patients

**Dependent patients**
- Disabled people
- Nursing home patients
- Dependent people
- Terminal patients

**Care givers**
- Carers
  - Health professionals: physicians, nurses
  - Patients’ groups
Clustering of commitments & shared elements

- Advocacy
- Functional decline
- Miscellaneous
- Physical activity
- Cognitive decline
- Nutrition
- Dependency
- Frailty
- Action Group: Frailty & Functional decline
- Industry market
NOW IS THE TIME TO IMPLEMENT

THE EVIDENCE
Focus on Activities
Specific Deliverables
Collaboration - Governance
Measurable Outcomes
Monitoring
Gaps for expanding in the future

European Innovation Partnership on Active and Healthy Ageing
ACTION PLAN
on ‘Prescription and adherence to treatment’

Adopted: 6 XI 2012
A3 Action Group Prevention and early diagnosis of frailty and functional decline

AIMS

But also, to fill

Gaps in our knowledge
A3 Activities: a practical example

Interventions:
- social sector / health sector / community / scaling up

Empowerment:
- empowerment / health literacy / patients information / caregivers information

Prevention:
- prevention / screening / monitoring performance

Integration of care:
- coordinated interventions between social and health carers

Research:
- research / basic research / knowledge generation

Training:
- training professionals / capacity building patients / capacity building care-givers

Advocacy / communication / cooperation:
- raise awareness / dissemination results / dissemination evidence / communication / translational research
General Objective:

Create integrated pathways of care, while encouraging a systematic and integrated approach to implementing strategies for the secondary and tertiary prevention of frailty to reduce the associated physical, functional and cognitive disability.
A3 Action Group Prevention and early diagnosis of frailty and functional decline

Specific Objectives

- Facilitate the organization of health and care systems to deliver a comprehensive, coordinated and integrated approach to secondary and tertiary prevention strategies for frailty and functional decline

- Facilitate the coordination of the different settings of health care to detect risk situations, to provide continued care and to monitor the evolution of older frail patients and patients with functional decline

- Prevent functional decline by providing skilled assessment of older frail people in situations of high risk

- Provide facilities designed to give evidence based most effective attention to frail patients to prevent their functional decline and progression to disability.

- Integrate frailty prevention in the primary and community care network underpinned by ICT.

- Optimize the use of ICT to deliver screening, triage, assessment and treatment / rehabilitation interventions at scale.
### A3 Action Group Prevention and Early Diagnosis of Frailty and Functional Decline

**Objective 4: Create integrated pathways of care, while encouraging a systematic and integrated approach to implementing strategies for the secondary and tertiary prevention of frailty to reduce the associated physical, functional and cognitive disability**

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<tr>
<th>Domain</th>
<th>Partners*</th>
<th>Deliverables</th>
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<td>Business model</td>
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<td>ICT Interventions</td>
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<td>Support Interventions</td>
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<td>15</td>
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<tr>
<td>Training**</td>
<td>5</td>
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*Some partners participate in several domains and deliverables

**The CPME Network, within I2Fresco Program, targets the Primary Care Physicians and other Healthcare Providers to improve knowledge and understanding on Frailty
At least 18/32 Commitments are on-going in 2013
## A3 Action Group

**Prevention and early diagnosis of frailty and functional decline**

### European Commission 2013

**Northern Ireland**

Summary of activities and planned activities related to Undernutrition

**European Innovation Partnership on Active and Healthy Ageing**

**Objective 4**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Status</th>
<th>Actions/Outcomes</th>
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<tbody>
<tr>
<td>Establish mealtime companions programme in hospitals as part of personal care plan</td>
<td>Currently piloting in one Trust</td>
<td>Expand mealtime companions programme to additional Trusts</td>
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<tr>
<td></td>
<td></td>
<td>Design training programme for use in all Trusts and deliver training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liaise with Volunteer Now NI and recruit mealtime companions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Evaluate roll out and patient satisfaction</td>
</tr>
</tbody>
</table>

Marina.lupari@northerntrust.hscni.net
Pauline.mulholland@setrust.hscni.net
Preventative and Anticipatory Care

- Build social networks and opportunities for participation.
- Early diagnosis of dementia.
- Prevention of Falls and Fractures.
- Information & Support for Self Management & self directed support.
- Prediction of risk of recurrent admissions.
- Anticipatory Care Planning.
- Suitable, and varied, housing and housing support.
- Support for carers.

Proactive Care and Support at Home

- Responsive flexible, self-directed home care.
- Integrated Case/Care Management.
- Carer Support.
- Rapid access to equipment.
- Timely adaptations, including housing adaptations.
- Telehealthcare.

Effective Care at Times of Transition

- Reablement & Rehabilitation.
- Specialist clinical advice for community teams.
- NHS24, SAS and Out of Hours access ACPs.
- Range of Intermediate Care alternatives to emergency admission.
- Responsive and flexible palliative care.
- Medicines Management.
- Access to range of housing options.
- Support for carers.

Hospital and Care Home(s)

- Urgent triage to identify frail older people.
- Early assessment and rehab in the appropriate specialist unit.
- Prevention and treatment of delirium.
- Effective and timely discharge home or transfer to intermediate care.
- Medicine reconciliation and reviews.
- Specialist clinical support for care homes.
- Carers as equal Partners.

Enablers
Outcomes focussed assessment
Co-production
Technology/eHealth/Data Sharing
Workforce Development/Skill Mix/Integrated Working
Organisation Development and Improvement Support
Information and Evaluation
Commissioning and Integration Resource Framework
A3 Action Group Prevention and early diagnosis of frailty and functional decline

FILLING THE GAPS OF KNOWLEDGE

DIABFRAIL-STOP PROJECT

HUG-SERMAS/IDOP/EUROPEAN CONSORTIA

ACTIONS IN OBJECTIVE 4

FOCUSED ON FRAILTY
Call 3: 4.2.1.2 Supporting the priorities of the European Innovation Partnership on Active and Healthy Ageing

**FRAILCLINIC-DG SANCO**

**PRIMARY CARE**

**HOME CARE**

**SPECIALIZED CARE**

**OTHER HOSPITAL-BASED DEPARTMENTS/SERVICES**

**GERIATRICS DEPARTMENT**
- ACU*
- Rehabilitation Unit
- Stroke Unit
- Orthogeriatric Unit

**OTHER DEPARTMENTS/SERVICES**
- Consultation Teams
- Day Hospital
- Outpatients Office

*ACU: Acute Care Unit
Good practice booklet
Delivering common products
<table>
<thead>
<tr>
<th>Themes</th>
<th>FRAILTY</th>
<th>COGNITIVE DECLINE</th>
<th>FUNCTIONAL DECLINE</th>
<th>NUTRITION</th>
<th>PHYSICAL EXERCISE</th>
<th>DEPENDENCY</th>
<th>MISCELLANEOUS</th>
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<td>SUSTAINABILITY</td>
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<td>COOPERATION (ADVOCACY)</td>
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### Implementation of Action Plan A3

#### Objectives

<table>
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<th>Themes</th>
<th>FRAILTY</th>
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<td>SUSTAINABILITY</td>
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<tr>
<td>COOPERATION (ADVOCACY)</td>
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</tbody>
</table>

#### Current activities

- Screening
- Training
- Empowerment
- Research
- etc.
- etc.

#### Expected outcomes/results

- Guidelines
- Large database
- Training materials

---

**2012**

**2015**
Reference Sites – concept, objectives, scope

Objectives of the EIP Reference Sites

- excellent examples of cost-effective and – efficient good practice & impact on the ground
- scalability, transferability and replicability across Europe - when there is clear need for care systems modernisation
- dissemination of good practices – e.g. the couching and training of other regions/care systems
- a tool to reduce inequalities in lagging behind regions in terms of health and care outcomes
46 submissions => 14 MSs
for candidate Reference Sites

32 RSs => 12 MSs
selected for self-assessment and peer-review
(innovation, scalability, outcomes)

72 good practices of innovation-based integrated care models with sound impact on the ground

1 July 2013 – Star Ceremony
nomination of best RSs with stars, ready for replication and coaching
Annex 1: Criteria for the peer review of the RS good practices

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Sub-criterion [1 point per each]</th>
<th>Good Practice 1</th>
<th>Good Practice 2</th>
<th>Good Practice 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation</td>
<td>relevance [Link to the 3 pillars of the EIP, prevention and early diagnosis, care and cure, and independent living and active ageing]</td>
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<td></td>
<td>added value [Innovative elements and their relative advantages and benefits over existing models]</td>
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<td></td>
<td>integrated approach across 3 pillars [Integration of 3 pillars - either how it is already achieved or the strategy to achieve it, strategic planning, financing and purchasing schemes, integration of services &amp; coordination across care providers/services]</td>
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<tr>
<td>Scaling up &amp; replicability</td>
<td>scaling-up strategy [strategic planning, means of communication, dissemination, facilities for transfer of knowledge to other regions, promotion]</td>
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<td></td>
<td>involvement of relevant partners [local coalition of stakeholders, collaboration/partnerships with other actors outside your region]</td>
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<td></td>
<td>mobilization [expanding coverage of the innovative solution in your local population, identification and commitment of partners, education and training efforts, funding sources, political advocacy/lead]</td>
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<tr>
<td>Outcomes</td>
<td>for citizens [Demonstration, based on indicators, of impacts on health status and quality of life of your local population]</td>
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<td>for care systems [Demonstration, based on indicators, of impacts on the sustainability and efficiency of your health and social care systems]</td>
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<td>for growth and markets [Demonstration, based on indicators, of impacts on at least one of the following: competitiveness of EU industry, expansion of new markets and growth, employment &amp; job creation]</td>
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<td></td>
<td>coverage [Demonstration that more than 10% of the local target population receives the innovative service]</td>
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<td></td>
<td>transferability (internal and external) [Demonstration that your innovative service has been adopted, tailored and validated in at least 2 other settings, either inside or outside your region]</td>
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<td></td>
<td>total/final score</td>
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MADRID Y EL HOSPITAL DE GETAFE, CENTRO DE REFERENCIA EUROPEO
EN PROGRAMAS DE ATENCIÓN A LOS PROBLEMAS DE SALUD DE LOS ANCIANOS

- Programa de Atención coordinada e integral intra- y extrahospitalaria para ancianos
- Programa de Atención Experta a pacientes ancianos con caídas y fracturas

Site: Region de Madrid-Consejería de Sanidad-Hospital Universitario de Getafe

✓ Programa de Atención coordinada e integral intra- y extrahospitalaria para ancianos
✓ Programa de Atención Experta a pacientes ancianos con caídas y fracturas
1. Patient-Centered Health Systems: Our Target

2. Potential pathways of care: Main criteria

3. Strategies to face frailty in Europe: the EIP-AHA

4. IAGG actions to tackle the challenge of frailty

5. Final remarks
“Promoting access to innovation and clinical research for frail old persons”

January 20-21, 2012
Athens, Greece
<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
<th>Date</th>
<th>Time</th>
<th>Venue</th>
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<tbody>
<tr>
<td>SP24 315</td>
<td><strong>IAGG GARN SYMPOSium on Implementing Frailty into Clinical Practice and Clinical Research</strong></td>
<td>June 24, 13:30-17:30</td>
<td>E5, 3F, Hall E</td>
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<tr>
<td>PS24 312-C</td>
<td><strong>Frailty and Sarcopenia</strong></td>
<td>June 24, 14:10-15:40</td>
<td>E2</td>
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<td>Convenor: Jean-Pierre Michel (Switzerland)</td>
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<td></td>
<td>Chair: Jeffrey Halter(USA), Hyunrim Choi (Korea)</td>
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<tr>
<td>PS24 201-R</td>
<td><strong>Geriatric Syndromes Related with Frailty, Dementia, and Diabetes Mellitus</strong></td>
<td>June 24, 10:50-12:20</td>
<td>Auditorium</td>
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<tr>
<td></td>
<td>Convenor: Hyung Joon Yoo (Korea), Chair: Howard Bergman (Canada)</td>
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<tr>
<td>PS24 204-R</td>
<td><strong>Immune Frailty and Defense Against Infections</strong></td>
<td>June 24, 10:50-12:20</td>
<td>103</td>
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<tr>
<td></td>
<td>Convenor &amp; Chair: Graham Pawelec (Germany)</td>
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</table>
ICFSR 2014 International Conference on Frailty & Sarcopenia Research

Wednesday 12th, Thursday 13th & Friday 14th March, 2014 Barcelona, Spain

Implementing Frailty and Sarcopenia into Clinical Practice: Clinical Core
Wednesday 12th March, 2014
09:00AM - 09:30AM
Welcome by the Organizing Committee

International Conference on Frailty & Sarcopenia Research (ICFSR 2014)
Thursday 13th March, 2014
09:00AM - 09:15AM
Welcome by the Organizing Committee

Friday 14th March, 2014
09:00AM - 09:30AM
Keynote:
Characteristics of the Patient

“CLASSIC” PATIENT (XXth Century)
One acute/chronic disease
Without functional impact
Without functional sequelae

WE MUST CHANGE OUR MINDS

MODERN PATIENT (XXIth Century)
Several chronic diseases, with usual acute episodes
With functional impact
With functional sequelae

Rodríguez-Mañas; 2001
Los Stones recurren a un geriatra

Mañana actúan en Noruega bajo la mirada atenta de un médico especializado en la vejez.

«Es tranquilizador tener a un médico que sabe atender los males típicos de su edad», afirman los organizadores del concierto, que temen otra suspensión.

Miguel Miélgo
Horsens (Dinamarca)

Cuesta reconocerlo, ellos mismos no lo tienen muy asumido, pero los Rolling Stones ya bordean la tercera edad. Mick Jagger tiene 63 años; Keith Richards, un año menos y Charlie Watts, 65. El «benjamín» es Ron Wood con 58 años. Y, aunque por activa y por pasiva, se afirma que están en buena forma, los organizadores del concierto que ofrecerán mañana en Noruega han solicitado los servicios de Paal Naalsund, el jefe médico del departamento de geriatría del hospital municipal de Bergen. El doctor velará por las estrellas, antes, durante y después del
A3 Action Group Prevention and early diagnosis of frailty and functional decline