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[1] **For deliverables: R** = Report; **P** = Prototype; **D** = Demonstrator; **S** = Software/Simulator; **O** = Other
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Dissemination level		
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TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

Before developing a model of care for the detection, management and treatment of frailty and multimorbidity to be applied across Europe, it is important to verify which are the resources and organizations currently in place. For this reason, the SUNFRAIL project has conducted a preliminary description of the current situation across the participating reference sites located across Europe.
The present report, responsive to deliverables of Workpackage 5 and directly feeding deliverables of Workpackages 4 and 6, describes the results of the surveys conducted by the SUNFRAIL consortium across the involved reference sites. Results of this task demonstrate a major heterogeneity across Europe for the resources and models devoted at detecting and managing frail older persons. The report identifies the few commonalities present across the reference sites and then proposes a possible model of care taking advantage of these shared points.

2. INTRODUCTION

2.1. Objective

To describe the patterns and resources of clinical care offered to frail and multimorbid older persons across the reference sites of the SUNFRAIL project.

2.2. Nature of the questionnaires

For understanding current models of care and describe the clinical care offered to frail and multimorbid older persons across the reference sites, the SUNFRAIL consortium developed two questionnaires for internal use.

The first questionnaire (Annex I) was specifically focused at exploring the coverage, basic entitlements and accessibility of older persons with frailty and multimorbidity to local care services. This questionnaire was asked to be completed by local public health authorities, decision makers and/or representatives at the reference sites.

The second questionnaire (Annex II) was instead devoted at understanding the community outreach, diagnosis and management approaches towards frailty and multimorbidity at the reference sites. This second questionnaire has been completed by health and/or social professionals with direct, first-hand knowledge of the services provided to frail and multimorbid older persons.

2.3. Reference sites

The following SUNFRAIL partners where directly involved in the accomplishment of the present task: Regione Emilia Romagna and Università di Parma (Italy), Regione Campania (Italy), Regione Liguria (Italy), Regione Piemonte – Assessorato Sanità (Italy), Region Languedoc-Roussillon-Midi-Pyrenees and Centre Hospitalier Universitaire de Toulouse (France), Department of Health, Health and Social Care (Northern Ireland), Medical University of Lodz (Poland), Universidad de Deusto (Spain).
Each partner served for contacting the local stakeholders and public health authorities in order to retrieve the key data of interest and provide the description of the local reference sites.

3. RESULTS

The questionnaires were drafted by the coordinator and Workpackage 5 partners. The first draft of the questionnaires was distributed via email to the SUNFRAIL partners for obtaining suggestions and comments. The questionnaires have also been discussed in a formal meeting held in Bologna (Italy) during the SUNFRAIL Translational Workshop ("Understanding and caring for frailty and multimorbidity") on March 21-22, 2016.

Taking into account all the comments and feedbacks received, the questionnaires have been finalized by the specific WorkPackage partners. Subsequently, the two questionnaires were sent by email to the local coordinators of the reference sites. Each reference site then handled the questionnaires providing the requested answers according to available data and experience.

The questionnaires have been completed by the reference sites according to locally available data and information.

The details of the answers provided to the Questionnaires are presented below. Please note that, although all the reference sites actively collaborated in the completion of the surveys, some data might not have been available/applicable to certain partner, resulting in missing information.

QUESTIONNAIRE 1. REPORT ON SERVICE COVERAGE, BASIC ENTITLEMENTS AND ACCESSIBILITY

The description about the service coverage, basic entitlements and accessibility to care across the SUNFRAIL Reference Sites are summarized in the following tables.

For each of the basic primary care coverage option below, please indicate where applicable, the proportion of access by the population aged 65 and over	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Automatic coverage, universal entitlement	100%	90%	100%	100%	1-5.4%	100%	Almost 100%	
Mandatory health and social insurance	-	-	-	NA	96.2%	-	Almost 100%	
Voluntary health and social coverage	NA	-	About 7%	Minority	80%	Unknown	NA	

In **Italy** and **Northern Ireland**, the affiliation with a particular insurance/fund is a matter of choice, and people can choose among different options. In Italy (in 2010), around 5.5% of the Italian population had voluntary health insurance coverage (1,33 million families), a 0.5% increase compared to 2008. Insurance take-up is concentrated in higher socio-economic groups (16.3% of the families in the highest quintile vs. 1.4% in the lowest quintiles) and among middle-aged groups compared to younger and older age groups (Bank of Italy, 2012).
In **France**, the automatic coverage is estimated 1% by the CMUC (2013) and 5.4% by the Min Viellesse (2013). The mandatory health and social insurance is estimated using data from the Régime général (2013). The complementary social coverage is mandatory in France.
In **Poland**, the affiliation to a specific insurance/fund is not a matter of choice, but linked to professional status, geographic situation, or employer.

Range of social and health services provided to population aged 65 and over and direct cost-participation (main provider)	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Cancer screening	FC	FC	FC	CS	FC	FC	FC	
Seasonal flu vaccinations	FC	CS	FC	FC	FC	FC	P	
Nutritional advice	FC, P	CS	FC	FC, P	CI, P, VO	FC	FC	
Nutritional supplements	FC	CS		FC, P	CS	FC	P	
Outpatient primary health care (general practitioners and family nurses)	FC	FC	FC	FC	FC	FC	FC	
Outpatient specialist geriatric care	CS	FC	CS	FC, P	FC	FC	FC, CI	
Acute inpatient care	FC	FC	FC	FC	FC	FC	FC	
Long term care: residential (institutional) care	CS	CI	CS	CS	CS	FC	CS	
Domiciliary care	FC	FC	FC	FC	CS	FC	FC, P	
Pharmaceuticals	CS	CS	FC	CS, P	FC	FC	CS	
Clinical laboratory tests and diagnostic imaging	CS	CS	CS	FC, CS	FC	FC	FC, P	
Palliative care	FC	FC	FC	FC, VO	FC	FC	CS	
Eye glasses and/or contact lenses	P	CS	P	P	CI	FC, CS, P	CS, P	
Dental care	FC, P	FC	P	P	CS	FC, CS, P	CS, P	
Dental prostheses	FC, P	CS	P	P	CS	FC, P	CS, P	
Transportation for health related issues	FC, P, VO	FC	FC, P, VO	FC, P, VO	FC	FC, P, VO	FC, P	
Psychological support	FC, P		P		P	FC	FC	
Cognitive stimulation	FC		FC	FC, P	VO	FC	FC, CS	
Leisure/ social activation	P, VO		P, VO	CI, P	VO		P, VO	

Physical activity	FC, P, VO	P	P, VO	CI, P	P	FC, P, VO	P, VO	
Domestic work*	P		P	CS, CI, P	VO	FC, P, VO	P	
Informal care for dependent people	P		P	CS, P	VO	FC	P, VO	
Day time wardship	FC, P		FC, P	CS, P	VO		CS, P	
Transportation for social activities or social issues	P, VO	CI	P, VO	CS, P	VO	FC, P, VO	P	
Income support (living and housing)	FC, VO		VO	CS, P	VO	FC	P, VO	
Feeding (meals)**	P	FC	VO	CS, P, VO	VO	FC, P, VO	P, VO	

* These services refer to home based support to elders living alone (housekeeping, cooking, shopping) (not for dependent or disabled people).
** Community support to elders living alone (community canteens, soup kitchen) (not for dependent or disabled people).
FC: Fully covered by NHS or main insurer; CS: NHS or main insurer with cost-sharing; CI: Voluntary, complementary insurance; P: Private, out-of-pocket; VO: 3rd sector, voluntary organizations, NA: Not applicable

In the **Emilia Romagna** region, transportation for health-related issues and income support (living and housing) are specifically covered by municipalities.
In **Northern Ireland**, the approach for provision of eye glasses/contact lenses, dental protheses, transportation, physical activity, domestic work may vary according to needs or services. The income support is mostly relying on the Welfare System rather than the Health and Social Care one.
In **Poland**, all patients covered by the public health insurance system in Poland are entitled to free specialist geriatric care. Domiciliary care may be financed by the NHS but in specified conditions. Most of the clinical laboratory tests and diagnostic imaging may be financed from the NHS. However, the waiting time is sometimes very long and then the tests are carried out privately. Patients in Poland can choose between public and private dental care. Public dentists in Poland provide the necessary treatments to ensure patient's oral health. However, there are some limitations. For example, the materials used in public dental care are limited. Therefore, patients can co-pay for other materials or use fully private sector. Because of financial constraints, the most advanced dental procedures and materials (such as titanium implants or porcelain crowns) are only available in the private sector. Therefore, patients can co-pay for other materials/procedures or use fully private sector. If reduced mobility prevents the patient from the use of public transport, medical transport in such cases is free of charge. Depending on the need and condition of the patient, mental care may be provided in outpatient mental health clinics, in day-care psychiatric wards or in inpatient settings (psychiatric hospitals, psychiatric care wards in general hospitals, psychiatric ZOLs and ZPOs). The cognitive stimulation applies also to nursing homes residents, who co-pay for their staying. Informal care for dependent people, Income support (living and housing), Feeding (meals) may be organized by the 3rd sector organizations or must be paid privately.

Description of service coverage and infrastructures in the different Regions. Sources for the present data are available upon demand.

Referring to the services provided in your Region: how many practices, centres, hospitals (public and/or private) exist, and how many persons aged 65 and over have attended them in the last year?	**Italy**				**France**	**Northern Ireland**	**Poland**	**Spain**
	Emilia Romagna	**Campania**	**Liguria**	**Piemonte**				
Primary care contacts (GP or equivalent)								
Average number of primary care consultations per capita in the last year (general population):	NA	NA	NA		5.2	6.60	4.67	
Average number of primary care consultations for people aged 65 and over in the last year:	NA	NA	NA		212,594		3,576,800	
Domiciliary care								
Percentage of people receiving domiciliary care (% of people aged 65 and over)	9.4	3.0	4	7.5	1.03-2.97	6.8	3	
Out-patient contacts with a geriatric specialist								
Number of out-patient units for geriatric specialty care:	194	1	19	60	20	20	3	
Number of out-patient visits with a geriatric specialist:	66,891	300	NA	40,186	120,000	22,577	2,000	
Psychological support								
Number of mental health centres:	49	13	45	53	52	NA	5	
Total number of mental health visits for persons (65 and over):	115,835		NA	45,500	150,000	NA	90,000	
Long term care: residential and/or institutional care								

Number of residential or nursing home facilities:	329		320	600	1,015	463	59	
Number of admissions per thousand inhabitants (65 and over):	20.2		NA			35	2.32	
Inpatient care								
Number of hospitals:	116	1	18	37	443	41	71	
Number of admissions per thousand inhabitants (65 and over) for any condition:	345.4	14	NA			853	452.5	
Total number of beds in inpatient geriatric units (if applicable):	552		90	213	600	714.5	21	
Median Length of stay (LOS) for patients aged 65 and over	7		12	12.95		4	6.6	
Emergency care								
Number of admissions to emergency units of persons aged 65 and over:	533,939		NA	516,654	209,075	134,833	970,803	
Palliative care								
Number of hospices or end-of-life centres:	22	581	6	13	875	NK	7	
Number of admissions per thousand inhabitants (65 and over) to palliative end-of-life care:	3.8	2,524	NA			NK	3.4	
Direct monetary support for living and housing								
Percentage of persons aged 65 and over who received cash income support / care check:	0.98	75.1	5	0.72	0.98-12.42	NK		
Average amount of money transferred to a person aged 65 and over receiving monetary support:	2,635	974,55	350/month			NK		

NK: Not known

In **Piemonte**, there are 51 units for geriatric evaluation and 9 outpatient hospitals. Moreover, there are 13 main primary psychiatric services and 27 hospital services for mental health; 13 territorial outpatient services for psychological support are also available.
In **France**, the percentage of persons aged 65 years and older receiving home care is variable according to the different service and insurance fund. About 1.0% of older persons receive home visits by nurses for care and help in the activities of daily living. About 3.0% of the older population receives home support by their insurance in the housekeeping (no nursing service). The number of hospitals (n=443) and hospital beds (n=17,990) are inclusive of public and private facilities. The number of end-of-life facilities (n=875) and beds (n=63,016) are inclusive of palliative care units and nursing homes. The percentage of older persons receiving income support varies according to the service (2.22% for ASPA, 0.98% for ASH, 12.42% for APA). The amount of money is also variable according to the revenue, setting, and functional status (measured with the Group Iso Ressource (GIR) scale. ASPA may provide a maximum of 801 euros/month; ASH supports some or all the accommodation costs of the resident; APA ranges from 662.95 euros/month (GIR4) to 1,713.09 euros/month (GIR1).
In **Northern Ireland**, the consultation rate per person for surgery consultations with general practitioners was 4.88 for 2013/14. Data are crude rates based on survey returns from General Practices. Rates are not available for separate age bands and this is the most recent data available.

Are primary care services provided predominantly in...	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Public primary care clinics staffed by physicians only								
Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)	X (4.4)		X (NA)				X	
Outpatient departments of public hospital		X (4)						
Private solo practices								
Private group practices staffed by physicians only					X			
Private group practices staffed by physicians and other health professionals (e.g., nurses)						X (3.7)		
Outpatient departments of private hospital								
Other				X				

In parentheses, it is indicated the average number of physicians in the practice/clinic when the predominant mode of primary care provision is "Group practice" or "Primary Care Centres".

Please indicate the number of health and social professionals working in the Region (last available year) working exclusively or predominantly with persons aged 65 and over. Whenever this proportion is difficult to assess, please provide the total number of professionals for each category active in your Region.	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Primary care physicians	2,930	4	1,367	3,120		1,274	486	
Nurses	26,309	12	About 2,000	19,547		17,119	17,453	
Geriatricians	159+35	4	120	73		NA	9	
Social workers	369		455	2,411		3,831		
Other				5,909				

In **France**, it is not possible to provide the number of geriatricians because it is included in that of other medical specialists.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
What is the minimum State pension a person aged 65 and over can expect (in euro)?	6,500/year	700/month	6,500/year	448/month	800		190	

In **Emilia Romagna** and **Liguria**, total exemptions from cost-sharing are applied to people aged 65 and over who live in households with a gross income below a certain threshold (approximately €8263 for single and €11 362 for larger households). People with chronic or rare diseases, people who are HIV-positive, and pregnant women are exempt from cost-sharing for treatments related to their condition. Most screening services are provided free of charge.

In **France**, the following exemption schemes may also apply according to the clinical and sociodemographic profile:

- CMUC (Couverture Maladie Universelle Complémentaire, Complementary Universal Health Coverage): max 721€/month;
- ACS (Aide Complémentaire Santé, Complementary Health Assistance): max 973€/month;
- AME (Aide Médicale de l'Etat, State Medical Help): 721€/month.

In **Poland**, exemptions are available for the following services/devices: medications, orthopaedic equipment, diapers, catheters, institutional care, and domiciliary care.

Can a person aged 65 and over choose among the following providers? If so, how freely?	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Primary care physicians	Always	Always	Always	Always	Always	Always	Always	
Specialists out-patient setting	Limited	Always	Limited	Always	Limited	Limited	Always	
Case manager	No		No		No	No	No	
Hospital	Always	Always	Always	Limited	Limited	Limited	Always	

No: No choice, the person is assigned by NHS or insurer; Limited: Person's choice is limited; Always: Person can always choose

In **France**, the access to specialists and hospital may be limited by geographical and economic barriers.
In **Northern Ireland**, the patient's choice could be very limited, and he/she may only be able to exercise when individual expresses strong views about the provided.
In **Poland**, the patients can change the public primary care physician twice a year with no extra charge. The choice of the specialist may be suggested by the primary care physician, but the decision on the choice belongs to the patients. The choice of the hospital may be suggested by the primary care physician, but the decision on the choice is made by the patients.

QUESTIONNAIRE 2. REPORT ON COMMUNITY OUTREACH, DIAGNOSIS AND MANAGEMENT OF FRAILTY

Frailty identification, prevention and management require a multiple steps approach and multidisciplinary pathways. The description about the methods and strategies adopted across the SUNFRAIL Reference Sites for the early identification and primary prevention of frailty are summarized in the following tables.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	**Campania**	**Liguria**	**Piemonte**				
Are there regional targets set to improve health outcomes in elderly population? (Periodic biochemical blood checks, blood pressure, vaccination coverage, domiciliary care, etc.)	Yes	Yes	No	Yes	Yes	No	No	Yes

For **Emilia Romagna, Campania** and **Piemonte**, the regional targets are set by local and national public health authorities (Regione Emilia Romagna, Regione Piemonte, Regione Campania, National Ministry of Health). Examples of targets are: flu vaccination coverage, information for heat waves, use of special pathways for specific diseases (e.g., COPD, diabetes), cancer screening.

In **France**, targets are set by multiple institutions: Regional Health Agency, National Health Insurance Fund, and the Personne âgée à Risque de Perte d'Autonomie (PAERPA) program. The PAERPA program is specifically aimed at detecting older adults at risk of dependency (e.g., recent admission to emergency room, multimorbidity, polypharmacy, fall history, mobility impairment, social or economic difficulties…) in order to implement personalized preventive plans against disability. Moreover, in France, the Regional Team on Aging and Prevention of Disability is a special unit supporting the development of frailty clinics and the community-based projects on disability prevention in all the departments of the region.

For **Spain**, the regional targets are set by local public health (the Basque Health Service, respectively). In Spain, examples of regional targets are blood pressure assessment, vaccination coverage, home care.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Are there population surveys addressing health, social and economic conditions of elders?	Yes	Yes	Yes	Yes	No	No	Yes	No

For **Emilia Romagna**, such surveys exist both at regional (Regional Action Plan for the elderly population, PAR) and national (Silver Steps) level.
For **Liguria**, such surveys exist at national (Silver Steps) level.
For **Piemonte**, such surveys exist both at regional (RUPAR PIEMONTE) and national (PASSI D'ARGENTO, ISTAT) level. PASSI D'ARGENTO (Progressi delle Aziende Sanitarie per la Salute in Italia) is a population-based surveillance system developed more than 64 years ago. ISTAT is the national demographic institute coordinating a regular survey of the population. RUPAR PIEMONTE is Regional Information Flow, that is the collection of business and financial data from public health agencies and private partner entities involved in different areas of provision of health services for residents and non-resident citizens.
For **Campania**, surveys exist at national level (ISTAT).
In **Poland**, the national surveys are available (POLSENIOR [http://polsenior.iimcb.gov.pl], NATPOL [http://www.ptkt.pl]).

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Are there participatory processes involving citizens aged 65 and over regarding their expectations, satisfaction and barriers to access to services provided? (Community labs, questionnaires, focus groups, Delphi)	Yes	No		Yes	Yes	Yes	No	Yes

For **Emilia Romagna**, community labs, qualitative questionnaires, and focus groups are available for involving older persons in the development of services.
For **Piemonte**, this process is conducted at local level with councils or voluntary association initiative (e.g., Cittadinanzaattiva, Federanziani).
In **France**, all the main stakeholders of the health system (including patients) are involved in the processes for development and implementation of policies for dialogue and consultation. It is coordinated by the Regional Health Agency. Some local associations also organize ad hoc focus groups.
For what concerns **Northern Ireland**: within the Health & Social Care Trusts, there are various Older People's Service Users Forum or other forms of Personal/Public Involvement (PPI) groups. In Northern Ireland PPI is now a legislative requirement for Health and Social Care organisations as laid down in the Health and Social Services (Reform) Northern Ireland Act 2009. The Public Health Agency (PHA) has responsibility for leading implementation of policy on PPI across Health and Social Care as a result of the Act. The PHA has a wide range of additional Leadership responsibilities in PPI, which were confirmed with the issuing of a further Departmental Circular on PPI in September 2012. Many of these functions are delivered through the Regional HSC PPI Forum, which is chaired, serviced and managed by the PHA. The Forum, led by the PHA, has been established on a collaborative basis with other HSC organisations. Working with and through the Forum, the PHA is responsible for establishing and leading the Regional HSC PPI Forum, encouraging collaboration, consistency and coordination in approach to PPI across HSC and raising awareness about PPI and communication. For more information about PPI please see: http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/allied-health-professions-and-personal-and-publi-5
In **Spain**, a satisfaction survey is yearly conducted.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Do general practitioners in primary care practices (or centres) perform early identification of frailty?	Yes	Yes	No	Yes	Yes	Yes	No	Yes

In **Emilia Romagna**, the so-called Case della Salute (Patient-centred Medical Homes) conduct such systematic screening through general practitioners.
In **Piemonte** and **Campania**, this is not systematically conducted, and largely based upon the general practitioner's activity.
In **France**, the general practitioners are regularly informed and updated about the frailty concept. They are not required do to systematically detect frailty systematically, but encouraged to do it. Specific training material and instruments are also diffused with this aim. Some general practitioners work in the so-called Maisons de Santé Pluridisciplinaires (Multidisciplinary clinics) where other healthcare professionals and specialists may provide support to primary care. Within these infrastructures, one of the healthcare objectives is the detection and prevention of frailty as specified by the Haute Autorité de Santé (High Authority for Health) and based on the notion of continuity of care.
In **Northern Ireland**, there is frail elderly assessment in General Practice where patients are risk stratified by co-morbidity and annual face-to-face assessment is performed in the patient's home to examine both clinical and social areas of need. This is performed for a limited number of patients annually. Specific templates for review are completed.
In **Spain**, frailty is not specifically or systematically targeted. However, all the population is stratified via a multi-pathological approach in order to identify individuals exposed at increased risk of negative outcomes. All the Basque citizens have their own risk score in their clinical records.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Are there other health / social professionals than general practitioners performing early identification of frailty in the community setting?	Yes	no	Yes	No	Yes	No	No	Yes

In **Emilia Romagna**, specialists, nurses, social workers, and voluntary associations are also involved in the screening of frailty in the community.
In **Liguria**, family and community nurses (CONSENSO project – pilot) are also involved in the screening of frailty in the community.
In **Piemonte**, district nurses, social workers, healthcare professionals may informally report the general practitioner. They tend to do this reactively after a problem is already arisen, and not as an early identification.
In **France**, All the health professionals in the region are informed about frailty concepts and some perform early identification of frailty in the community setting, especially pharmacists and nurses. Some projects are conducted to screen frail subjects using self-administered questionnaires sent by municipalities or health assurances. However, these actions are not systematically conducted.
In **Spain**, nurses collaborate with general practitioners in the risk assessment of the individual.

Are the following risk factors for frailty systematically monitored in Primary Care? Please specify also the professional/s involved (GP, nurse, social worker, pharmacist, psychologist, others)?	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Nutritional status	S	NR	NR	S	NR	NR	NR	NR
Physical activity	S	S	NR	NR	NR	NR	NR	S
Smoking habit	S	S	NR	S	S	S	NR	S
Alcohol consumption	S	S	NR	NR	NR	S	NR	S
Oral health	S	S	NR	NR	NR	NR	NR	NR
Mood	S	S	NR	NR	S	S	NR	NR
Life events*	S	S	NR	NR	NR	NR	NR	NR
History of falls	S	S	NR	S	S	S	NR	NR
Concurrence of 3 or more chronic conditions	S	S	NR	S	S	S	NR	S
Social status (e.g., isolation)	S	S	NR	NR	S	S	NR	NR
Polypharmacy: 5 or more drugs taken on a regular basis	S	S	NR	S	NR	S	NR	S
Economic status (e.g., constraints)	S	S	NR	S	NR	NR	NR	NR
Educational level	S	S	NR	NR	NR		NR	NR

*incl.: death or serious illness of a loved one, divorce or end of an important relationship, traffic accident, crime (Gobbens R et al. 2010)
S: systematically, NR: never or rarely

In **Emilia Romagna**, **Campania**, **Piemonte** as well as in **Spain**, these risk factors are all measured by the general practitioner and nurses. In Emilia Romagna and Piemonte, social workers may intervene for some of them (social status, economic status, education). Specialist may also be

involved for specific risk factors (nutritional status, behaviours, oral health, mood, life events, multimorbidity, polypharmacy). In Piemonte, access to emergency rooms and hospitalizations are also regularly monitored by general practitioner, nurses, and social workers.
In **Liguria**, the detection of the risk factors is in charge of the general practitioner or nurses.
In **France**, the detection of the risk factors is in charge of the general practitioner.
In **Northern Ireland**, general practitioners and nurses are leading the identifications of the risk factors, sometimes in the context of disease-specific assessment protocols (e.g., for diabetes, COPD, asthma, depression, dementia). Some risk factors are not systematically evaluated, but only among individuals with an increased risk profile. Thus, it may happen that some individuals aged 75 years and older may not be screened for important risk factors (e.g., depressed mood, history of falls; multimorbidity, social isolation, polypharmacy).

	Italy				**France**	**Northern Ireland**	**Poland**	**Spain**
	Emilia Romagna	**Campania**	**Liguria**	**Piemonte**				
Is there a validated questionnaire or instrument used to assess frailty in primary care?	TFI, P7, E, GS	Other	FPh, FRAIL, GS	No	GFST	No	No	No

TFI: Tilburg Frailty Indicator; P7: PRISMA-7; E: Edmonton Frailty Scale; GS: Gait speed; FPh: Frailty phenotype by Fried and colleagues; FRAIL: FRAIL tool by Morley and colleagues; GFST: Gèrontopôle Frailty Screening Tool

In **Piemonte**, the use of multiple instruments for the comprehensive geriatric assessment of the older person is quite common though heterogeneous.
In **Campania**, the Local Health Agency Frailty Sheet is adopted for the assessment of frailty.

What types of preventive activities to safeguard against risk factors of frailty are available at community level?	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Transportation for health related issues	IS, CI	IS, CI		IS, CI	IS	IS, CI	IS	IS
Psychological support	IS	IS, CI		IS, CI	IS, CI	IS, CI	IS	
Cognitive stimulation (ICT training, memory stimulation)	IS	CI	IS	IS	IS, CI		IS	
Leisure / social activation (voluntary work, playgrounds, cinema, day trip, vacations, folk dance)	IS, CI	IS, CI	CI	CI	IS, CI	IS, CI	CI	CI
Adapted physical activity (including yoga, Thai-chi, postural training)	IS, CI	CI	IS, CI	IS, CI	CI	IS, CI	CI	
Day time wardship	IS, CI			IS, CI			IS	
Transportation for social activities and social services	IS, CI		IS, CI	CI	CI	IS, CI		
Income support (living and housing)	IS			IS	IS	IS, CI	CI	IS
Feeding (Community canteens, soup kitchen)	IS, CI	CI		IS, CI	CI		CI	CI
Meals at home *	IS, CI			IS	CI	IS, CI		
Monitoring at distance *	IS, CI			IS	IS	IS, CI		IS
Domestic work**	IS, CI	IS		CI	IS	CI	CI	IS

* Considered as home based support to elders living alone (not for dependent or disabled people).
** Considered as home based support to elders living alone (housekeeping, cooking, shopping) (not for dependent or disabled people).
IS: Institutional health or social sector; CI: Community initiative

In **Italy** (Emilia Romagna region), day time wardship and transportation for social activities and social services are only provided for individuals with very low incomes. In **Liguria**, it is also active the MAC project, addressed to older persons with weak or no family support network at home for guaranteeing safe hospital discharges.
In **France**, preventive activities can be non-systematically provided by some municipalities or private insurances.
In **Northern Ireland**, ambulance transport to outpatients is available, door-to-door service and community rural networks transport. Others include Red Cross Transport. Contact NI provides support to all ages from children to elderly. Psychiatry of Old Age team will provide Community Psychiatric Nurse (CPN) support in patient's home. Private nursing homes provide a variety of social activities (including day trips/tea dances/music/painting, etc.). Local churches and voluntary associations (such as "AGENDA") provide a variety of community-based leisure activities. There are limited places in some of the HSC Trust-owned Day Centres who also supply activities such as day trips, health development programs etc. Institutional health sector provide limited Strength and Balance classes (falls prevention programmes). Care management team will support patients with identifying benefits available. Age Concern and Citizens Advise Bureau will also assists for income support.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Is there a specialist or a team in charge of a multidimensional evaluation of frailty in community-dwelling older persons?	Yes	No	No	Yes	Yes	No	No	No

In **Emilia Romagna**, general practitioners, nurses, psychologists, social workers, and in-patient specialists can refer the frail community-dwelling older person to a secondary level of multidimensional assessment. The patient can access to such evaluation by booking the appointment through the referring professional or through the health/social services in the community. The multidisciplinary team usually includes the general practitioner, the geriatrician, the nurse, the psychologist, and social workers. The team is focused at exploring the physical, cognitive, psychological, and social domains. The assessment is supported by the use of the following tools for the measurement of frailty: the Tilburg Frailty Indicator, the PRISMA-7, the Edmonton Frailty Scale, and the gait speed. In **Piemonte**, the Comprehensive Geriatric Assessment units are active. General practitioners, nurses, and social workers can address frail patients to these services. The patient can access to such evaluation by booking the appointment through the referring professional or through the health/social services in the community. The multidisciplinary team

usually includes the geriatrician, the nurse, and social worker. The team is focused at exploring the physical, cognitive, psychological, socioeconomic domains.
In **France**, general practitioners, nurses, and in-patient specialists can refer the frail community-dwelling older person to a secondary level of multidimensional assessment. The patient can access to such evaluation by booking the appointment through the referring professional. The multidisciplinary team usually includes the general practitioner, the geriatrician, the nurse, the psychologist, social workers, and other healthcare professionals (physical trainer, nutritionist, ophthalmologist, pharmacist). The team is focused at exploring the physical, cognitive, psychological, and social domains. The assessment is supported by the use of the following tools for the measurement of frailty: the frailty phenotype and the gait speed.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	**Campania**	**Liguria**	**Piemonte**				
Who is the health professional most directly involved in the assessment of frailty?	GP, G, OS, N, SW	GP	GP, G, N	G, N, SW	GP, G	GP	G	GP, N

GP: General practitioner; G: Geriatrician or internist trained in geriatric care; OS: other medical specialist; N: Nurse; SW: Social worker

In **Emilia Romagna**, **Campania**, and **Piemonte**, the services for the assessment of frailty are predominantly provided by public sector in multi-specialty clinics and out-patient public hospitals.
In **France** and **Liguria**, the services for the assessment of frailty are predominantly provided by public sector in multi-specialty clinics and out-patient public hospitals.
In **Northern Ireland**, the services for the assessment of frailty are predominantly provided by public sector in outpatient public hospitals.
In **Poland**, the services for the assessment of frailty are predominantly provided by self-employed geriatricians or as part as of the public sector activities. Usually, these are conducted in public multi-specialty clinics or in private solo specialty practice.
In **Spain**, the services for the assessment of frailty are predominantly provided by public sector in multi-specialty clinics and outpatient public hospitals.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	**Campania**	**Liguria**	**Piemonte**				
Once frailty is identified, what type of response takes place? What kind of interventions is available/proposed?	Ex, I, MP, Oth	Ex, I, MP	Oth	Ex, I, MP, Oth	Ex, I, MP, Oth	Ex, I, MP, Oth	Ex, MP	Ex, I, MP

Ex: Diagnostic examinations and evaluation; I: Interventions targeting functional recovery and further disability prevention; MP: Interventions for managing multimorbidity and polypharmacy; Oth: Other

In **Emilia Romagna**, the individual might also be proposed with economic assistance, social activity initiatives, help for transportation and grocery shopping, home care support.
In **Liguria**, the individual might be proposed with adapted physical activity programs and/or sessions of memory training.
In **France**, the individual recognized as frail by his general practitioner is referred to a dedicated day hospital unit located in several major hospital of the region. Here, a multidisciplinary team conducts an in-depth comprehensive geriatric assessment using validated and standardized tools. The team, under the coordination of a geriatrician, then design a personalized plan of intervention according to the individual's priorities and resources. The plan of action is shared with the GP for obtaining his validation and willingness to follow. Follow-up contacts at the outpatient clinic can be organized for monitoring the individual's health status modifications and adherence to the provided recommendations.
In **Northern Ireland**, a comprehensive geriatric assessment is also proposed as part of the interventions.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
How is continuity of care following a positive assessment of frailty guaranteed?	DL, RTC, FU	DL	FU	DL, Oth	DL, FU	DL, RTC, FU, Oth.	DL	DL, RTC, FU

DL: Discharge letter to the general practitioner (or care manager) with eventual periodic reassessment by specialist; RTC: Real time communication through electronic shared record system between specialist and general practitioner; FU: Follow-up by multiprofessional team supported by electronic records; Oth.: Other interventions

In **Piemonte**, continuity of care is also assured by the so-called Piano di Assistenza Individuale (Personalized Care Plan).
In **Northern Ireland**, continuity of care is also assured by liaison with Trust Care Manager/District Nurse and general practitioner.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Are there programs based on the case-manager model available for older people with complex chronic conditions?	Yes	No	Yes	Yes	Yes	Yes	No	Yes

In **Emilia Romagna** and **Piemonte**, programs based on the case-manager model are coordinated by physicians, nurses, or social workers.
In **France**, programs based on the case-manager model are coordinated by nurses, or social workers.
In **Northern Ireland**, programs based on the case-manager model are coordinated by healthcare professionals other than nurses and doctors.
In **Spain** and **Liguria**, programs based on the case-manager model are coordinated by nurses.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Is there a systematic/standardized approach (procedure or pathway) to manage hospital admission and hospitalization of frail patients?	Yes	No	No	Yes	No	No	No	No

In **Emilia Romagna** and **Piemonte**, the hospital discharge is planned with home care activation (Dimissioni protette) for frail patients. In Piemonte, the Silver Code program, supporting the triage of older persons in emergency rooms, is also active.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Are there specific screening tools for evaluating potentially frail patients when they are admitted to an emergency department or a hospital ward?	No	No	No	Yes	Yes	Yes	No	No

In **Piemonte**, the BRASS (Blaylock Risk Assessment Screening) tool is frequently used for redirecting the patients towards long-term care, nursing homes, or home care programs.
In several public hospitals in **France**, the emergency room physicians use the Gèrontopôle Frailty Screening Tool for identifying frail older persons and forward the case to the hospital geriatricians.
In **Northern Ireland**, care managers assess social needs and liaise with District Nursing and GP with regards to physical needs. In the case of secondary care, whilst some specific tools are available, these are NOT routinely used.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Is hospital discharge planned in an integrated way between the hospital and the community (including primary care)?	Yes	No	Yes	Yes	Yes	Yes	No	No

In **Emilia Romagna**, the hospital discharge is planned with home care activation (Dimissioni protette) for frail patients.
In **Liguria**, plans for protected discharge are applied in orthogeriatric units and geriatric wards.
In **France**, a medical record is systematically sent to patient's general practitioner.
In **Northern Ireland**, Review of clinical and social support required are generally assessed in hospital and communicated to Community team. If social support is required, generally needs to be in place for discharge.

	Italy				France	Northern Ireland	Poland	Spain
	Emilia Romagna	Campania	Liguria	Piemonte				
Are some patients maintained in acute care settings because of a lack of availability for more suitable healthcare settings (e.g., long-term care or rehabilitation beds, nursing homes, home care)?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

In **Piemonte**, 2-3 days of delay in the discharge procedures can be estimated when the patients is allocated to home care services. The waiting for nursing home may delay of 7-10 days the discharge from acute care wards.
In **Liguria** and **Campania**, the phenomenon especially concerns the 5-10% of frail elders admitted to the hospital.
In **France**, **Northern Ireland** and **Poland**, although there is awareness of the "bed-blocking" phenomenon of patients maintained in acute care wards due to lack of long-term care facilities, there is no official or regular estimate of it.
In **Spain**, the phenomenon is decreasing since the implementation of a system at the emergency departments of the hospitals for directly transferring older persons in the need of long-term care to the adapted facilities (without the need of hospital admission).

4. DISCUSSION

4.1. Healthcare services

Looking at the results of the questionnaires, it appears a major heterogeneity across the reference sites both for what concerns the coverage, basic entitlements, and accessibility to care services as well as the clinical approach and management of frailty and multimorbidity.

Across reference sites (with the only exception of France where health and social insurance is mandatory), primary care is automatically covered with universal entitlement. Several services are similarly taken into charge by public health services across reference sites with full coverage. These include: cancer screening, outpatient primary health care, acute inpatient care, transportation for health-related issues, home care (with the exception of France were cost-sharing is asked), palliative care (with the exception of Poland requiring some cost-sharing), outpatient geriatric care (with the exception of Emilia Romagna and Liguria requiring cost-sharing), cognitive stimulation (except for France), and seasonal flu vaccination (with the exception of Campania and Poland).
Long-term care is mainly based on a model of cost-sharing (with the national healthcare system or private insurances) across all the reference sites.
The provision of eye glasses/contact lenses, dental care, and dental prostheses is quite heterogeneous across Europe. In some countries/regions (e.g., Emilia Romagna, Northern Ireland) these services might be fully covered by public healthcare. In other regions, they are completely on charge of the individual (e.g., Liguria, Piemonte), or only partially reimbursed by public/private models of cost-sharing (e.g., France, Poland). Quite heterogeneous is also the management of pharmaceuticals and clinical laboratory tests, which are sometimes fully covered by the national health system, some others partially requiring cost-sharing.
Some interventions for frail and multimorbid older persons largely rely on services paid out-of-pocket by the individual or provided on a volunteer basis. These include psychological support (although fully covered in Emilia Romagna, Northern Ireland and Poland), leisure/social activation, physical activity, housekeeping, informal care for dependent persons, and transportation for social activities or issues.

It is noteworthy that throughout the reference sites, the same services could be differently framed, managed, and organized. The same clinical activity might sometimes be included in different services across referent sites, or the same service offer quite diverse activities elsewhere. The organization of primary care is also quite heterogeneously structured, sometimes tending towards public models (e.g., Italy, Poland), some others with characteristics of private services (e.g., France, Northern Ireland).

A great heterogeneity both in qualitative and quantitative terms is also evident for what concerns the retirement fees and exemption system for healthcare-related costs across reference sites. The minimum retirement pension is variable across Europe, with even a 4-fold difference across sites. At the same time, the methods for applying exemptions to healthcare costs are also quite diverse. At some sites, a maximum exemption cost is applied according to the clinical and sociodemographic profile of the individual (e.g., France). In other regions, exemptions are applied to the offered services without specific limitations (e.g., Poland, Italy).

It has been reported that the individual is always free to choose his/her primary care physician across reference sites, but never the case manager. Some limitations may be present in the choice of the specialists in the outpatient setting and of the hospital personnel.

4.2. Detection and management of frailty and multimorbidity

It is worth to highlight that regional targets setting the strategies to improve health outcomes in older persons are not always present across the reference sites. Similarly, population surveys addressing health, social and economic conditions of elders are not necessarily available in each country/region.
It is, however, important to underline that older persons are consistently involved in the processes regarding the structure and organization of the services provided to them. In this context, dialogue platforms may be more or less formally organized, and including voluntaries as well as patients' representatives' organizations.

The detection of frailty in primary care is consistently present at the reference sites, although different professionals might be in charge of this task. The frailty screening is frequently conducted by the general practitioner, but nurses, social workers, and other specialists might (formally or informally) support this activity.

One of the most striking messages documented across the reference sites is related to the extreme heterogeneity in the clinical assessment of the risk profile of the older person. The common risk factors for disabling conditions are not always systematically explored in primary care (in certain regions quite rarely). Moreover, differences also exist about the risk factors that are prioritized for evaluation at each reference site. Nevertheless, it appears that smoking habit, history of falls, multimorbidity, and polypharmacy are the risk conditions that are attracting more attention during the screening of older persons in primary care.
An even greater heterogeneity was evidenced when the reference sites reported the questionnaires/instruments that more than others are locally used for the identification of frailty in primary care. Most of the reference sites have no specific instrument implemented in the clinical routine. When instruments are available/recommended by local public health authorities, it is unlikely to find the recommendation of a single

tool; it is more likely to have multiple instruments proposed (or also endorsed) by public health authorities as suitable for the task, leaving to the healthcare professional the choice of the most convenient one to use.

For what concerns the preventive interventions in place for counteracting the disabling cascade, those that are more frequently provided by institutional health or social sector are: transportation for health-related issues, psychological support, cognitive estimation programs, and income support (for living and housing). Differently, leisure/social activation programs, adapted physical activity programs, transportation for social activities and social services, and feeding (community canteens, soup kitchens) are the most common coordinated by community initiatives. Meals at home, monitoring at distance, and housekeeping help are also quite common across reference sites, but their organization (institutional versus community) is variable.

The evaluation of the older persons through a multidisciplinary team adopting the comprehensive geriatric assessment is not always present at the reference sites. Only some Italian regions and France present this kind of model at this time.

The health professionals directly involved in the assessment of frailty are usually the general practitioners, followed by geriatricians and nurses. In some regions, social workers may also be called at assessing frailty, but usually as part of a multidisciplinary team.

Once frailty is detected, the model of intervention put in place is quite homogeneous across reference sites. It consists of 1) diagnostic examinations and clinical evaluation, 2) management of multimorbidity and polypharmacy, and 3) design of a plan aimed at preventing functional loss. Specific preventive activities might also be proposed according to the locally available services and resources. Usually, continuity of care is guaranteed by a discharge letter sent to general practitioner or case manager. In some systems, real time communication through electronic data also supports the communication among health professionals and the patient's follow-up.

Although programs based on the case-manager model are largely diffused across reference sites (with the only exception of Poland), there is no standardized procedure for managing hospital admissions and hospitalizations of frail older patients. Also, the use of tools for measuring frailty in the hospital setting is quite inconsistent and relatively rare. However, there is the tendency at having a good network for guaranteeing a safe discharge of the patient from the hospital to the territory across reference sites (only Poland and Spain have no formal organization for supporting the return of the patient to his environment). The availability of systems for the protected discharge of the patients might be related to the common and frequent problem (existing almost everywhere) of the "bed-blocking" due to the limited number of home care and long term services. This might be the cause for which some integration between the hospital and the primary care is expected and currently under development.

5. CONCLUSION

Overall, the SUNFRAIL project with these surveys has highlighted a major heterogeneity in the clinical services and models aimed at counteracting frailty and multimorbidity in the elderly. Given the importance of the topic (especially in our ageing societies), it is important to build up on the few commonalities for standardizing the care of frailty and multimorbidity across Europe. It seems difficult to federate such existing diversities in a single and rigid model of care.

The definition of a too detailed model, not respectful of regional differences, might resemble a theoretical work, which will face huge difficulties when clinically implemented. Differently, the provision of a general structure taking advantage of the few commonalities existing across sites might be more practical and feasible. In this context, the few points to be carefully retained and on which the model should be founded are:

- Frailty and multimorbidity are relevant conditions, considered everywhere across Europe;
- The general practitioner (i.e., primary care) is the main referent for the detection of frailty and the implementation of the first interventions;
- No instrument can today be indicated as "gold standard" for the screening and assessment of frailty;
- Few risk factors for disabling conditions are systematically screened in primary care across Europe, showing that the existing approach is largely insufficient (under both quantitative and qualitative perspectives);

At the same time, it cannot be ignored the burden of clinical activities conducted in primary care, with both preventive and therapeutic objectives. In order to implement a solid preventive strategy, it is thus needed to delegate some tasks to actors who are not adequately invested in the systems and models of care. Among these, the person him/herself and social workers may strongly contribute for the modeling of a successful model of care.

6. ANNEXES

Annex I
Questionnaire 1. Service Coverage, basic entitlements and accessibility.
To be filled-up by regional decision maker or representative.

Annex II
Questionnaire 2. Community outreach, diagnosis and management of frailty.
To be completed by health or social professional with a first-hand knowledge of the services provided.

6.1. Annex I

Questionnaire 1. Service coverage, basic entitlements and accessibility

To be filled-up by regional decision maker or representative

Name of respondent:
Contact information:

Questionnaire 1. Service coverage, basic entitlements and accessibility

1.1. For each of the basic primary care coverage option below, please indicate where applicable, the proportion of access by the population aged 65 and over (please select 1 or more options):

	(%) population 65 and over
a. Automatic coverage, universal entitlement (tax-financed health system)	____%
b. Mandatory health and social insurance	____%
c. Voluntary (complementary or supplementary) health and social coverage	____%

If you answered to b or c with a percentage higher than 0%, how is the affiliation with a particular insurance/fund determined?

¨ Affiliation to a specific insurance/fund is not a matter of choice; it is linked to professional status, geographic situation, or employer

¨ Affiliation is a matter of choice; people can choose among several insurers/funds.

1.2. Range of social and health services provided to population aged 65 and over and direct cost-participation (main provider)

When the services indicated below are NOT covered by the national health service (NHS) or main insurer, please distinguish if private voluntary (complementary) forms of insurance are available, or if their cost is mainly borne by individuals and their families (private out-of-pocket).

If service provision is made through different coverage schemes, and you have difficulty in defining the main provider, please mark more options and write some additional comments in the table below.

	Covered mainly by					
Service	Fully covered by NHS or main insurer	NHS or main insurer with cost-sharing	Voluntary, complementary insurance	Private out of pocket	3rd sector, Voluntary organizations	Not applicable
Cancer screening	•	•	•	•	•	•
Seasonal flu vaccinations	•	•	•	•	•	•
Nutritional advice	•	•	•	•	•	•
Nutritional supplements	•	•	•	•	•	•
Outpatient primary health care (general practitioners and family nurses)	•	•	•	•	•	•
Outpatient specialist geriatric care	•	•	•	•	•	•
Acute inpatient care	•	•	•	•	•	•
Long term care: residential (institutional) care	•	•	•	•	•	•
Domiciliary care	•	•	•	•	•	•
Pharmaceuticals	•	•	•	•	•	•
Clinical laboratory tests and diagnostic imaging	•	•	•	•	•	•

Palliative care	•	•	•	•	•	•
Eye glasses and/or contact lenses	•	•	•	•	•	•
Dental care	•	•	•	•	•	•
Dental prostheses	•	•	•	•	•	•
Transportation for health related issues	•	•	•	•	•	•
Psychological support	•	•	•	•	•	•
Cognitive stimulation	•	•	•	•	•	•
Leisure/ social activation	•	•	•	•	•	•
Physical activity	•	•	•	•	•	•
Domestic work*	•	•	•	•	•	•
Informal care for dependent people	•	•	•	•	•	•
Day time wardship	•	•	•	•	•	•
Transportation for social activities or social issues	•	•	•	•	•	•
Income support (living and housing)	•	•	•	•	•	•
Feeding (meals)**	•	•	•	•	•	•
Other relevant (to be specified)	•	•	•	•	•	•

* These services refer to home based support to elders living alone (housekeeping, cooking, shopping) (**not for dependent or disabled people**).
** Community support to elders living alone (community canteens, soup kitchen) (**not for dependent or disabled people**).

Additional Comments:

1.3. Description of service coverage and infrastructures in your Region

Referring to the services provided in your Region: how many practices, centres, hospitals (public and/or private) exist, and how many persons aged 65 and over have attended them in the last year?

	Data	Year of reference and source
Primary care contacts (GP or equivalent)		
Average number of primary care consultations per capita in the last year (general population):		
Average number of primary care consultations for people aged 65 and over in the last year:		
Domiciliary care		
Percentage of people receiving domiciliary care (% of people aged 65 and over)		
Out-patient contacts with a geriatric specialist		
Number of out-patient units for geriatric specialty care:		
Number of out-patient visits with a geriatric specialist:		
Psychological support		
Number of mental health centres:		
Total number of mental health visits for persons (65 and over):		
Long term care: residential and/or institutional care		
Number of residential or nursing home facilities:		
Number of admissions per thousand inhabitants (65 and over):		
Inpatient care		
Number of hospitals:		
Number of admissions per thousand inhabitants (65 and over) for any condition:		
Total number of beds in inpatient geriatric units (if applicable):		
Median Length of stay (LOS) for patients aged 65 and over		

	Data	Year of reference and source
Emergency care		
Number of admissions to emergency units of persons aged 65 and over:		
Palliative care		
Number of hospices or end-of-life centres:		
Number of admissions per thousand inhabitants (65 and over) to palliative end-of-life care:		
Direct monetary support for living and housing		
Percentage of persons aged 65 and over who received cash income support / care check:		
Average amount of money transferred to a person aged 65 and over receiving monetary support:		

1.4. Are primary care services provided predominantly in (please select only one option):

- ¨ Public primary care clinics staffed by physicians only
- ¨ Public primary care clinics staffed by physicians and other health professionals (e.g., nurses)
- ¨ Outpatient departments of public hospital
- ¨ Private solo practices
- ¨ Private group practices staffed by physicians only
- ¨ Private group practices staffed by physicians and other health professionals (e.g., nurses)
- ¨ Outpatient departments of private hospital
- ¨ Other, please specify _____

1.4.1. If the predominant mode of provision of primary care services is **group practice or Primary Care Centres**, please specify the average number of physicians in the practice/clinic:

_____

1.5. Health and social professionals involved in the identification and management of frailty

Please indicate the number of health and social professionals working in the Region (last available year) working **exclusively or predominantly** with persons aged 65 and over. Whenever this proportion is difficult to assess, please provide the total number of professionals for each category active in your Region.

	Main working setting (hospital, primary care centre, individual practice)	N (head count)
Primary care physicians		
Nurses		
Geriatricians		
Social worker		
Other:		

1.6. Protection against excessive out-of-pocket expenditures

1.6.1. What is the minimum State pension a person aged 65 and over can expect (in euro)? _____

1.6.2. Please list the main co-payment exemption schemes which apply to a citizen whose age is 65 and over due to seniority and/or multimorbidity: _____

1.7. Person's choice

Can a person aged 65 and over choose among the following providers? If so, how freely?

Provider	No choice, Person assigned by NHS or insurer	Person's choice is limited *	Person can always choose
Primary care physicians	•	•	•
Specialists out-patient setting	•	•	•
Case manager	•	•	•
Hospital	•	•	•

* if patient's choice is allowed please specify under which incentives and conditions:

_____

6.2. Annex II

Questionnaire 2. Community outreach, diagnosis and management of frailty

To be filled-up by health or social professional with a first-hand knowledge of the services provided

Name of respondent:
Contact information:

Questionnaire 2. Community outreach, diagnosis and management of frailty

Frailty identification, prevention and management require a multiple steps approach and multidisciplinary pathways.
Please attempt to describe how in your Reference Site these steps are organized (A. Early identification/primary prevention;
B. Health and social response/secondary level specialized care), by indicating the main setting, health & social professionals involved, the tools and the pathways.

A. Early identification / primary prevention

A.1. Are there regional targets set to improve health outcomes in elderly population?

(Periodic biochemical blood checks, blood pressure, vaccination coverage, domiciliary care, etc.)

- ¨ No
- ¨ Yes

If yes, who sets these targets?

_____

Please provide a few examples of targets:

_____

A.2. Are there population surveys addressing health and social /economical conditions of elders?

- ¨ No
- ¨ Yes, at national level
- ¨ Yes, at regional level

Please provide the references to the surveys:

_____

A.3. Are there participatory processes involving citizens aged 65 and over regarding their expectations, satisfaction and barriers to access to services provided? (Community labs, questionnaires, focus groups, Delphi)

¨ No
¨ Yes
If yes, explain

_____

A.4. Do general practitioners in primary care practices (or centres) perform early identification of frailty?

¨ No
¨ Yes
If yes, are they required to do it systematically? In which setting?

_____

A.5. Are there other health / social professionals than general practitioners performing early identification of frailty in the community setting?

¨ No
¨ Yes
If yes, which professionals and in which setting? (family nurses, social workers, pharmacists, health visitors, voluntary associations)

_____

A.6. Are the following risk factors for frailty systematically monitored in Primary Care? Please specify also the professional/s involved (GP, nurse, social worker, pharmacist, psychologist, others).

	Never or rarely	Systematically	Key health/social professional involved
Nutritional status	•	•	
Physical activity	•	•	
Smoking habit	•	•	
Alcohol consumption	•	•	
Oral health	•	•	
Mood	•	•	
Life events*	•	•	
History of falls	•	•	
Concurrence of 3 or more chronic conditions	•	•	
Social status (e.g., isolation)	•	•	
Polypharmacy: 5 or more drugs taken on a regular basis	•	•	
Economic status (e.g., constraints)	•	•	
Educational level	•	•	
Other (indicate the risk factor and frequency of monitoring): _____	•	•	

***incl.:** death of a loved one, serious illness, serious illness in a loved one, divorce or end of an important relationship, traffic accident, and crime (Gobbens R et al. 2010)

A.6.1. is there a validated questionnaire or instrument used to assess frailty **in primary care**?

- ¨ The Tilburg Frailty Indicator proposed by Gobbens and colleagues
- ¨ The Frailty Phenotype proposed by Fried and colleagues
- ¨ The FRAIL tool proposed by Morley and colleagues
- ¨ The Sherbrook Postal Questionnaire proposed by Hebert and colleagues
- ¨ The 9-item Clinical Frailty Scale proposed by Rockwood and colleagues
- ¨ PRISMA-7 proposed by Raiche and colleagues
- ¨ The Edmonton Frailty Scale proposed by Rolfson and colleagues
- ¨ Gait speed
- ¨ Other (specify)_____

If other, please provide a reference to the tool: _____

A.7. What types of preventive activities to safeguard against risk factors of frailty are available at community level?
Please indicate whether these are provided by health and social care institutions or by community voluntary initiatives (if available, please include examples of both formal and informal initiatives).

Activity	Institutional health or social sector	Community initiative	Provide e.g. of special initiatives
Transportation for health related issues	•	•	
Psychological support	•	•	
Cognitive stimulation (ICT training, memory stimulation)	•	•	
Leisure / social activation (voluntary work, playgrounds, cinema, day trip, vacations, folk dance)	•	•	
Adapted physical activity (including yoga, Thai-chi, postural training)	•	•	
Day time wardship	•	•	
Transportation for social activities and social services	•	•	
Income support (living and housing)	•	•	
Feeding (Community canteens, soup kitchen)	•	•	
Meals at home *	•	•	
Monitoring at distance *	•	•	
Domestic work**	•	•	
Other (to be specified)	•	•	

* Considered as home based support to elders living alone (**not for dependent or disabled people**).
** Considered as home based support to elders living alone (housekeeping, cooking, shopping) (**not for dependent or disabled people**).

B. Health & social response / secondary level specialized care

B.1. Is there a specialist or a team in charge of a multidimensional evaluation of frailty in community-dwelling older persons?

- ¨ No, if so then go to question B.2
- ¨ Yes, if so:

B.1.1. which professional does the **referral** to such secondary level of multidimensional assessment? (more options allowed)

- ¨ Primary care physician
- ¨ Nurse
- ¨ Psychologist
- ¨ Social worker
- ¨ Inpatient specialists
- ¨ Other (specify): _____

B.1.2. How do **patients access** to this evaluation? (more options allowed)

- ¨ booking made directly by the referring professional
- ¨ on-line booking / Call centre
- ¨ booking via a pharmacy
- ¨ booking through health and social centres in the community
- ¨ no need of booking
- ¨ Other (specify):_____

B.1.3. **If** there is a team in charge of a multidimensional evaluation of frailty**,** what professions are involved? (more options allowed)

- ¨ Primary care physician
- ¨ Geriatricians or other general internists dealing with elders
- ¨ Nurse
- ¨ Psychologist
- ¨ Social worker

¨ Other (specify): _____

B.1.4. Are the following **frailty domains** assessed? (more options allowed)

¨ Physical domain
¨ Cognitive domain
¨ Psychological domain
¨ Social domain
¨ Other (specify):_____

B.1.5. If any of the above domains are assessed, which validated **grid or tool** (or list of items) is used?

¨ The Tilburg Frailty Indicator proposed by Gobbens and colleagues
¨ The Frailty Phenotype proposed by Fried and colleagues
¨ The FRAIL tool proposed by Morley and colleagues
¨ The Sherbrook Postal Questionnaire proposed by Hebert and colleagues
¨ The 9-item Clinical Frailty Scale proposed by Rockwood and colleagues
¨ PRISMA-7 proposed by Raiche and colleagues
¨ The Edmonton Frailty Scale proposed by Rolfson and colleagues
¨ Gait speed
¨ Other (specify)_____

If other, please provide a reference to the tool: _____

B.2. Who is the <u>health</u> professional <u>most</u> directly involved in the assessment of <u>frailty</u>?

- Family doctor or general practitioner
- Geriatrician or internist trained in geriatric care
- Other medical specialist
- Other healthcare professional (specify): _____

B.2.1.This type of professional is supplying this service predominantly:

¨ Self-employed

¨ Publically employed

¨ Privately employed

B.2.2. Ambulatory/outpatient specialists' services for older people are provided predominantly in:

¨ Public multi-specialty clinic

¨ Outpatient department of public hospital

¨ Private solo specialists

¨ Private group practice

¨ Outpatient department of private hospital

B.3. Once <u>frailty</u> is identified, what type of response takes place? What kind of interventions are available/proposed? (more options allowed)

- Diagnostic examinations and evaluation
- Interventions targeting functional recovery and further disability prevention
- Specific interventions or pathways for managing multimorbidity and polypharmacy
- Other interventions

Please describe these interventions in details:

_____

B.4. How is continuity of care following a positive assessment of frailty guaranteed? (more options allowed)

- ¨ Discharge letter and referral to general practitioner (or other care-manager, such as nurse) with eventual periodic re-assessment by geriatric care specialist
- ¨ Real-time communication through an electronic shared record system between specialist and general practitioner
- ¨ Follow-up by a multiprofessional team through shared electronic records and periodic contacts
- ¨ Other (specify): _____

B.5. Are there programs based on the case-manager model available for older people with complex chronic conditions? (more options allowed)

- ¨ No
- ¨ Yes

If yes, are these services coordinated by:

- ¨ Physicians
- ¨ Nurses
- ¨ Professionals with qualifications other than nurses and doctors (specify): _____

B.6. Is there a systematic/standardized approach (procedure or pathway) to manage hospital admission and hospitalization of frail patients?

- ¨ No
- ¨ Yes

If yes, explain: _____

B.7. Are there specific screening tools for evaluating potentially frail patients when they are admitted to an emergency department or a hospital ward?

- ¨ No
- ¨ Yes

If yes, explain: _____

B.8. Is hospital discharge planned in an integrated way between the hospital and the community (including primary care)?

¨ No
¨ Yes
If yes, explain: _____

B.10. Are some patients maintained in acute care settings because of a lack of availability for more suitable healthcare settings (e.g., long-term care or rehabilitation beds, nursing homes, home care)?

¨ No
¨ Yes
If yes, is there any estimate of this problem (e.g. number of delayed discharges)?

_____