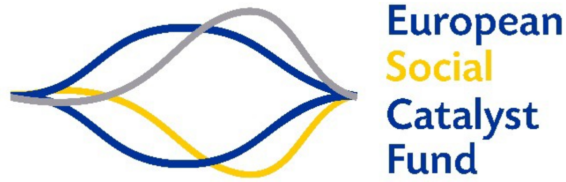
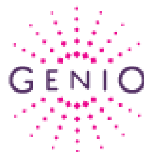


European Social Catalyst Fund

Scaling Plan: Long Live the Elderly!

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 870757.



Introduction

We propose to implement a Community-based pro-Active Monitoring Program (CAMP) called “Long Live the Elderly!” (LLE), targeting people aged >80, based on a pro-Active phone monitoring customized on the assessment of bio-psycho-social frailty and followed by the implementation of Individualized Care Plans (ICPs) in case of need. CAMP is thought to catalyse the public-private interaction in a win-win perspective, in order to address the needs of older adults. The deep knowledge of the social environment is needed to favour interaction between the clients and private and public services. Based on this knowing the social operators trigger the increase of social capital at community level improving the older adults' resilience.

The program will assess the needs for care of the clients by measuring the Bio-Psycho-Social frailty and developing Individual Care Plans (ICPs) in case of need. ICPs must take into consideration the need to integrate health and social care at community level[1]. In fact at European level this is considered a crucial issue that cannot be addressed by homogenous top-down solutions. This is why we want to build up a bottom-up approach to integrate health and social professionals based on the assessment of individuals’ needs and the use of shared tools. This approach needs to develop a plan for training professionals in order to make them familiar with procedures and tools that encompass a high level of information exchange as well as the share of care plans. A strong support to the CAMP comes from the ICT support to the developing of the model. This is strongly connected to the increase of the effectiveness of the intervention as well as to the capacity of the programme to involve clients and stakeholders in the process of developing the program itself. ICT solutions for increasing independent and safe life of older adults with physical impairment are powerful tools that need to be embedded in a services matrix to exploit their contribution. At the same time the potential of an ICT network to empower people for improving the social environment with the aim of counteracting social isolation and making people protagonists of their own care processes is still to be explored and implemented.

A strong communication campaign should precede the beginning of the service as an enabling factor. This campaign should be carried out by placing information points (in the streets, in the big markets, through public services etc), possibly managed by the program’s operators, so people can also meet in person the ones from whom they will possibly receive the call later. A second enabling factor is the collaboration with the municipality to increase the citizens’ trust in the new service.

The program also represents a job opportunity for youths, especially the ones with low education level that could have trouble getting into the labour market.

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[1] European Commission. TOOLS AND METHODOLOGIES TO ASSESS INTEGRATED CARE IN EUROPE. Report by the Expert Group on Health Systems Performance Assessment. Electronic version: ISBN 978-92-79-66678-0 doi:10.2875/69305 Catalogue number: EW-01-18-187-ENN, pag iii; pag 1.

Lead organisation

Vereniging voor Solidariteit, Belgium

Other organisations in the consortium

- Fundacja Sant'Egidio, Poland
- Community of S.Egidio-ACAP, Italy
- Biomedicine and Prevention Dept -University of Rome "Tor Vergata", Italy
- Komunita S. Egidio, Czech Republic
- Charles University, Faculty of Philosophy, Czech Republic
- Dedalus Italia s.p.a., Italy
- Gemeinschaft Sant'Egidio e.V., Germany

Primary social challenges that the innovation seeks to address

Ageing, Employment and Job Creation, Community Development

Relevance of this Social Innovation

The overarching issue to be addressed by this plan is the fragmentation of the society, which is the main reason for the increase of social isolation and social exclusion, major risk factors for negative events affecting the older adult population. The fragmentation of the society is expressed by the weakening of social ties and the lack of integration of care services addressing the need for care of people with disability or at risk of functional decline because of their frail or pre-frail status. Indicators of the weakening of social ties are the increasing percentage of EU citizens who claim they have nobody on which they can discuss personal matter, which are on average 9.2% among people older than 75 years, peaking at 14.2% and 12.3% in Italy and Belgium respectively[2]; another indicator is the size of households that is progressively decreasing: living alone is the most frequent living arrangement and it is the one quicker increasing from 2007, peaking at 41.4% in Germany[3]. In Czechia the average number of people per household showed the highest decreasing rate (about 10%) in the last decade together with Ireland, France and Italy[4].

The progressive reduction of quantity and quality of social ties, which is even more pronounced among the older adults, is associated with the high prevalence of people living longer with disabilities, which represents good news, but also a challenge for the whole society. In 2014 about 50% of European older adults reported difficulties in performing the Activities of Daily Living (ADL) with a peak of 67.5% in Czechia (the highest rate at EU level)

[2] EUROSTAT, statistics explained. People who do not have someone to ask for help and people who do not have someone to discuss personal matters with, by age, 2015 (% share). https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:People_who_do_not_have_someone_to_ask_for_help_and_people_who_do_not_have_someone_to_discuss_personal_matters_with,_by_age,_2015_(%25_share)_QOL18.png&oldid=399700, accessed on 26.08.2021

[3] EUROSTAT, statistics explained Average household size, 2008 and 2018 (average number of persons in private households). https://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Average_household_size,_2008_and_2018_(average_number_of_persons_in_private_households)_new.png accessed on 26.08.2021

[4] EUROSTAT, statistics explained. Average household size - EU-SILC survey. https://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do accessed on 26.08.2021

and 57.4% in Poland: about half of them claimed of not having support to perform these activities[5].

A survey commissioned by the King Baudouin Foundation in 2017[6] and again in 2020[7] into the views of Belgian over-60s on growing older confirms the above findings and stresses the importance of social contact in order to better cope with old age.

The most striking shift in the results of the 2020 King Baudouin Foundation survey compared to 2017 is growing loneliness, which is a common issue across EU countries. More than half of the over-75s feel lonely occasionally to regularly, and the figures increase with age. At the same time, there is great potential for organizing social contacts, solidarity and mutual help at neighbourhood level. Almost 70% of respondents in the age group between 60 and 75 would be willing to get involved in a neighbourhood network, but only 10% know of one. Finally, the research also shows that the various negative factors (poor health, social isolation, being unskilled or working in a low-skilled job) reinforce each other, but the risk of problems in old age is indeed reduced if people maintain a social network and prepare for old age.

Fragmentation of services and subsidies does not help, making it difficult to get the needed help.

"Despite large variation in health systems design, countries participating in the survey reported a number of similar dimensions and challenges related to integrated care. These include primarily coordination and integration of primary and specialist care, and the coordination of health care and social care. Reported barriers to achieve more integrated and coordinated care included lack of effective information structures, organisational differences and resistance from health professionals." [8]

Among the main obstacles to develop an integrated approach to individual care which is crucial to achieve a patient-centred care (the declared mainstream of health social care thinking in Europe in the last decade) the quoted document reported:

ICT and information structures;

- Resistance from health professionals to change work practices and to co-operate;
- Health literacy and patient participation;
- Questions about how to organise new governance arrangements, which need to include elements of accountability, oversight and distributed leadership, while at the same time considering the national, regional and local context."

Here below the witnesses of several caregivers, gathered during these months of project preparation, have been synthesized in order to provide the point of view of the service beneficiaries in Prague[9]:

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[5] EUROSTAT, statistics explained. Disability statistics - elderly needs for help or assistance https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Disability_statistics_-_elderly_needs_for_help_or_assistance. accessed on 26.08.2021

[6] Koning Boudewijnstichting. (2017, 25 september)

[7] Busschaert, S., Minnebo, J., Indiville, & Samyn, W. (2020)

[8] European Commission. TOOLS AND METHODOLOGIES TO ASSESS INTEGRATED CARE IN EUROPE. Report by the Expert Group on Health Systems Performance Assessment. Electronic version: ISBN 978-92-79-66678-0 doi:10.2875/69305 Catalogue number: EW-01-18-187-ENN, page 118. The report was published in 2017 by a large working group coordinated by the Belgian Ministry of Health and Social Affairs D Reynders and by A Rys from the European Commission – DG Health and Food Safety Director for health systems, medical products and innovation. The working group included member of international organizations and included also some representatives of the European Innovation Partnership on Active and Healthy Ageing – B3 group on integrated care

[9] Analysis of semi structured interviews Prague – Annex 5

"There is no special assistance for my husband with severe dementia so that he could stay at home as long as possible"

- Missing continuity of health and social services is a complication.
- Information on services is difficult to find – help for lonely older people to search information on internet and to use mobile phone is missing.
- It is difficult and time consuming to search, to telephone and personally look for information regarding specific problems in different places. It is practically impossible in case of urgent need.
- There is no information on the quality of services.
- Territorial differences between city districts in the offer of services - some services for Prague citizens exist only outside of the capital.
- Missing community and socialization programs, lack of counselling services specialized in various life situations.

These are only examples of what is experienced in many EU countries: it claims for deep changes of the policies in the field of community care.

Interestingly, nobody mentioned the lack of a bottom up approach to the integration which is what is currently happening when a family has to deal with the problem of taking care of a loved one experiencing functional decline. In fact, this approach is completely lacking when the person is really alone, without anyone who can help in dealing with the services, a situation that usually results in the admission to a Nursing Home (NH) or to an Assisted Living Facility (ALF) even if this could have been avoided with limited home help.

The point of view of the EU report quoted above[8] is the ones of the care service providers, so the lack of the client's perspective is understandable, even if this is probably what could really help to overcome the current difficulties in EU countries. The care organization in Belgium, is rather complex and shredded, making access to care and support more difficult, especially for people with limited health literacy[10]. A qualitative study in 2019 on access to care of community-dwelling elderly in Belgium[11] brings to attention that despite all policy measures, access to a broad spectrum of care and support services remains a challenge in the Belgian ageing society. An important barrier mentioned by the respondents is affordability. Pensions in Belgium are rather low compared to other EU countries. The respondents indicated they prefer to live in their own house for as long as possible, but are concerned about the high cost. Accessibility also puts people in trouble: it can refer to geographical barriers, but it also concerns waiting lists for care services[12]. In Czechia also older adults experience relevant barriers to access care services, due to the shortage on offer and the lack of awareness of the older adults themselves. Moreover, the authors of the report on Czech Republic Community Care Context underline that "the role of prevention and screening should be promoted**.** Providers also mention the need to support informal caregivers. They themselves often lack the necessary information, and do not know how to coordinate different types of care. Similarly, service staff should be informed of ways to assist informal caregivers with a combination of informal and formal care." [13] Obstacles to access home services by older adults, due to the difficulties of managing the relation with the

[10] ISTAT. I PRESIDI RESIDENZIALI SOCIO-ASSISTENZIALI E SOCIO-SANITARI. Presidi residenziali socio-assistenziali e socio-sanitari - Anno 2015 (istat.it) accessed on 21.09.2021

[11] Fret, B., De Donder, L., Lambotte, D., Dury, S., Van der Elst, M., De Witte, N., Switsers, L., Hoens, S., Van Regenmortel, S., & Verté, D. (2019)

[12] "Long Live the Elderly!". Context Report Belgium - Annex 1

[13] K Samalova, H Janechova. Implementation of the Long Live The Elderly! in the territory of Prague 7 – Annex 3

public services and the care organization which is all on the clients/family shoulders, are mentioned also by the German report on community care as well as by the Italian partners. In Poland the development of community care services is lower than in the other four countries taken into account in this project: "…in a case of illness older people counted mainly on the help of their spouse or life partner (46%) and children (including son-in-law, daughter-in-law) or grandchildren (42%). They were followed by: neighbours (less than 4%), siblings (approx. 3%) and friends or acquaintances (2%). Almost absent from the list of potential help resources, in the case of solving everyday problems, were people from social welfare institutions or people who would have to be paid for such help"[14].

The reality is that in many cases when the functional decline begins, entering a residential care facility is the easiest possibility to get even a minimal amount of care. In many EU countries, ageing is quite always associated with the perspective of institutionalization, which becomes a reality for a large number of individuals as they age. In Germany close to 40% of people aged >90 (in need of care) live in Assisted Living Facilities or in a Nursing Home. However, a relevant portion of older adults receiving residential care could have remained at home with little help. In fact, in Flanders, about 20 % of Long Term Care Facility (LTFC) residents are independent elderly or elderly with low care-dependency (category O or A of the Katz scale[15] as it is also in Italy.) Institutionalization is not an answer to the need for care of European older adults because it is expensive and offers a questionable quality of life, sometimes exposed to sudden worsening and increased risk of death as it happened during the COVID-19 crisis. However, a compromised quality of life is also not acceptable for the ones who remain at home, with lack of support as it happens to a considerable number of EU older citizens.

There is also a big shortage of senior caregivers in Czechia, which results in a longer waiting list for Long Term Care (LTC) services. Moreover, occupational levels among the younger population dropped after the 2011 economic crisis. To involve young people into the care of the seniors could be an option to support occupational levels. In Belgium the youth unemployment rate stands at 17.7% and it has been increasing for the last 15 years. Again an innovative model of community care could be an attractive employment perspective.

The extent to which this innovation has already been implemented in countries in Europe

Until now the program has been fully implemented in Italy since 2004. LLE is currently operating in 9 Italian cities (Rome, Novara, Genoa, Padua, Parma, Civitavecchia, Napoli, Brindisi, Sassari) through formal agreement with the municipalities. Overall, about 20,000 citizens aged >80 are followed up in these nine cities.

[14] GUS- Quality of life of elderly people in Poland p. 77
[15] Rusthuisbarometer: Analyse bewonersfacturen in woonzorgcentra (2017)

Scope

Where the innovation is planned to be implemented

Antwerp City, Merksem Urban Area;

Prague City, Prague 7 Urban Area

Reasons the geographical areas were chosen for implementation

Prague 7 is a very well equipped, open and modern district of Prague. Almost a half of the households of senior citizens in Prague live and farm as individuals, most often after the death of a partner or after a divorce. Prague 7 is no exception, and the proportion of households of independent seniors is even higher than the Prague average (CSU, 2015). 36.7 %, i.e. about 2,740 seniors from Prague 7 live in an apartment completely alone.)

The Sant'Egidio Community has worked with this urban area and on its territory for several years. Up to now, the most important activity is helping homeless people. Since 1993 Sant´Egidio works in Prague with the elderly, especially with those in nursing homes. Sant´Egidio activities are aimed at dialogue between generations and also at national level.

Sant'Egidio has been well embedded in the Merksem district for years with, among other things, a service for the elderly: volunteers visiting the elderly at home and the elderly coming together for a range of activities. The Sant'Egidio Community of Merksem follows about 40 community dwelling elderly with about 10 volunteers and visits elderly people in the two nursing homes in the area that together host about 400 older adults.

Young people are engaged in the School for Peace, supporting children from very different and often difficult backgrounds to develop and grow into open and responsible young people who can live together peacefully and feel at home in a global world. New Europeans are welcomed in the 'language learning opportunities club' where they can practice Dutch and discover our society together with new friends. The 'Amici' (people with disabilities) have regular meetings in their Art Studio and maintain friendship with the elderly. In the Martin Luther King House, a group of chronically ill homeless people found a new home, supported by volunteers. Around 35 adult and 25 young volunteers are involved in those activities, reaching about 150 beneficiaries.

All these activities together already form a small but strong and attractive social fabric that the LLE Program wants to build on and expand.

At the same time, there have been few initiatives so far to put the recent policy choices of the Flemish government to promote and support community care into practice in the area of Merksem. The two LTCF in the district - where the Sant'Egidio volunteers are regular visitors - together with the large offer of Assisted Living Facilities seem to be the easiest solution when elderly are confronted with physical decline. A common observation of our volunteers is that the prominent presence of this 'easy solution' increases the resistance or difficulty of the elderly to think about alternatives. When we visit them later in the retirement home, we find that they regret their choice. Starting a preventive programme like LLE can therefore prevent a lot of suffering.

Level of implementation of the innovation anticipated

Antwerp: Level 2 - Partial adoption by regional/municipal social services

Prague: Level 4 - Pilots external to mainstream social services

Level of Adoption	Description
1	Consistent Adoption by mainstream social services at national/federal level
2	**Partial adoption by regional/municipal social services**
3	Inter-connected demonstration projects
4	**Pilots external to mainstream social services**

Anticipated measurable outcomes

Within 2 years

ANTWERP: The experience of the program in Rome shows that a half-time employee (80h/month) according to the methodology of Long Live the Elderly can follow up about 300 elderly people (when the program is running at full speed).

With resources available in Antwerp, we expect in the first year to have available a full-time coordinator and five half-time employees, who will take care of the main activities. In accordance with the conditions set by the city for the conclusion of an agreement, the program will start in three zones of Antwerp (the districts of Merksem, Hoboken and Wilrijk)

This staff will be able to put the database for the project into operation and start the collaboration with local welfare and care actors.

With these resources in the second year, we will work at full regime and we will be able to include in the program 1,800 elderly = 1,080 (robust or pre-frail) + 480 (frail) + 240 (very frail)

According to the program's methodology we want to call the first group, robust and pre-frail once in the first year. The frail elderly are called three times and the very frail elderly six times. So for the first year we arrive at:

1,080 x 1 call + 480 x 3 calls + 240 x 6 calls = 3,960 telephone contacts

According to the evidence generated by the phone calls and the assessment of frailty, Individual Care Plans will be drafted.

In addition to these beneficiaries, all the elderly in the areas involved (approximately 6,300 individuals) will be reached by public and awareness-raising activities aimed at creating or strengthening social networks. Moreover, a phone number will be available for all the beneficiaries to be reached in case of need from Monday to Friday, from 9.00am to 16.00pm. This service is not intended as an emergency service, but only as a way to offer the chance of contact to those who will need it.

PRAGUE: The approach will be the same as Antwerp, but the program in Prague will be a pilot one involving 100-300 beneficiaries according to the available funds.

Beyond 2 years

It is planned to gradually enlarge the number of elderly people involved (with an increase in the resources available and a more efficient use of them) until reaching the entire population of the neighbourhoods included, with the full program.

Evidence

The LLE program halves the increase of mortality rates registered during a heat wave[16] (quasi-experimental study - Level III, see Appendix 2). The study compares the number of deaths recorded by the municipality of Rome during the heat waves occurred in the 2015 summer, according to the urban zones served or not served by the LLE program

The reduction of mortality was also observed during the COVID-19 emergency in a sample of LLE clients living in the cities of Genoa and Rome (cohort study - Level IV, see Appendix 2)[17]. In these two papers the role of social connectedness promoted by the LLE program has been associated with mortality reduction.

The LLE program is able to reduce hospital admissions of its clients (quasi-experimental study and cohort study - Levels III and IV, see Appendix 2)[18]. The study compares a randomized sample of the LLE program, and a similar population enrolled in the longitudinal study on frailty carried out by the Biomedicine and Prevention Department of the University of Rome “Tor Vergata”. The multivariate analysis, adjusted for age, gender and frailty, showed a 10% reduction of the hospital admission probability for the older adults included in the LLE program compared with the other ones. Moreover, the LLE program clients did not re-enter the hospital after the first discharge within the first year of follow-up, but that was not the case for the control sample. A nested case-control study (Level IV) showed that the integration of LLE with the community nurses is able to further reduce one-year hospitalization of people aged >75 close to 30% (from 15.4% to 10.8%)[19].

Similar results have been reported for the Long-Term Care Facilities admission rate, which was halved (cohort studies - Level III, see Appendix 2)[16].

Two reports on the activities of the European Innovation Partnership on Active and Healthy Ageing (EIPonAHA) - A3 Action group included the LLE program among the good practices

[16] Liotta, G. et al. Social Interventions to Prevent Heat-Related Mortality in the Older Adult in Rome, Italy: A Quasi-Experimental Study. Int. J. Environ. Res. Public Health 2018, 15, E715.
[17] Palombi L, Liotta G, Emberti Gialloreti L, Marazzi MC. Does the COVID-19 pandemic call for a new model of elderly care? Frontiers in Public Health 8, 311 www.frontiersin.org/article/10.3389/fpubh.2020.00311
[18] G Liotta, et al Impact of social care on Hospital Admissions in a sample of community-dwelling older adults: Results of a quasi-experimental study. Ann. Ig 30, 378-386
[19] E. Terracciano et al. The effect of community nurse on mortality and hospitalization in a group of over-75 older adults: a nested case-control study. Ann Ig 2021 Sept-Oct; 33(5): 487-498. doi:10.7416/ai.2020.2398.

that achieved results on the field in mitigating the impact of bio-psycho-social frailty on the citizens' quality of life[20] [21] [22] (expert reports - Level VII, see Appendix 2).

Scaling Methods

Italy: The program has been implemented for 17 years up to now. It is currently run in nine Italian cities (Rome, Novara, Genoa, Civitavecchia, Naples, Brindisi, Sassari, Padua and Parma), two of which started this year, with about 20,000 beneficiaries.

Antwerp: The program will start October 1st, 2021, supported by the municipality with a grant of 150,000 euro per one year, as a result of the negotiation carried out during the period covered by the ESCF.

Prague: Community of Sant'Egidio is ready to implement the various phases of the program, and the municipality assured a consent to this hypothesis. However, it was not possible to arrive to the final agreement yet, because of the need to include the new service in the framework of the municipality service provision due to the rearrangement of this framework that is still ongoing. To be included means also to receive funds, which is still the main obstacle to the implementation of the program. It is likely the program will start early next year as a pilot one, as a result of the negotiation carried out during the period covered by the ESCF. As a pros point, there are discussions ongoing with other non-for-profit organizations to involve them in the program implementation.

Wurzburg: The program is not starting right now because the conditions needed are not in place yet, mainly the environmental ones. The attitude in Germany is much more towards institutionalization and public bodies are not fully supporting community-oriented intervention. The Community of Sant'Egidio in Wurzburg is strongly involved in an awareness campaign in favour of domiciliary care, and it is supporting the wishes of many older adults also with practical interventions like the setup of a small experience of elderly co-housing.

Warsaw: Care for the elderly is still mainly a "private" issue and then community care services for older adults is not a burning issue for decision-makers. The community of Sant'Egidio is going to increase its effort to increase the awareness of the importance of older adults' care and the need for a stronger involvement of public bodies in this issue. This is crucial to orient funds towards this sector.

Key partners

In Prague, funding should be obtained by the district Prague 7, plus regular campaigns to ask for philanthropic support of the project will be run. It is fundamental to find public and

[20] Liotta G, Ussai S, Illario M, et al. Frailty as the Future Core Business of Public Health: Report of the Activities of the A3 Action Group of the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA). Int J Environ Res Public Health. 2018;15(12):2843. Published 2018 Dec 13. doi:10.3390/ijerph15122843
[21] Cano A, Dargent G, Carriazo A, et al. Tackling frailty and functional decline: Background of the action group A3 of the European innovation partnership for active and healthy ageing. Maturitas. 2018; 115:69-73. doi: 10.1016/j.maturitas.2018.06.009
[22] Marazzi, M., Inzerilli, M., Madaro, O., Palombi, L., Scarcella, P., Orlando, S., Maurici, M. and Liotta, G. (2015) Impact of the Community-Based Active Monitoring Program on the Long-Term Care Services Use and In-Patient Admissions of the Over-74 Population. Advances in Aging Research, 4, 187-194. doi: 10.4236/aar.2015.46020.

private support, as the service must be free for the elderly. Život 90, one of the main NGOs working with elderly at home since the beginning of 1990s, is ready to help in building capacities, unfortunately they are not able to finance our service. There is however a possibility to collaborate with a philanthropic foundation in Prague.

As mentioned above, in the district of Merksem collaboration with several partners is in a planning phase. We already have the city of Antwerp as a key partner, as well as the public entity 'Primary Care Zone' in Antwerp North (Eerstelijnszone Noord), a coordinating platform for health and social services in an area that covers some districts north of Antwerp, including Merksem. It is also our intention to develop partnerships with the various providers of social assistance and care in Merksem and with the associations that offer support or activities for the elderly. As far as the district administration of Merksem is concerned, they will not participate in the program as an active partner but are in favour of the implementation of the LLE Program.

The districts of Hoboken and Wilrijk are part of the same "Primary Care Zone", (Antwerp South - Eerstelijnszone Zuid), with whom a first meeting is planned in October. As Sant'Egidio has been present in the southern periphery of Antwerp with a service for the elderly since the 1990s, and particularly in Hoboken for five years, we've already been collaborating with several home care services in the area to support individual elderly people. In the coming months, more structured co-operation will be initiated based on these contacts. There is already a co-operation with the Hoboken district through the Alderman for Senior Citizens' Affairs and the Senior Citizens' Advisor since we have already taken part in activities organised by the district on several occasions. A meeting with both of them took place on September 27th to present the LLE Program. Further steps will be taken to concretise a collaboration for LLE. Since Sant'Egidio was not active in Wilrijk until now and the decision to start the programme there is recent, the work to find partners in this area is in a start-up phase. The agreement with the city and the forthcoming meeting with the Primary Care Zone will certainly open doors here as well.

Role(s) each partner will play

Prague: Prague 7 shall provide a guarantee of close collaboration of its social assistants with the project. It shall also take the responsibility of awareness raising within its territory.

S. Egidio will run the project in close collaboration with Prague 7, as well as with other NGOs and civil society gatherings active on territory of Prague 7 in order to help frail elderly people.

Antwerp: City of Antwerp

Financial support of the program

- Concludes with LLE (Vereniging voor Solidariteit vzw - (VVS) a processor's agreement giving LLE access to the civil register data.
- Facilitates contacts and agreements with potential partners in the area.
- Follow-up of the program with a focus on accounting for the use of funds and on adjusting the program and the co-operation agreement on the basis of the results achieved.

The District of Merksem is willing to give us access to information and to support and facilitate the communication campaign, and to cooperate occasionally for events.

The District of Hoboken is willing to cooperate on terms that still have to be defined.

With the District of Wilrijk a first contact still has to be established.

The "Primary Care Zone North" (Eerstelijnszone - ELZ), a crucial partner as they were installed by the Flemish Government to execute the primary care reform, let us know that as a network organisation, they are prepared to jump on the bandwagon of this project, as neighbourhood-oriented care fits completely within the mission and vision of the ELZ. They do have a concern about available manpower. At the moment, most of the team is burdened with Covid-19 and the vaccination campaign and they don't know yet what 2022 will bring (in the context of vaccination/Covid 19) and how many FTEs they will have available that period for regular projects. The concrete description of our co-operation will therefore be determined at a later date.

The role of other partners in the three districts is still to be determined in detail, but LLE is interested in co-operating with regard to the situation of individual elderly people (referral, consultation between care providers involved). In addition, LLE wants to take the initiative to bring together the various partners in care and welfare to exchange information and experiences about supporting community dwelling elderly.

Who will scale the innovation?

The program shall be run well, by well-educated and motivated people, in order to bring best possible results. To guarantee and maintain the basic idea of the program, engaging volunteers seems to be crucial.

The programme will need to have three main categories of staff - coordinators and operators.

Coordinators should have at least a secondary education, preferably in social work or health care. A selection procedure will be launched for the position of coordinator, in which candidates will submit their CV and proof of education. The most suitable candidates will be selected on the basis of a personal interview with the person responsible for the project - the project director, in cooperation with representatives of the city or district where the project will be implemented. An employment relationship will then be established with the selected candidate in accordance with national legislation.

Operators should have at least a secondary education, preferably in social work or health care. Some of the operators will be hired on a part-time basis, following a selection procedure, as in the case of coordinators.

ICT experts are crucial to adapt the program to the exigencies of workers as well as to the desires of clients. ICT support also helps to manage the day-by day of the program.

Other operators will work for the project on a voluntary basis. Their activities will be governed by GDPR rules for the protection of privacy and sensitive data of seniors.

All staff members must undergo a special training course and their activities should be regularly monitored.

Involving end beneficiaries/service users

Service users and/or end beneficiaries are requested to participate in the program also as supporters. Each of them can develop a specific part of the program involving themselves into a relationship with the program and other end beneficiaries. Those who want to participate will be involved in a week long training course dedicated to knowing the program deeply and to become volunteers helping the other peers. In this case they are in contact with a responsible for the volunteers who can lead them for a while, and then they become the ones who can receive information and transmit to the programme operators. The volunteers can decide how to bring ahead the relation with a client, keeping informed the program operator on the developments.

Funding and Financing arrangements

Costs of scaling the innovation envisaged

The cost of rolling out the programme is estimated on the basis of the program's budgets in Rome, taking into account the fact that expenditure in Belgium will be slightly higher than in Italy. In addition, the number of elderly people to be included in the program is also a determining factor. We estimate that the program for 1,000 elderly people will cost around €100,000 per year, which is less than €0.28 per elderly person per day.

Funders

For Prague, the main funder will be Prague 7, money put in it will be conditioned by support of European funding. Some philanthropic activities will be enacted as well.

For Merksem, Hoboken and Wilrijk, the main funder will be the City of Antwerp.

VVS is also preparing to submit the LLE Program in response to a call of the Minister of Welfare, Public Health, the Family and Poverty Reduction who wants to support Community Care Projects, and for which the submission date is 8 November 2021.

Financial arrangements and instruments planned to scale the innovation

Prague 7 is still considering the possibility to introduce LLE on its territory. Main concerns are financial sustainability and long-term perspective. Unfortunately, at the moment of the deadline of this report, no concrete data on future financial arrangements and instruments can be provided. However, several initiatives have been started and a generic availability to support the program has been expressed by public and private bodies.

In Antwerp, the programme will start with a grant of 150,000 euros from the city, in an agreement that runs from 1 October 2021 to 31 December 2022. In the course of the negotiations, it seemed that the city would be prepared to consider the possibility of a subsidy for a second year. We are currently working on the application for a 'Caring Neighbourhoods' project subsidy to the Flemish Ministry of Welfare, for which the deadline for submission is 8 November 2021. The ministry wants to grant at least 95 projects in Flanders a subsidy of €50,000 in two consecutive years. Meanwhile, we continue to look for funds from private investors and social funding organisations.

Cost implications of the model compared to alternative approaches to the social challenge(s)

The model implemented in the Long Live the Elderly program follows a preventive approach. Like all prevention programs, the program generates meagre but regular costs per beneficiary, depending on the number of beneficiaries reached. These programs are cost-effective only if they significantly reduce the likelihood of diseases that are very expensive to treat in the future. In the case of the older population, it is known that the probability of chronic diseases that are very expensive to treat is very high. Therefore, even if the program minimally reduces adverse health events, a cost-effectiveness threshold is quickly exceeded, generating net savings for the health sector.

As regards the LLE program, the most critical expected effect from an economic point of view is the reduction of access to the emergency room and hospital admissions, the cost of which is very high. A 2015 analysis carried out in the context of Rome, Italy, shows that net savings have been generated on a sample of approximately 1,400 seniors, in the range of 5-13% of the annual cost for acute and long-term care.

The current project did not foresee a cost analysis of this type. Therefore, it is impossible to estimate the expected savings in Belgium or the Czech Republic. However, it is reasonable to think that if the costs of social and health care in these two contexts were higher, it would generate an increase in both the costs of the program and the savings generated and therefore, the net savings can be of different magnitude but always positive.

Suppose it is possible to implement the program in these contexts. In that case, an economic analysis is recommended both in the preliminary and monitoring phases of the activities. In fact, one of the benefits of the program is precisely to develop solutions that in the event of scalability can reduce the cost of care for the elderly, which is becoming unsustainable in all Western societies characterized by very high average age and therefore by the strong presence of costly chronic diseases.

Sustaining and further scaling of the innovation

The care for older adults is an increasing problem at EU level especially because of the cost of doing nothing. To find a different model of care is a well-known issue. At Italian level the program is sharply increasing sites and beneficiaries (two more cities have been added in the last six months). The unexpected positive quick answer of the Antwerp municipality is a sign of the urgency of finding a new way for providing care to older adults. The COVID-19 pandemic further increased this urgency showing the devastating impact of poor community care, when you need people to stay at home. Similar consideration can be done for the increase in the frequency of heat waves in southern Europe or floods in Central Northern Europe. To have a map of frailty in this case means to increase the effectiveness of prevention interventions as well as of negative outcomes mitigation strategies. In Eastern Europe the low diffusion of community care services for older adults could turn in the opportunity of building up a person-centered model based on community care more than on residential care

Measuring the Impact of Scaling

The intervention aims at reducing social isolation in the sub-population of over 80. Therefore, the primary outcome would be measured with validated tools to measure variations in social isolation. The most indicated are the tools based on the UCLA loneliness scale[23] that could be administered to a sample of beneficiaries of the program. Overall, the general aim of the program is to prevent/lower functional decline by reducing frailty. To measure frailty is one of the main specific objectives of the intervention based on the hypothesis that frailty is the risk factor for negative events. Frailty will be measured by administering the Short Functional Geriatric Questionnaire[24] already tested in Italy and translated.

The secondary outcomes are related to:

1. Quality of life of the beneficiaries
2. Increase of efficiency (cost-effectiveness) of delivery of socio-health services to older population

The first one could be measured with EuroQoL-5D survey[25] administered to a sample of beneficiaries (baseline and every year)

The second one it is a complex indicator, but the main components are:

- Rate of hospitalisation (number of hospital admission divided by population for over 75) for the population living in the catchment area of the program.
- Average length of hospitalisation.
- Access to emergency unit (number of accesses divided by population) for the population living in the catchment area of the program.

As a final health outcome, the average mortality rate in the older population can also be measured, even if the intervention's main objectives are an increase in quality of life and reduction of costs for health services. Reduction of mortality is hard to be achieved in a population aged >80, so it is the aim only in case of environmental crisis like heat wave, cold wave, flood or others when the sharp increase of mortality could be mitigated by timely interventions targeting the frailest individuals.

Challenges and Risks

The main challenge is about medium-long term funds that can be overcome only by investing in a strong fund research from different sources. The second one is how to replicate the program on a large scale, which needs to involve other associations to make them available and able to replicate the programme. We developed a series of materials for training in order to be able to communicate the practical as well as the theoretical approach of the LLE program, and we are available to train people in implementing this approach. Further challenges that shall be faced are:

[23] Russell D, Peplau LA, Cutrona CE. The revised UCLA Loneliness Scale: concurrent and discriminant validity evidence. J Pers Soc Psychol. 1980 Sep;39(3):472-80. doi: 10.1037//0022-3514.39.3.472. PMID: 7431205.
[24] A Capanna et al, Advances in Aging Research, Vol.7 No.3, 2018
[25] https://euroqol.org/eq-5d-instruments/

- How to get data/data on people over 80 in Prague 7 and especially contacts to them - crucial will be the awareness raising campaign and a door-to-door work in a concrete district.
- How to communicate and explain to people how the GDPR issue is dealt with.
- Develop a concept for integrating this program into the existing network of services and activities/initiatives, this involves introducing the service to providers of social and health services in the area.
- How to create a plan for staffing the service, reaching out to volunteers.
- How to prepare an overview of selected co-operating services/institutions etc.
- How to involve carers in this program.
- How to overcome the difficulties in getting personal contacts with any kind of organisations that have become extremely reduced due to digitalisation and Covid-19: what should be a simple intervention turns into a time-consuming operation.
- How to reach a paradigm shift in elderly care, away from the nursing home as first and best solution.
- How to create strong ties with the elderly in fragile situations, to form collaborators and volunteers to develop the skills to do so.
- How to involve large and powerful organisations who have a financial interest in keeping the big institutions in place and are not waiting for such a paradigm shift. Hence the need to find like-minded people who can make their voices heard in this debate

Most of these challenges need a strong communication campaign to overcome and be implemented at different levels: with the health and social professionals as well as with the citizens. This campaign should find the way to reach most of the potential beneficiaries/actors of the program in order to involve them. Use of leaflets, involving GPs, being on the road with a recognizable logo of the program, explaining the program in public gatherings that are held in the urban zone of interest, involving the local media are all activities that should be part of the campaign.

Mitigation

The main risk is the shortage of funds. To mitigate this risk in either Antwerp and in Prague, fundraising campaigns have been started, targeting public and private bodies. A second risk is the lack of adhesion of older adults to the program. In this case we planned a big and capillary awareness campaign to involve the older adults and some key representatives of the society in strong contact with them (the General Practitioners for example or the pharmacists) in order to increase the people's trust in the program. The third risk is connected with the GDPR regulation which can prevent people from fully adhering to the program. Again, the awareness campaign should reach most of the potential beneficiaries in order to make them more confident in the program.

In Prague 7 as well as in Merksem at a certain point, a concern has been raised, how the LLE Program will be implemented together with all other activities already enacted in the district. This concern has been turned into an opportunity and several ways of close collaboration and mutual coordination were found especially with the public bodies, but also with the private ones.