Interreg Italia-Slovenija
CrossCare 2.0

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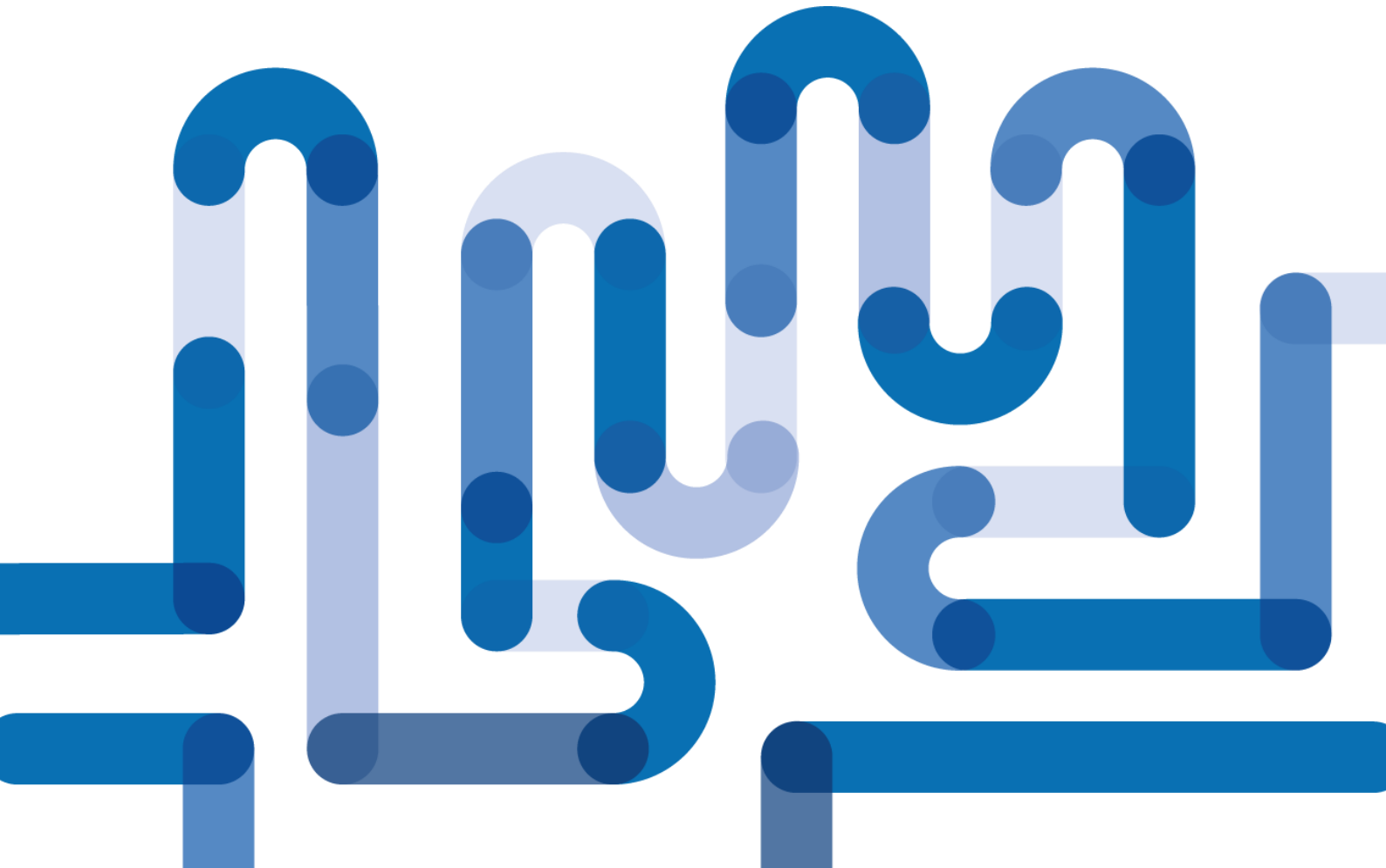
PROJECT CROSSCARE 2.0

CrossCare® model guidelines



CROSSCARE® MODEL GUIDELINES

CROSSCARE 2.0 PROJECT

SKUPNE INTEGRIRANE STRATEGIJE ZA KAPITALIZACIJO CROSSCARE MODELA/ STRATEGIE INTEGRATE E CONDIVISE PER LA CAPITALIZZAZIONE DEL MODELLO CROSSCARE / JOINT INTEGRATED STRATEGIES FOR CAPITALIZING ON THE CROSSCARE MODEL

INTERREG V-A ITALY-SLOVENIA 2021-2027

Capitalization tender No. 01/2022 of the Interreg VI-A Italy-Slovenia Programme

Policy objective: ISO 1 - A better cooperation governance;
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Project partners:

- Itaca cooperative social cooperative society onlus
- Public Personal Services Corporation ITIS
- IPAB Residence for the Elderly Giuseppe Francescon
- DEOS, celostna oskrba starostnikov, d.o.o.
- Dom starejših občanov Grosuplje
- Don Moschetta Special Company

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Contents

INTRODUCTION

Dear readers!

In front of you is a document, the cross-border guidelines, which contains references for each component of the CrossCare® model and serves as an information tool for the transferability of the model. The cross-border guidelines also contain information developed during trainings for health and social workers and broader audiences in order to transfer information about the model and useful content from cross-border training.

The contents of the guidelines are divided into key contents of the CrossCare® model, such as: The Care Manager's professional figure (roles and functions); the tools for measuring user needs used by the Care Manager in the implementation and evaluation of the model; the criteria for multiprofessional assessment in the care of the elderly (therapeutic arc, polar scheme); existing and innovative measures for the treatment and care of the elderly person and his/her family (Gentle Care, Validation); an overview of cross-border training courses for social health operators and the Care Manager's professional figure as a coordinator in the community.

Each section also contains knowledge and instruction from the educational program, which facilitated the integration of the CrossCare® model and the implementation of project activities. We also reinforced the professional knowledge and content with practical examples. The examples are presented descriptively and graphically in the form of a comic strip, so that everyone can easily master the approaches and instructions.

Through the paper we would like to present to the general public additional knowledge from cross-border training under the CrossCare® 2.0 project on the strengthened model and other aspects of long-term care and home care for the elderly. This knowledge is particularly aimed at the elderly, their relatives and others working in the field of elderly care in the cross-border area, with the aim of providing quality knowledge for the implementation of the integrated elderly care model. In this way we want to enable the elderly and other stakeholders to acquire the knowledge and skills needed to ensure a better quality of life and greater independence in old age, and to obtain guidance on who to contact for information or help when they need it.

The knowledge is aimed at deepening skills that each individual can use in their daily work to provide better care for the elderly or to live with them. The content can be adapted according to the changing needs of users.

In addition to the individual content sets of the CrossCare® model, we have also made available a thematic bibliography in QR code format that may be useful for older adults, health care professionals and other interested parties to obtain additional information, and literature on each individual topic.

The purpose of this document-guidelines-is to transfer knowledge to field workers and providers, older people and their relatives, on the topics of active ageing, innovative approaches in the field of dementia, home care and social care. We also want to strengthen the use and implementation of the CrossCare® model among other social care providers. We want to consolidate the common goal of supporting the elderly and strengthen care work for this target group. With the guidelines, we also want to encourage and strengthen the work of community professionals and foster cooperation among different institutions to implement an integrated approach to elderly care.

PROJECT PRESENTATION

Project CrossCare 2.0 - Joint Integrated Strategies for capitalising on the CrossCare model, aims at developing an adequate response to the ageing trend in the population, a common challenge in the Programme Area that will have a significant impact on healthcare and social inclusion policies in the medium term. CrossCare 2.0 is co-financed by the European Union under the Interreg VI-A Italy-Slovenia Programme, funded by the European Regional Development Fund.

Goals

- The overall goal is to strengthen cooperation and governance of public-private decision-making processes among key institutions and practitioners of social and health services for elderly care in the Program Area.
- Through capitalizing on and strengthening the CrossCare® Model, to develop shared strategies in response to the common challenge of aging and enhance coordination of existing cross-border area services.
- The project's innovative approach involves the experimental implementation of cross-border Community Pacts at the local level to support a model of integrated and personalized care of the elderly and their families, in synergy between public and private services and through collaboration with civil society and all formal and informal entities active in the area.

Output

- Strengthening the skills of PPs, PAs and practitioners through participation in joint training courses on Crosscare® methods and approaches;
- Consolidation of the Model and cross-border collaboration through the implementation of Community Pacts for an innovative approach to elder care;
- Improved services for active aging through the implementation of community-based strategies with the CrossCare 2.0 Model pilot experience with at least 50 users.

PRESENTATION OF PROJECT PARTNERS

CrossCare 2.0 involves six project partners from Italy and Slovenia and nine associated partners.

Cooperativa Itaca società cooperativa sociale onlus

Itaca social cooperative: history and mission

Founded on June 29, 1992, in Pordenone, Itaca is a Type "A" Social Cooperative operating in social, health, and educational sectors. It manages services divided into six productive areas: Home Care for the Elderly, Residential Care for the Elderly, Disability Services, Mental Health, Childhood and Adolescent Services, and Community Development and Youth Policies. Itaca operates in a wide geographical area that includes Friuli Venezia Giulia, the Veneto provinces of Treviso, Venice, and Belluno, and the autonomous province of Bolzano. Since its establishment, Itaca has been affiliated with the National League of Cooperatives and Mutuals and the sector-specific association Legacoopsociali, as well as corresponding regional organizations in Friuli Venezia Giulia, Veneto, and the autonomous province of Bolzano.

The Mission of Itaca Cooperative has been clearly stated in our Social Statute since its inception:

"The no profit purpose Cooperative" aims to pursue the general interest of the community for human promotion and social integration of citizens through the management of socio-health and educational services. These services are primarily, but not exclusively, aimed at addressing the needs of individuals in conditions of physical, psychological, and social disadvantage, the elderly, and minors. In performing its activities, the Cooperative predominantly relies on the work of its members. The mutualistic purpose pursued by the Cooperative's worker members is to achieve, through associative management, continuity of employment and the best social, professional, and economic conditions."

Elderly Services Area:

Itaca's Elderly Services Area offers both territorial and residential services aimed at improving the well-being and prolonging the home residence of individuals over fifty with varying degrees of disability.

The **FOUNDING PRINCIPLES** in implementing the services in this area are:

- Mission-focused: Emphasizing the Cooperative's values with a strong focus on the user and their families.
- Family-centered: The family, within which the user is integrated, is the active core around which the service revolves. The service is structured in spaces, programs, and operators catering to the families and their needs.
- Intervention philosophy: Based on principles of respect and acceptance of the individual, service individualization and personalization, promotion of self-determination, maintenance of user autonomy, privacy respect, and professional conduct by the operators.

As of December 31, Itaca assists 2,670 users across all traditional services, including meal delivery for solitary, frail individuals lacking support networks, and users of social centers. The predominant user demographic is elderly individuals over 85 years old.

Contact: mail: itaca@itaca.coopsoc.it ; tel: +390434504000

Website: https://itaca.coop/

Social networks: https://www.facebook.com/CooperativaItaca
https://www.instagram.com/cooperativasocialeitaca/

Azienda Pubblica di Servizi alla Persona ITIS

A.S.P. ITIS: The public company for personal services ITIS was born from the transformation of the Triestino Institute for Social Interventions, a public institution for assistance and charity, which took place as a result of LR 11 December 2003, n. 19 and has historical origins from the General Institute of the Poor, established on 12 December 1818 and renamed the Triestino Institute for Social Interventions on 20 September 1976.

The Company operates in the field of personal services and its primary, but not exclusive, purpose is the assistance to elderly people, through individualized plans and in full respect of the dignity and personality of the users. To this end, it implements services and carries out interventions aimed at the prevention, treatment and rehabilitation of non-self-sufficiency, offering to take care of needs in the home, semi-residential and residential context and a series of flexible and articulated responses, developing the function of a service center at old age.

Itis has its main headquarters in via Pascoli 31, on the ground floor there are the administrative offices and the common areas of the bar, the auditorium, the multipurpose rooms and the gym. Outside there is a large garden while the residences are located on the upper floors.

The ITIS public personal services company is authorized to operate fully, as part of the reclassification process (Title with a capacity of 411 beds divided into 17 N3 typology nuclei.

The company also provides various other services in the field of long-term care such providing care at home, providing care at assisted living accommodations, day care centres, etc.

Contact details: tel.: +39 0403736210

Website: www.itis.it

Social networks: https://www.facebook.com/aspitis

IPAB Residenza per Anziani Giuseppe Francescon

The Giuseppe Francescon Elderly Residence, active since the early 1900s in Portogruaro, is a modern center for elderly services known for the quality of its care. It has 138 beds for non-self-sufficient elderly, 4 for self-sufficient elderly, and a day center with 4 places. The facility, located near the historic center and well-connected, offers single and double rooms with private bathrooms and common areas such as a garden, recreational rooms, a library, and a chapel.

The care philosophy is based on humanizing assistance and promoting the quality of life, respecting the dignity and autonomy of each guest. The nursing home is committed to providing health and emotional-relational care, fostering personal and family relationships in a serene environment.

Approach to Dementia

The Francescon Residence pays particular attention to guests with dementia, offering a protected unit and cognitive and functional rehabilitation activities supervised by psychologists. The SFERA project supports and trains the families of people with cognitive decline.

Integrated with the community, the nursing home collaborates with the Ulss 4 Veneto Orientale Company, the Municipality of Portogruaro, and local associations to meet the needs of families. Initiatives such as the Alzheimer's Café offer meetings for the families of people with dementia, while the "Walking Groups" promote active aging and socialization.

Events like "Games without Barriers" involve guests and other centers in recreational-motor activities, and intergenerational projects facilitate meetings between young and elderly people, enriching the guests' lives and strengthening community bonds.

Contact: email: scrivi@residenzafrancescon.it ; tel. +39 0421 71329

Website: https://www.residenzafrancescon.it/

RESIDENZA francescon

DEOS, celostna oskrba starostnikov, d.o.o.

DEOS, Integrated Care for the Elderly, Ltd. is a privately owned company. It was founded in 1995. The company's core activities include institutional care for the elderly in nine DEOS Centres for the Elderly across Slovenia, the provision of social services in assisted living facilities and the provision of home care and social services in the surroundings of our Centres. Today, DEOS has ten Senior Centres across Slovenia, employs more than 900 staff and provides care for more than 2000 elderly people.

Our mission is to create a home for the elderly where they have the opportunity to grow and live a quality life. Through our activities, we provide a wide range of services tailored to the needs of the elderly, enabling them to lead a quality, independent and varied life. Whether an individual chooses to live in their own home or in a retirement home, we create a stimulating environment where everyone feels accepted and included. Our services are person-centred and based on the needs and wishes of the individual. Through the development of processes and knowledge, we ensure the high quality of our services to enable individuals to age with care and activity.

At DEOS, we develop our own processes and know-how so that we can always provide the most appropriate and best care for all our residents. Through a wide range of activities, we continuously encourage our residents to live as active and independent a life as possible. We also pay special attention to the relatives of our residents so that they can get the information they need at any time.

Our vision is to put a smile on the face of every elderly person. By actively contributing to the development of the long-term care system and new skills and approaches, we will work to raise the quality of care services for older people in Slovenia. Through the development of new services for older people, we want to make it easy for every individual to access the service that is most appropriate to their needs and preferences.

DEOS is actively involved in the development of services for the long-term care of the elderly through its own research team registered with the Slovenian Public Agency for Research. We are actively involved in the education of young people through cooperation with a number of educational institutions. We offer scholarships and internships for young people.

We also work with partners at home and abroad through a number of national and European projects addressing key issues in the field of long-term care for the elderly. Major projects include the development of a new social care service - farm stays for the elderly (https://www.deos.si/bivanje-starejsih-na-kmetiji/), the development of a modern centre for people with dementia, Poppy World (https://www.deos.si/makov-svet/), and the project for a new platform for home care and support for the elderly, Heroes at Home (http://junaknadomu.si/).

Contact: email: projektnapisarna@deos.si ; tel: 080 2737 or phone the project office 082002436

Website: https://www.deos.si/

Social networks: https://www.facebook.com/deoscentri/

DEOS
USTVARIMO PRILOŽNOSTI

Dom starejših občanov Grosuplje

Senior Citizens' Home Grosuplje

Grosuplje is a fairly young settlement, just a 15-minute drive from Ljubljana on the motorway towards Zagreb. Geographically, almost the entire area of the municipality is covered by the Grosuplje Basin, which is surrounded by the surrounding hills, characterised by numerous small valleys and karst fields. The proximity of Ljubljana and good road and rail connections have contributed to the rapid population growth and, consequently, to the accelerated economic development of the municipality.

Senior Citizens' Home Grosuplje opened its doors to its first residents on the 24th of February 1984. It is situated on the outskirts of the town, in a quiet location, near a forest. It provides a home for 183 senior citizens who, due to age and other circumstances, are unable or unwilling to live alone or with a family. It is the Home's wish and concern that the residents live as independent and safe a life as possible in well-equipped and adapted facilities.

Vision of Dom starejših občanov Grosuplje

We want to build a friendly home that enjoys a professional reputation and is highly trusted by residents and their relatives. Our primary task is to enable the residents to spend their old age in a quality way.

We want to offer a wide range of quality services to our residents. Our aim is to make the elderly feel comfortable in the presence of friendly and understanding staff. We will respect their wishes and individual needs. It is the care and wish of the home's staff that residents live as independently and safely as possible, within the limits of their psycho-physical abilities, of course. With the participation of the residents, all the staff, relatives and the interested public, we will create a home tailored to the old person's needs. We will strive to inform, support and cooperate with the relatives of our residents. We also want to share our knowledge and experience with other stakeholders and contribute to a quality old age for both residents and other citizens.

Contacts: tel: 01/7810-700

Website: https://www.dso-grosuplje.si/

Azienda Speciale Don Moschetta

The Don Moschetta Nursing Home has been active since 1977 in providing care for the elderly. Over the years, it has progressively specialized in the care and assistance of its residents, with the aim of ensuring their well-being and respecting their identity and social role through daily work based on interpersonal relationships.

The "Don Moschetta" Special Company is a public entity established in 2011, thus replacing the previous "institution," solely for the management of the namesake Nursing Home.

From January 1, 2017, it has also been responsible for managing the "Santa Margherita" Municipal Campsite, outdoor blue zone parking subscriptions for the Municipality of Caorle, public green space maintenance, and organizing the staff employed at the Municipal Fish Market.

Services Managed by the Don Moschetta Special Company:

- Nursing Home Management: The Don Moschetta Nursing Home has 76 beds and is surrounded by a large garden.
- Municipal Parking, Blue Zones: The Don Moschetta Special Company manages the issuance of blue zone parking subscriptions in the Caorle area. Starting this year, the procedure is entirely online.
- Home Assistance and Meal Delivery Service: The Don Moschetta Special Company handles the preparation, distribution, and delivery of meals to homes.
- Municipal Fish Market: The Municipal Fish Market, now managed by the Don Moschetta Special Company, is one of the symbolic places in the history of Caorle.
- School Cafeteria: The school cafeteria service provides meals to all students attending kindergartens and primary schools in the Municipality of Caorle.

The Don Moschetta Special Company has evolved over the years to provide a wide range of services, including elderly care, parking management, home meal delivery, and school cafeteria services. With its extensive experience and commitment to the community, the company ensures high-quality service across various sectors.

Useful information about these activities can be found on the dedicated websites: "www.casadiriposodonmoschetta.it" and "www.campingcaorle.it".

Contact: mail: segreteria@donmoschetta.it ; tel: +39 0421219411

Website: www.donmoschetta.it

CROSSCARE 2.0 MODEL ®

The Crosscare 2.0 project aims to strengthen and enhance the CrossCare Model ®, to develop shared strategies to address the common challenge of population aging and improve coordination of existing services in the cross-border area. The innovative approach of the project lies in the pilot action that establishes cross-border Community Covenants at the local level to support an integrated, person-centered care model for older people and their caregivers, in synergy between public and private services, through a partnership with civil society and all formal and informal groups active in the community.

Thus, the idea is to enhance the CrossCare® Model through three main outcomes:

1. **Strengthening the skills of PPs, PAs and professionals** through participation in joint training courses on CrossCare® methods and approaches.
2. **Consolidation of the Model and cross-border collaboration** through the implementation of Community Pacts for an innovative approach in elderly care.
3. **Improved active aging services** through implementation of community strategies based on the pilot project for the CrossCare 2.0 Model, with at least 50 users.

Through the cross-border approach, project partners will be able to enhance their expertise and develop a common integrated strategy to address the needs of the elderly population, as well as co-design and implement generative welfare actions. The goal of the integrated and personalized care model for the elderly is to help improve the quality of life and independence of the elderly involved in the pilot and, subsequently, of the people receiving care and services.

Care Manager professional figure (roles and functions)

A key aspect of the project is the role of the Care Manager. The Care Manager ensures that the elderly person receives services according to his or her actual needs and preferences. At the same time, he ensures that services are provided in one place. In doing so, he brings together various professionals within the institution (multidisciplinary team) and external providers from other organizations in the area through the use of community pacts. The Care Manager then acts as a care coordinator for the elderly person to ensure that he or she receives the highest quality services as quickly as possible. He or she accompanies the elderly person over time and adapts services according to the individual's evidence and changing needs.

Thus, the job of the care coordinator ("Care Manager ") consists of coordinating a multidisciplinary team, receiving requests for participation in the project from the elderly person, providing information about existing services in the setting, and coordinating the provision of services by the different services in the setting for the user. Its most important function is to monitor the individual's needs and the impact of different services on improving the elderly person's quality of life and independence.

Watch a video about the CrossCare® model on VIDEO (video of the 1st project)

Tools for measuring user needs used by the Care Manager in the implementation and evaluation of the model

The process of providing integrated and personalized care for the elderly begins with the establishment of gerontological service centers. Care of the elderly is entrusted to a care coordinator ("care manager"). User involvement in care begins when the elderly person asks for help, support or information. The care coordinator ("care manager") meets with the elderly person and provides information and assistance within his or her own organization or refers him or her to other services if necessary. The care manager's role is to help the elderly person get the information or help he or she needs and all services in one place. Based on the user's life history and individual plan, the elderly person's needs, wishes and expectations are highlighted. A needs assessment questionnaire can also be used to help the professional in his or her work.

The model is based on an assessment made on different aspects of the individual's life (multidimensional needs assessment model). Based on the individual's measured and expressed needs, we can provide him or her with appropriate (individualized) assistance or services. The impact of services on the individual and his or her life is monitored using the model and tests.

Criteria for multiprofessional assessment in elderly care (therapeutic arc, polar scheme)

The individual's needs and the effectiveness of services are not only implemented but also evaluated through the perspective of a multidisciplinary team. The multidisciplinary team and the care coordinator provide support to the frail elderly person, his or her family members and any caregivers, monitoring the individual's needs in all aspects of his or her life. In order to assess all the needs of the elderly person, it is necessary to work together in a multidisciplinary way and assess the individual from the perspective of different needs.

In their work, professionals use a variety of techniques and skills necessary to effectively provide individualized care and support to the individual through the administration of a series of tests and evaluate the most appropriate services to improve the elderly person's autonomy in different areas.

THERAPEUTIC ARC AND POLAR SCHEME

Schema polare

The assessment considered in this project includes an evaluation of the older person's physical and menta! health and functional and social status. The polar scheme is a new method conceived by a multi-disciplinary team (Vergani et al., 2004), to represent the user's condition, through the so-called 'polar diagram' or 'polar scheme' (see Fig. 1).

The polar scheme is consistent with the International Classification of Functioning and Health (World Health Organization, 2001), and shows the subject's scores on the evaluation scales (arranged radially inside the circular area) during the care pathway at different times (Vecchiato, 2004a; Pilati et al., 2023). The outer edges of the figure denote the optimum condition. This enables gaps between the optimum condition and the actual recorded scores to be easily identified. This tool can be used to monitor the condition of the elderly person, and to evaluate the changes in the outcomes. It also supports the decisions, the responsibilities in delivering the care process, and the resources for reaching expected outcomes.

In Cross Care 2.0 we considered a polar scheme consisting of a circle divided into three sectors. Each sector represents the principal domains covered by the initial assessment:

- the cognitive and behavioural domain (structures and cognitive functions)

- the physical and functional domain (body functions and activities)
- the socio-environmental domain (environmental and interpersonal factors).

Within each domain are 'rays' by which the scales are rated. These may vary, depending on the person under investigation. The outer part of the circle shows the individual's condition at their best. The centre shows their condition at its worst.

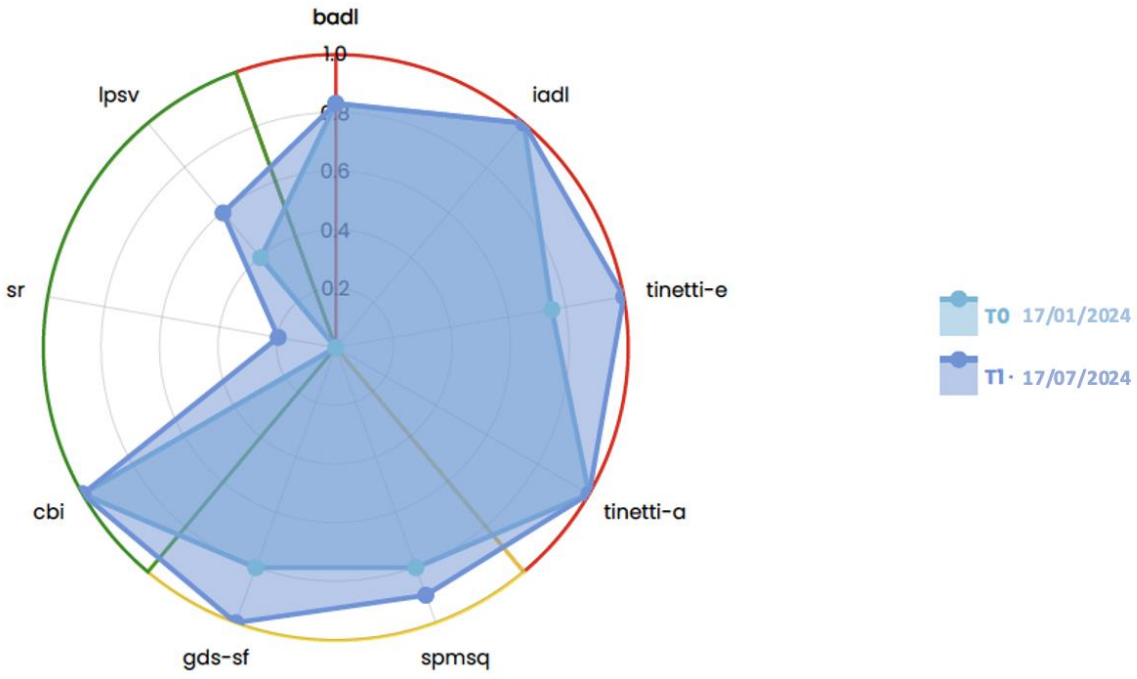
The cognitive and behaviour domain includes the Short Portable Mental Status Questionnaire (SPMSQ) and the Geriatric Depression Scale - Short Form (GDS-SF). The physical and functional domain includes the activities of daily living (ADL) scale, the instrumental activities of daily living (IADL) scale, and the Tinetti balance and Gait Scale (TINETTI-EA). The socio-environmental domain considers the caregiver burden inventory (CBI), the responsibility scale (SR), and the leve! of protection in life space (LPSV).

The different sections of the diagram indicate different measurements in time. The colors of the scales indicate the three observational and measurement areas for evaluating outcomes:

- structures and cognitive functions,
- body functions and activities,
- environmental and interpersonal factors.

The different values represented in the polar diagram can facilitate the integrated evaluation and choices of professionals involved in the care pathway together with the elderly person and his or her carers.

Fig. 1 – The polar scheme in 2 different point in time (T0 and T1)



The usage of the polar scheme can be better described using a case study. It refers to a 73-year-old woman called Maria. The care pathway considered her development in 3 different times. The case study is adapted from Vecchiato (Vecchiato, 2004b).

A case study: Maria

Maria is a 73-year-old woman. She is retired (she used to work in a factory) and she came to the attention of the service in October 2021. During the past two years she has experienced memory problems and behavioural changes, resulting in loss of autonomy in her daily life.

She has serious problems with mobility that lead to falls and accidents and she cannot eat without help (ADL: 1/6; IADL: 0/8; Tinetti 13/24).

Following a clinical examination, she is diagnosed with vascular dementia and is prescribed medication to treat her associated behavioural problems (SPMSQ: 7/10). Maria lives at home with her daughter, who works full-time during the day. For most of the day she is alone at home. This is a worry for her daughter, whose working performance and relationships have been affected (CBI: 65/96).

Social services are contacted to evaluate the family's income and investigate the possibility of a different support.

By January 2022, Maria shows an improvement in her attention capacity. Her behaviour has also improved. Her daug hter reports a reduction in the number of confused episodes, and Maria is sleeping throughout the night. Aspects of Maria's disability persist, but there are improvements in eating unassisted, due to socialisation interventions (ADL: 2/6; IADL: 0/8). Her mobility problems remain, but she has not had any falls (Tinetti 18/24) since the process started and there have been improvements in her daily living activities and environmental factors. Her daughter expresses an improvement in her quality of life too (CBI: 56/96).

By July 2022, Maria makes more progress (SPMSQ: 4/10). Her behavioural changes have disappeared, although her loss of autonomy remains (ADL: 2/6 , IADL: 0/8, Tinetti: 18/24). The daughter feels less stressed (CBI: 37/96). As a result of a comprehensive and integrated care combining different dimensions, Maria's situation has vastly improved.

The ARCO framework

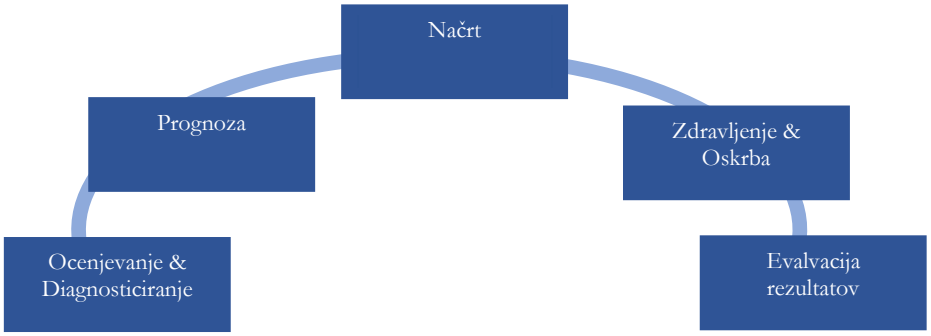
The polar scheme is part of a strategy called 'ARCO' (Vecchiato, 2015; 2022).

The idea of an ‘arch’ serves to connect the different phases of the care pathway and expresses the way in which the problem has been addressed by the demand of the person. In architecture, the arch was introduced to manage the forces of each stone in a convergent and unified manner. In this way, the arch can withstand very large forces. The therapeutic arch is also composed of stones, clinical stones, professional skills... which must be composed in a unified way. There is a need for positioning criteria that help to measure outcomes, sustainability and thus also 'standardisation and personalisation'. Standardisation comes from the structure of the therapeutic arch and personalisation comes from the personalised, dynamic and tailor-made management of the various components required to achieve the expected outcome.

The structure of the arch is organised into 5 components: Assessment & Diagnosis, Prognosis, Plan (Responsiveness), Cure & Care, Outcome Evaluation (Fig. 2). These five dimensions describe and represent the professional and organisational steps required to link diagnosis to prognosis, treatment to care, and production factors to expected and measured outcomes. They are elementary, intuitive components but should not be trivialised; on the contrary, they must be managed with the highest level of professional appropriateness.

This framework helps practitioners to avoid practices that are based on the diagnosis-prescription relationship that, technically, does not run the full arch. In this way, the care pathway becomes impoverished, disjointed, depowered, no longer technically able to guarantee appreciable outcomes. The framework also helps older people or their relatives to share the pathway and to engage in achieving the expected outcomes.

Fig. 2 – ARCO framework



Source: Vecchiato (2015)

The ARCO components

Assessment & Diagnosis

Assessment' represents the collection of quantitative and qualitative elements (fragilities and potentialities, capacities on a personal, relational and community scale). The 'diagnosis' is a summary of the analysis that emerges from the collection of elements, which makes it possible to identify the needs and capacities on which to impact and to define the expected results.

Prognosis

Prefiguration of 'goals' to be achieved described in terms of expected outcomes, both associated with the skills and responsibilities needed in the helping process. The 'prognosis' makes it possible to identify reciprocal commitments (of the service and the person) and to articulate them in the subsequent plan, to be implemented within defined and agreed timeframes, including with the person.

Plan

The plan is the synthesis of the previous phases, from the definition of the problem and capabilities, summarised in the diagnosis and transformed with the prognosis into the prefiguration of the expected outcomes. It is a unitary vision (synthesis) of the factors defining the problem, the capabilities and the solutions to be adopted. In the structure of the arch, it is the necessary element for the balancing of the competing forces.

The choices are transformed into a system of responsibilities (professional and non-professional, of the professional and the person) aimed at measurable outcomes.

Cure & Care

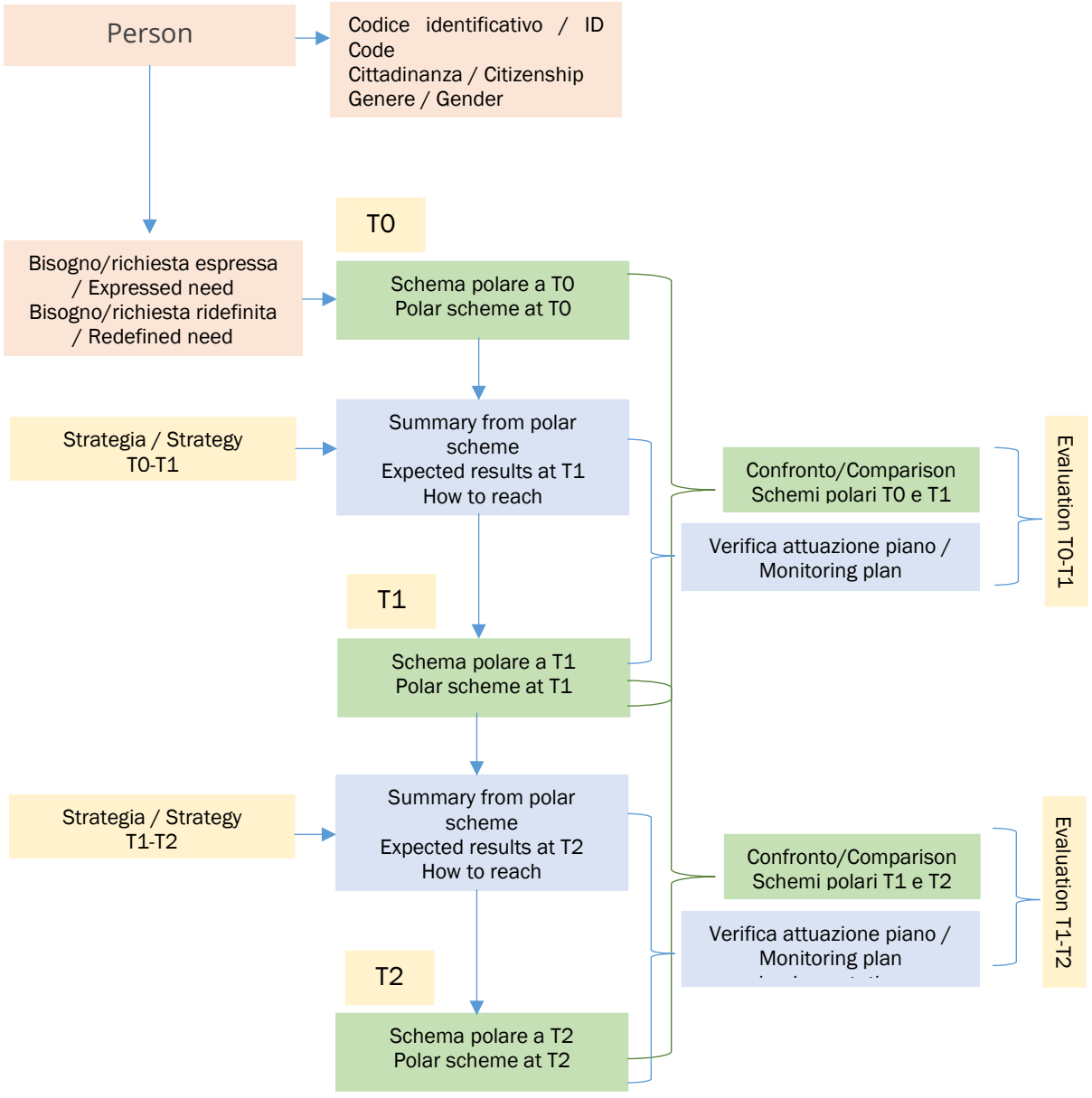
This is the implementation phase of the plan. In order to facilitate the effective exercise of responsibilities (professional, person, other components of his or her living space, ...) the path shared in phases 1, 2 and 3 is implemented and monitored with observable indicators.

Outcome evaluation

The evaluation of effectiveness has two stages. Measurement considers whether everything that was planned and agreed upon has been done, i.e. the content of the plan.

The evaluation (professional judgement) goes into the conditions of success and achievement of the expected outcomes. It makes use of the indices measured and helps to identify them, to better recognise them, to understand what determined them (Canali, 2015).

Fig. 3 – The flow combining polar scheme and ARCO



Literature:

Existing and innovative measures for the treatment and care of the elderly person and his/her family

In their work with older people, professionals use a variety of working methods to enhance the individual and his or her abilities in the third stage of life.

Care coordinators use different methods and approaches to work with people. The CrossCare® model also encourages the use of different techniques for working with people with dementia, as well as the use of knowledge and experience to draw on. Here are some skills and guidelines on methods, techniques, and approaches that any individual can use when working and/or living with family members with dementia. In addition to each topic, we have also provided useful literature and practical examples, presented descriptively and graphically.

GENTLECARE® METHOD

The Gentlecare® model: origins and development and in-depth study

The Gentlecare ® care system, devised by occupational therapist Moyra Jones, is a holistic and prosthetic approach aimed at the well-being of individuals with dementia. It is based on understanding the specifics of the disease, knowing the person, and enhancing their existing and potential capabilities.

Dementia is not just a disease but becomes a new way of being, a life condition characterized by "functional, cognitive, and behavioral" losses. These changes alter the personality of those affected and interfere with their relationships with their environment and caregivers.

The task of all those involved in the care process is to compensate for this deficit by implementing Protheses, an Individual Project consisting of three dynamically interrelated elements: the physical environment, people, and programs and activities.

The Environment is seen as the living space of the patient, aimed at providing areas for thought, speech, and activity. It must be adapted to the changing needs of the person in difficulty, whether these are primary needs or needs for socialization.

Activities aim to stimulate each individual's abilities, to build appropriate social roles, and thus meet the need to feel useful and competent.

People (and the relationships they build together) will be placed in a position to participate in a process that starts with welcoming the family unit and building a care alliance. This establishes the foundation of trust and reliance necessary to create a common, healthy project focused on the well-being of the entire care system. Formal and informal caregivers will be prepared, motivated, rewarded, and organized to provide a prompt and satisfactory response to the care needs of the fragile person, feeling part of a unique organizational element.

In residential and semi-residential care settings, programs are flexible, short, and composed of simple activities that every staff member must be able to perform to restore dignity and life to the patient and their family. Spaces are familiar, comfortable, safe, and carefully designed to stimulate and relax.

In community care, interventions are modulated and targeted, not only in managing space, time, and relationships with the fragile person but also in supporting and informing caregivers. This aims to trigger a virtuous cycle focused on the well-being of the elderly in their living environment.

This requires the design and management of services supported by high professionalism and strong interdisciplinarity, representing a cultural change even before an organizational one. It implies a way of

approaching the disease, the fragile person, and colleagues and collaborators that goes beyond a sectoral view of the organization, replaced by building a communal and circular system.

The Gentlecare Method provides tools to make this achievable, allowing everyone to become aware that their actions impact the entire organization, eventually becoming part of daily work, a common language, and, as such, transmissible.

Gruppo Ottima Senior adopts the Gentlecare model as the primary philosophy for managing services for people with dementia and general frailty. This model can be applied in various contexts and realized in diverse ways depending on resources. It is based on simple foundations, such as the well-being of the person entrusted to us, the importance of the quality of life in their past and daily existence, and attention to their families.

The main objectives of the Gentlecare method of care are:

- Promoting the well-being of the person, defining well-being as the "best possible functional level in the absence of stress conditions";
- Resolving or reducing the severity of major behavioral disorders;
- Reducing the stress of caregivers, whether formal or informal;
- Reducing the use of physical and/or pharmacological restraints.

Praktični primeri in rešitve situacij

- Visually impaired elderly woman with good mobility and a particular difficulty in accepting help from others (she had always worked as a housekeeper; very directive personality and not inclined to be assisted). She had a hard time tolerating all attempts to be accompanied from one area of the facility to another.

The staff decided to support her need for autonomy by helping her navigate the nursing home with a particularly soft and “furry” strip of fabric, especially on the handrail and the path leading to her room.

- An elderly former union representative; he exhibited a behavioral disturbance that caused him to continuously tap his hand on any table or surface in front of him. This activity not only annoyed the other residents but also put him at constant risk of injury.

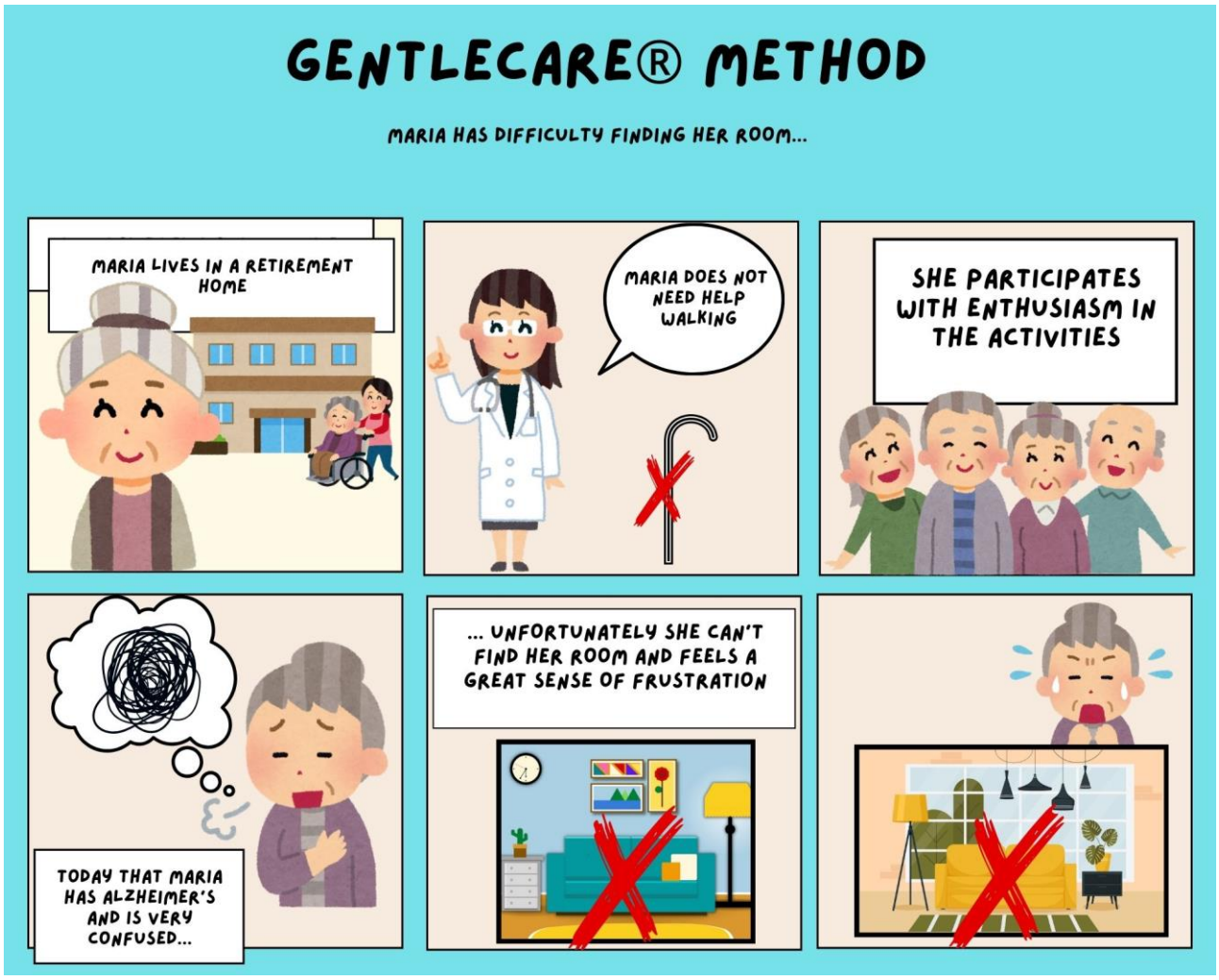
Therefore, to give this constant tapping a purpose, he was given a typewriter on whose keys he could repeatedly tap without hurting himself. In general, every surface available to him was covered with a soft material, capable of muffling the noise and reducing the risk of injury.

- Disoriented elderly man who urinated in all the bathroom containers (sink, bidet, shower) except the toilet.

Drawing from his experience of working in a factory abroad, the staff first thought of placing images above the toilet, then they placed a sign both in Italian and other languages stating that urination should be done sitting down and inside the toilet. He, being very meticulous and duty-bound by nature, carefully followed the written instructions and thus overcame the difficulty.

- Elderly woman who never finds her room in the nursing home; excellent mobility and participation in activities. Not being able to find her room caused her distress; she also couldn’t express herself during moments of tension, which increased her agitation.

The staff knew how sensitive she was to colors, so they decided to place a colored strip (yellow) to help guide her towards her room using this favored color.



In general, the root of all the assistive solutions of the Gentlecare method is the choice of different activities, always motivated by asking the elderly person for help in solving an issue, and ending by thanking them for their valuable contribution.

Doll therapy also follows this strategy: using dolls and the request to take care of them to "soothe" moments of particular tension or the desire to escape. The choice of when to offer the doll is based on an observational analysis of the elderly person and their behaviors to understand when to activate this tool. Typically, the most critical times of the day are mid-morning, afternoon, and dusk.

In the nursing home, doll therapy was used with good results, particularly with an elderly man who had always taken care of his grandchildren, so the opportunity to take care of the dolls reminded him of his past caregiving activities and calmed him down.

Literature:

THE VALIDATION® METHOD

The Validation® method - a way to communicate in dementia

The Validation Method, devised in the 1970s and 1980s by gerontologist Naomi Feil, is by definition a communication technique that helps to manage the difficult relationship with an elderly dementia patient with behavioural disorders. In caring for the impaired elderly, Feil realised that empathic acceptance of their inner world would have a positive impact on many factors of daily life, and in particular she observed from first-hand experience that listening to emotions could be an important alternative to spontaneous communication. In spite of good intentions, the latter often leads us to distract, reason, infantilise and much more; ways that often trigger vicious circles that increase rather than decrease behavioural disorders. The objectives that validation aims to achieve are many and can all be contained in the improvement of the quality of daily life: recovering self-esteem, improving verbal and non-verbal communication, reducing anxiety, preventing isolation and withdrawal, feeling the value of a life lived, improving deportment and physical well-being, reducing the need for physical and chemical restraint, promoting role taking and improving mood. Validation is also a developmental theory of the elderly, which describes their final struggles: Very old people change their behaviour not only because of cognitive decline. Many other factors intervene, such as the need to complete unfinished business, to 'solve life's unresolved tasks in their own way'. Indeed, one of the theoretical assumptions that motivated Feil to develop this method is E. Erikson's theory of existential tasks[ii]. He posited integrity as a goal to be achieved in old age, meaning that we can allow ourselves (also cognitively) to look back on our past life and take stock of it. Naomi Feil adds the stage of resolving existential tasks or unresolved conflicts, by which she means the 'resolving in their own way', the need to pack for the last journey, where it is not logic coherence that characterises behaviour. The enormous burden of emotions, often repressed for long years, finds a way to manifest itself through bizarre behaviour. Older people with cognitive impairment go back in time and fulfil many needs. Validation sees these behavioural disorders as a legitimate way of surviving, in a time that is extremely difficult to cope with due to the amount of physical, emotional and social loss, and the severe sensory and affective deprivation that is often associated with old age, especially for those living in Social Care Facilities.

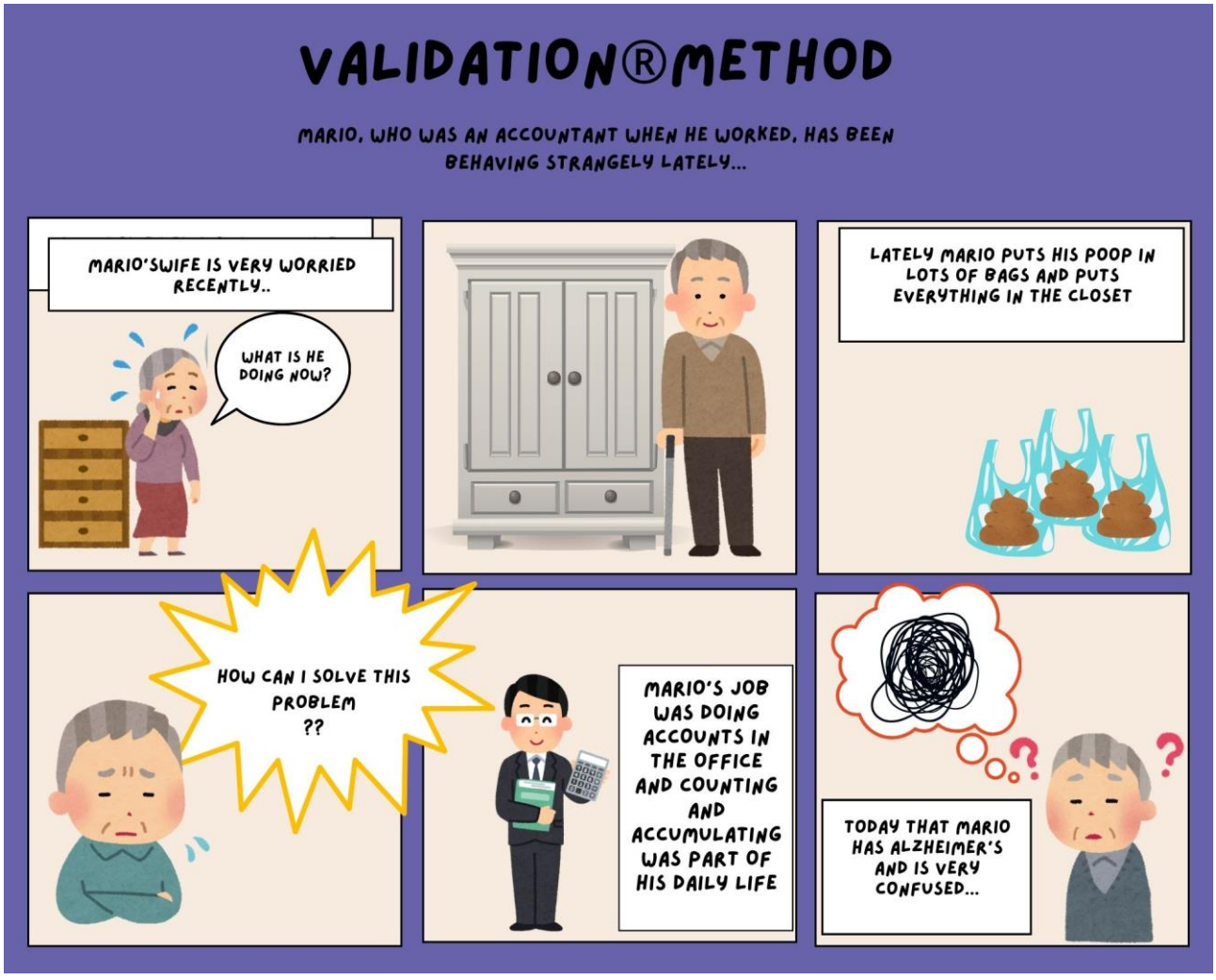
These elderly people need someone who listens to them with empathy, who knows how to accept them, and who supports and accompanies them in this struggle. If no one does this, the elderly person will gradually become more and more withdrawn and embark on a path of decay that will lead them to a vegetative phase of life. Validation does not require the elderly person to change (to do this would require intact cognitive abilities), it does not demand an effort on his part, and it does not 'lovingly reprimand' him for unsocial behaviour. Validation accepts and welcomes. One of the fundamental principles of the method states that there is always a reason behind every behaviour and argues that the inner reality of older people who are disoriented for this reason should be accepted and acknowledged. "To validate' means to give value. This method, with specific training courses, can be applied both individually and in groups. It is a strategy, a tool that, using specific verbal and non-verbal techniques, enables emotional expression, empathic listening and respectful acceptance of a world that does not correspond to our own, but which does exist. In the training courses one learns through practice to observe, to be authentic, to use eye contact, touch, to conform to rhythm, to mirror movements. The Validation practitioner can establish a relationship of trust without judging what the elderly person says, even if it does not correspond to reality. Trust contributes to strengthening feelings of security, self-esteem and dignity, which leads to a reduction in tension and, consequently, to a reduction in negative and disruptive behaviour. Finally, we do not want to overlook the important consideration of the weight of emotional acceptance. We are often frightened that acceptance of the emotional balances of others may affect us, may hurt us. This fear is justified; if we confirm it, we become

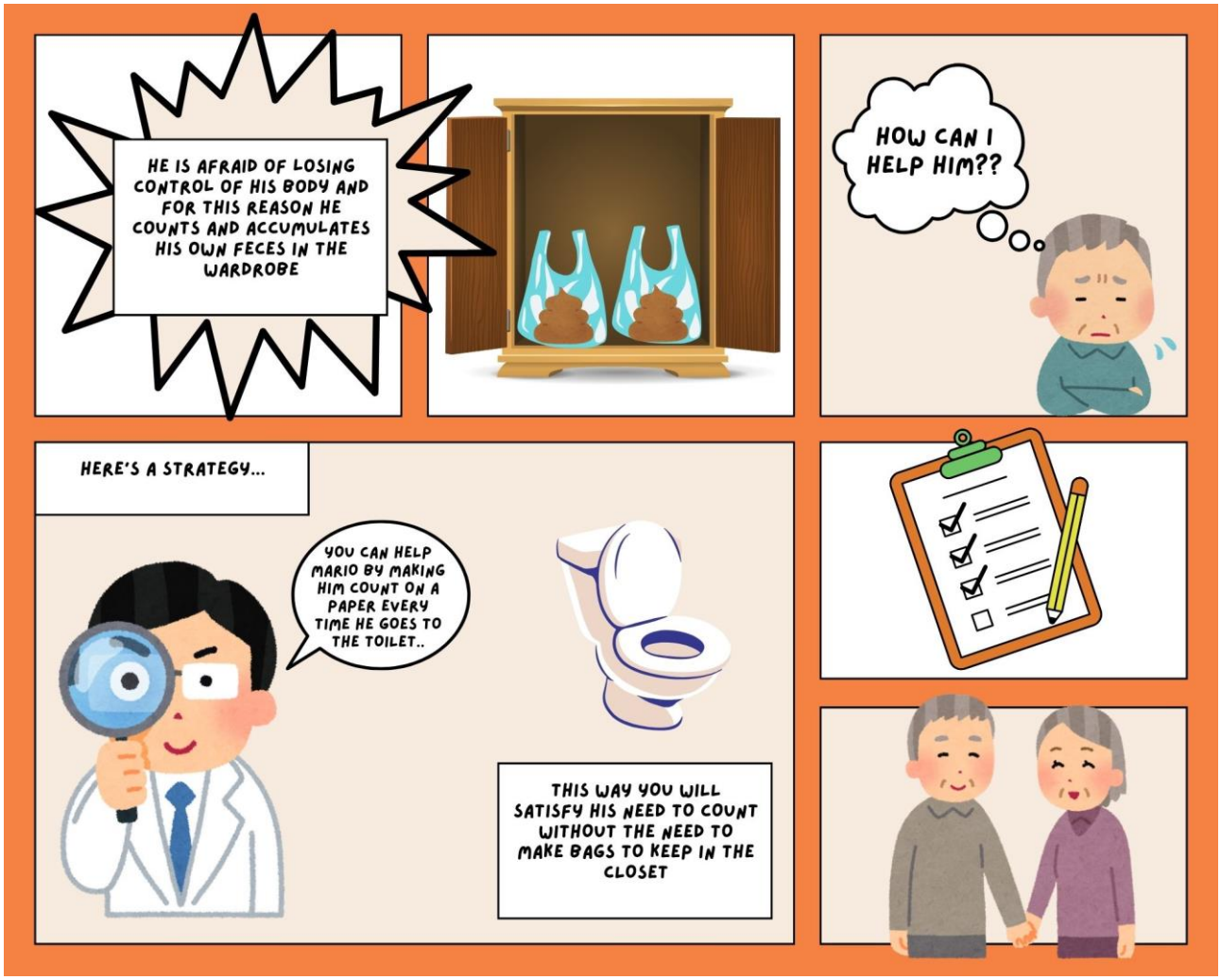
vulnerable. But there is a big difference between being overwhelmed and being empathetic. Validation also trains us in this area. Tools, exercises, techniques teach us not only how not to hurt ourselves, but even how to enjoy a better professional and personal life precisely because it is enriched by empathy. A real opportunity.

Practical examples and solutions to situations

1. We have the case of a gentleman who is dealing with his poo. He makes it, then packs it up and puts it in the closet. What can we do?

Working with poo is linked to the stage of autonomy. The gentleman is afraid of losing control of his body. Once we understand this, we need to give him an easy task that will allow him to be in control. Because he is losing control. Consequently, we have to enable him and thus satisfy the need for control.





2. Question: We have an example of a lady who uses a chair as a walker as she moves around the room. She holds on tightly to the arms of the chair and does not let anyone near "her chair". The lady becomes aggressive if we try to take the chair away from her. We do not know how to behave. What could be the cause of this behaviour?

First of all, we need to know the person's history, her biography, her losses and what she has had to face in her life. I understand from what you are telling me about her that she has never been able to build her own sentimental life. She always had to look after her parents. Her behaviour was always masculine, whereas she was a woman. From what you are telling me, I have to conclude that perhaps she was never able to fully express her sexuality. It was a time when people were less free than they are today. There were more taboos. Freud and Jung found that people use symbols. And Naomi Feil took these theories and translated them for disoriented older people. Perhaps now the ladies are trying to express their man parts as best they can before they die. And they do it in their own way, using something hard, tough, fake. The lady is trying to survive.

3. Case study

Mrs Lucia is a lady who is between the first and second stage of dementia. She still uses language but often "lives in the past". A past in which she regrets her family of origin. We know from her biography that her marriage was not a happy one and that she was unable to have children. A session with Mrs. Lucia takes place on a day when she was agitated because, as frequently happens to other elderly people, she is desperately

looking for her gold ring, a gift from her father, and accuses the staff of stealing it from her. In fact, everyone knows that the lady no longer has the ring, which her family took home and replaced with a less valuable one. However, instead of rational explanations, the operator preferred to "validate" the lady's emotion, her desperation, using phrases such as "You miss your ring so much! Such a beautiful gift, from your father ... He must have really loved you ... your father ...". The lady starts talking about her father, how good he was and how much he loved her. Gradually, the tension over the object eases as the lady and the worker manage to talk about what has really been lost: affection, loved ones, family, and that the object in such situations is often just a tool to processing one's losses. It is a contact on an emotional, affective level, not focused on reality.

Literature:

DEMENTIA

Memory is the ability to store, process and retain information and to recall it in the future when we need it. The prerequisite for smooth memory functioning is attention and the ability to process information efficiently. Information stored in memory is also important for generalising, judging, predicting and planning for the future. Memory plays a very important role in our everyday life, even if it is not only related to the retrieval of memorised information (Kejžar and Jenko, 2020, p. 56). Attention plays a very important role in memory. Attention could be compared to a controller that lets some information, stimuli, into our brain, into our consciousness, while letting other, irrelevant information 'pass by'. This prevents our brains from being overloaded with information.

According to the National Institute of Public Health (n.d.), in 2018 there were already 50 million people living with dementia worldwide, and by 2050 it is estimated that this number will more than triple to 152 million people with dementia.

Dementia is a chronic progressive disease caused by changes in brain cells (Lukič Zlobec et al., 2017, p. 13). "It is defined in the 10th International Classification as a syndrome caused by a disease of the brain, usually of a chronic and progressive nature. It involves impairment of many neural activities, such as memory, learning, the ability to express oneself verbally or to make judgements" (Mali, Mešl and Rihter, 2011, pp. 14-15). The first signs of dementia are: 'gradual loss of memory, difficulty in speaking and finding the right words, personal and behavioural changes, decline in intellectual abilities, inability to judge and orient, difficulty in everyday tasks, finding, losing and moving things, difficulty in locating and orienting oneself in time and place, endless repetition of the same questions, changes in emotions and mood, withdrawing into oneself and avoiding society' (Lukič Zlobec et al., 2017, pp. 18-21).

Dementia is not a natural part of ageing. However, the chance of getting dementia increases with age (Lukič Zlobec et al., 2017, p. 14). Dementia is mainly caused by problems with short-term memory, which means that a person forgets events that have happened recently. However, he or she remembers events that happened a long time ago, in the past (Lukič Zlobec et al., 2017, p. 18). There are many types of dementia, with different characteristics, course of the disease, frequency of occurrence and treatment options. Alzheimer's dementia is the most common, with memory impairment being its main feature. Alzheimer's dementia is also the best known. There is also Lewy body dementia, vascular dementia, frontotemporal dementia and many others (Mali, Mešl and Rihter, 2011, pp. 15-16). Each type of dementia has its own characteristics, and how the disease progresses depends on each type. Forgetfulness is still the most recognised first sign in society, but in some types it is not even one of the first to appear.

For a long time, it was believed that people with dementia were harder to communicate with. Today we know that they need more time to communicate, that they use fewer words to describe words, that they use them in an unusual order, in short that their way of communicating is based on different rules than ours. Instead of using a single word to describe an object, they use a description of the object or its usefulness. Sometimes they replace the words they have forgotten with new ones, which are not necessarily connected in a meaningful way to the missing ones, making it more difficult to understand the language of people with dementia (Mali, Mešl and Rihter, 2011).

It is important to consider them as equal interlocutors, to combine verbal communication with gestures and facial expressions, and above all to be flexible and resourceful. For people with dementia, the feelings they experience in contact with us mean more than words. We try to create an atmosphere where the person with dementia feels accepted, feels safe and is at the centre of the communication relationship. The social worker and the person with dementia can talk in their own words, in their own way, but it is important that they are in contact, because that is how they get to know each other. The person with dementia is unlikely to

remember your name, your professional role or the purpose of your visit, but they will remember the emotions they experienced when talking to you. Pleasant emotions will be a reassurance for your future work with the person with dementia (Mali, Mešl and Rihter, 2011).

Common communication problems can manifest as:

- problems with inner speech (difficulty forming ideas, resulting in disorganised and impulsive speech);

- poorer understanding of the context of the conversation (grammatical correctness of speech may be maintained or problems may arise later);

- difficulty in focusing on the topic of conversation, leading to random changes of topic;

- slow speech (may also occur due to searching for individual words);

- larger pauses between words;

- repetition of the same questions or the same pieces of information in a narrative;

- Exaggerated talk about the past, repeating the same stories from youth;

- forgetting names of people, places and objects;

- losing the red thread during a conversation (the person with dementia starts talking about something and in the middle forgets what they were talking about);

- confused speech (the person may say nonsensical things about their work and life) (Kejžar and Jenko, 2020, p. 56).

Prevention of dementia and factors that are important for staying healthy include (Kejžar and Jenko, 2020):

- Activity (physical and mental activities).

- Social network.

- Quality sleep.

- Healthy diet.

- No to sugar, alcohol and smoking.

Physical activity

One of the main activities that reduce the risk of dementia. Physical activity helps to circulate blood to the brain and stimulates the whole body system. It is important to move every day and if possible choose exercise or a walk in nature to make activity more beneficial to our health. Physical activity can delay the development of dementia and enable independence for longer. Balance and coordination exercises are very important for older people. This is because the elderly are more likely to fall, which is a common factor in serious injuries, hospitalisation and sometimes even immobility.

Mental activity

Mental activity strengthens connections between neurons and creates new ones, and it has been shown that people who stimulate their brain activity throughout their lives are at lower risk of dementia. To keep our brains active, it is important to avoid routine and find new ways to do everyday tasks. This can be done by preparing new dishes, walking on unfamiliar paths, taking a language course, reading more challenging books... Various mental activities: drawing, painting, singing, playing board games, etc.

Social network

Our social network also has an important influence on our health. People who have regular contact with friends, neighbours and family have a more positive attitude and can cope better with everyday problems. Social activities that have a positive impact on dementia prevention include: joining a club or group, regular weekly contact, visits to museums/churches/cinemas, volunteering, socialising with friends, etc.

Quality sleep

Sleep and rest are key to staying healthy. It has been confirmed that there is a link between poor sleep and the development of dementia. Tips to improve sleep quality include:

- Activities during the day.

- Regular sleeping hours (waking and going to bed at the same time).

- Factors for better sleep (darkness, sounds).

- Avoiding television in the bedroom.

Healthy diet

Excess weight can be a risk factor for developing dementia. A Mediterranean diet is recommended and is thought to inhibit the onset of dementia. It should consist of plenty of vegetables, legumes, fish, olive oil and wholemeal products. At least twice a week, it is recommended to consume protein, which is found in legumes, beans, fish, eggs and meat. Fats are also important in the diet, and care should be taken with regard to quantity and quality. It is important to eat as many fruit and vegetables as possible, as fruit and vegetables provide us with protective antioxidants and vitamins. It is also advisable to eat green vegetables such as cabbage, kale, lettuce, spinach, broccoli, or peppers. Fruits that are high in antioxidants include pomegranates, blueberries and red grapes. Onions and garlic are also recommended, as they act as natural antibiotics that inhibit inflammation in the body.

A balanced plate means 2/5 side dishes, 2/5 vegetables, 1/5 meat.

Practical examples and solutions to situations

1. You meet an elderly lady in a shop who looks like she is looking for something, looking at the shelves but not taking anything, acting confused. What do you do?

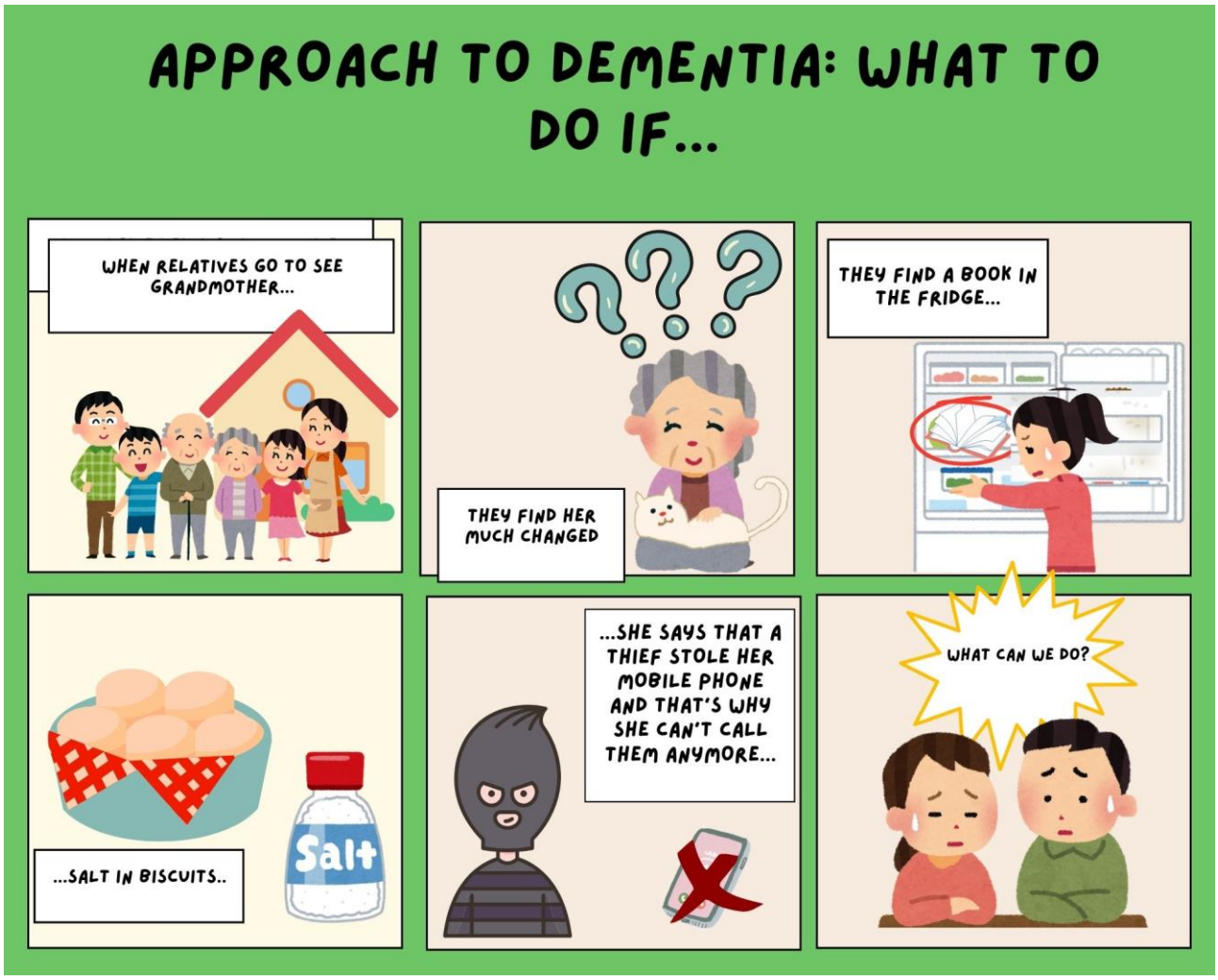
Approach calmly, make eye contact from the front and calmly ask if she needs help. If she can't answer, look around to see if there is a shop assistant and if she can get us a glass of water. We also ask if the lady might be known to them. We try to calm the lady down, check if she has any phone numbers, a bracelet/chain with an SOS button. Try to call the relatives. If this is not possible, try to see if the person knows where she is and what she is doing here. If the lady is still lost call the police. Do not leave the lady alone, be friendly and talk to her all the time.

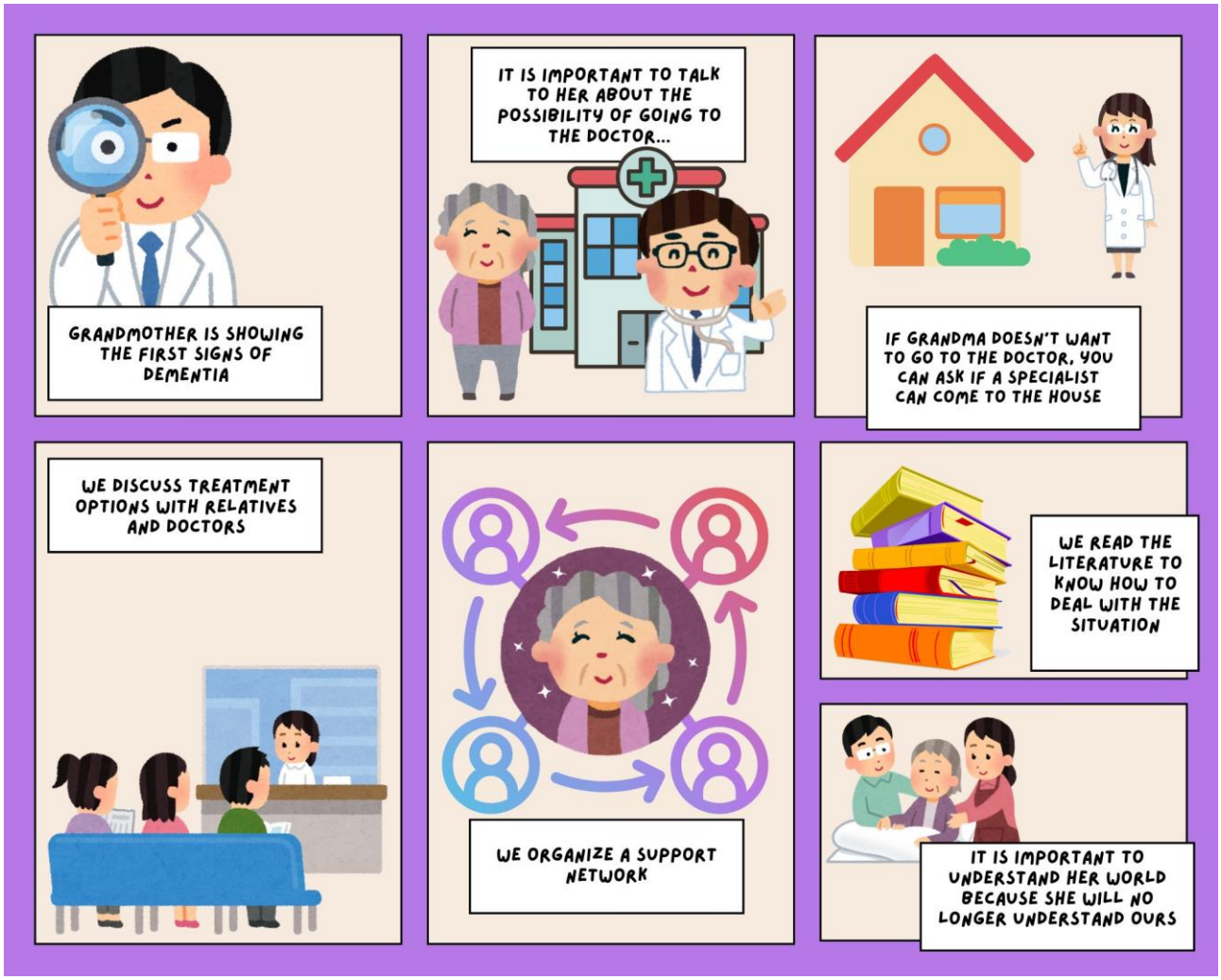
2. In a shop, there is a gentleman in front of us in the queue who has to pay. He is looking at his wallet but does not know which note to choose to pay the bill. What do you do?

We approach the gentleman and calmly ask him if he needs help. If he gives us permission, we choose the correct amount of money and pay the amount. If he feels bad because he is confused, we try to calm him down. We also check if he knows where he is at home.

3. On a visit to Grandma, we notice that she has changed recently. We find a book in the fridge, salt instead of sugar in the biscuits she baked herself. She tells us that someone has stolen her phone and she can't get in touch with us. What do we do?

Grandma is showing the first signs of dementia. It is important to talk to her about going to the doctor for a check-up. If your grandmother does not want to see a doctor, ask if a psychiatrist or neurologist in your area will also come to your home. We discuss our observations with other relatives and organise a support network. We look for a home help organisation in the area and discuss care options. We read the literature so that we know how to cope with the situation. We must never forget that grandmothers do things deliberately, not because they want to annoy. She does it because she cannot do otherwise. It is important to put ourselves in her world, because she will not be able to put herself in ours any more.





For more examples with solutions and literature, see:

To improve the work of professionals, relatives and other stakeholders, further education and training is also needed to strengthen their skills and competencies in working with users, the elderly and relatives.

Cross-border training courses for social health care operators - exchange of approaches and skills

Strengthening the skills of care managers and other professionals is promoted through joint training in CrossCare® methods and approaches. CrossCare trainings thus serve not only to exchange opinions and new ways of working with the elderly, but also to train the different professional profiles that accompany and work with the elderly user. In order to effectively monitor the needs of the individual, knowledge exchange and cooperation between professionals of different profiles is necessary.

Therefore, we have introduced new tests and skills for working with the elderly in the CrossCare® Model. We conducted training courses on Gentlecare® and Validation® working methods, the enhanced role of the Care Manager with knowledge of community covenants, the therapeutic arc and polar pattern, dementia and neuromotor exercises. All of the trainings were aimed at both professionals, in the form of cross-border trainings, and the general public (other health and social workers, the elderly, and family members) in the form of workshops. The trainings also included additional content that was identified as needed by practitioners for the work of the elderly, based on the perceived needs of the elderly themselves.

One of these is knowledge of neuro-motor skills, which is useful for practitioners in providing services for the elderly to improve the individual's autonomy. The knowledge gained was also tested by practitioners through a pilot of the model with services for the elderly. Thus, in addition to the polar pattern tests, the CrossCare model also included tests and exercises to monitor the neuromotor skills of the elders involved in the pilot testing of the model. The knowledge is also tested in the pilot experimental part of CrossCare 2.0 with elderly users.

COGNITIVE MOTOR CONTROL AND DAILY HABITS

Territorial Awareness for People with Frailty and the Elderly, Including Those Affected by Alzheimer's and Dementia

It is considered fundamentally important to create a culture of awareness and prevention to develop collective and personal tools aimed at ensuring better management of aging. In this regard, there is a need to accompany individuals in understanding their physical and neurological deterioration, with the goal of preventing and addressing aging with as many resources as possible. For this reason, we aim to create a moment of growth and technical-scientific acquisition by providing the opportunity to practically experiment with prevention strategies and benefit from the presence of an expert who can effectively guide practical and preventive activities.

Direct Objectives: The main objective is structured through a series of meetings that include three phases of intervention, starting with a motor screening of the participants, leading to the practical and personalized formulation of beneficial activities tailored to the personal and clinical characteristics of each individual. Each meeting will feature an expert personal trainer in neuromotor control and daily habits, who will guide the participants throughout the project. This project will not only offer opportunities for motor learning and experimentation but also the chance to share moments of intergenerational socialization.

Indirect Objective: Conceptually, this project offers the possibility of building a path of personal awareness and social sharing, aiming to functionally support individuals facing their aging process. The lessons will focus on the awareness of one's body, neuromotor difficulties, and compensatory strategies. The tools to be deployed for this project can be summarized as follows:

- **Physical tools:** Referring to the use of materials, spaces, and resources.
- **Relational tools:** Referring to the interactions between group participants and between participants and the personal trainer who will follow them throughout the project. The lessons will be conducted through initial tests (neuromotor screening), based on which various types of exercises and gymnastics will be structured, depending on the potentials and limits of the participants. The project will typically involve six lessons, each lasting one hour.

Meeting Format:

- **1st meeting:** This session will summarize the project's objectives and focus on its practical and preventive aspects. The personal trainer will conduct an initial phase of neuromotor tests.
- **2nd meeting:** Based on the results obtained during the first meeting, individual evaluations will be structured to create a specific exercise plan suited to the person's neuromotor profile.
- **3rd to 5th meetings:** The subsequent meetings will have participants practicing and exchanging strategies based on what they have learned and what is indicated in their technical sheet.
- **6th meeting:** The final meeting will aim to evaluate the knowledge acquired and improvements made during the various lessons, and to consolidate the appropriate exercises for each participant.

Target Group: People over 65 who are eager to experiment with new prevention and care methodologies for their neuromotor well-being, with a maximum of 40 participants.

In line with the CrossCare2.0 Experimentation, General Results:

- Promoting practices of prevention and care towards cognitive motor decline in individuals.
- Raising awareness about the difficulties associated with aging, particularly regarding motor and cognitive frailties.
- Fostering well-being and psychomotor competence in individuals.

Intangible Results: Through this project, we aim to give a group of elderly people the chance to experiment with new methods of motor coordination, with the goal of achieving greater personal awareness to meet the needs related to aging and neuromotor function deterioration.

Tangible Results: This project aims to offer an opportunity to develop practical strategies for the prevention and management of neuromotor situations where individuals feel they need support and wish to learn new skills.

Project Presentation:

- **Devices for Analysis T0 - T2 (60 days) - T4 (120 days), BIA-ACC:**
- https://www.biotekna.com/BIA-ACC-Analisi-composizione-corporea

Data of Interest for the Project:

- **TBW:** Total Body Water
- **ECW-ICW:** Distribution of water between intracellular and extracellular compartments
- **ECMatrix:** Extracellular matrix or myofascial tissue

- **HPA Axis Index:** Index of the circadian pattern of stress hormone expression
- **FFM:** Fat-Free Mass, particularly (T-score and S-Score)
- **FM:** Fat Mass, particularly (IMAT)
- https://pubmed.ncbi.nlm.nih.gov/36615884/
- https://pubmed.ncbi.nlm.nih.gov/28742506/
- **PPG Stress-Flow:**
- https://www.biotekna.com/PPG-Stress-Flow

Data of Interest for the Project:

- **SDNN:** Synthetic Index of HRV
- **ANS Balance:** Representation of the relationship between SNS and PNS activation
- https://pubmed.ncbi.nlm.nih.gov/35355570/
- https://pubmed.ncbi.nlm.nih.gov/35028916/

OSO-Test:

- https://www.biotekna.com/OSO-Test
- Test that represents and correlates all the parameters described above, providing an overall picture of the individual's situation.
- https://pubmed.ncbi.nlm.nih.gov/30935031/
- https://pubmed.ncbi.nlm.nih.gov/33947099/

ANS Control:

- https://itstore.melcalin.com/product/starter-pack-biotekna-plus-mobile/
- Device for Intermediate Analysis T1 (30 days) – T3 (90 days)

Device for Personal Use with 2 Functions:

- Remote measurement of SDNN, RMSSD, and ANS Balance values
- Use of the task management module via IOS/Android App for biofeedback, Stroop task, MUS questionnaires, NQ, NRS pain

COGNITIVE-MOTOR PROTOCOL

The brain, our central nervous system, is the organ where every movement of the body begins. Firstly by creating an idea and motivation for movement, followed by the selection of an appropriate (more or less automated) movement program with the simultaneous coordination of all the information that comes to the brain from the internal and external environment through a multitude of senses. Then the exact sequence of commands is sent to the organs responsible for the execution of the movement - the muscles. Thus, we see that our movement and mental (cognitive) activity are strongly intertwined and connected. In doing so, many movements (for example walking) can be performed with minimal mental control, which allows us to simultaneously redirect a larger or smaller part of our attention to other more complex activities.

A person's motor and cognitive abilities decline with age. With regular and appropriate physical and cognitive exercise, this decline can be reduced to a large extent or even prevented, as long as it does not involve certain medical conditions. Regular physical activity in adulthood reduces the risk of many negative consequences associated with aging, especially those associated with a modern sedentary lifestyle. It is known that the risk of falls, which are the leading cause of injury-related death in people over 65, increases with age, as they are usually associated with serious consequences such as fractures and other injuries. The most common causes of falls are problems with walking and balance, which are related to neurological and musculoskeletal problems, impaired thinking and memory, vision and environmental hazards. In addition, with a sedentary

lifestyle, irregular physical activity and also normal physiological processes of aging, the elderly lose muscle tone, decrease muscle strength, lose bone mass and flexibility, which further increases the risk of falls. The problem is complex, and the factors can be physiological, biological, behavioral, physical and socio-economic.

The proposed cognitive motor protocol consists of biofeedback, neuro training and cognitive gymnastics. Protocol aims to act on the frontal lobe, in turn divided into three regions: prefrontal cortex, sensory lobe and motor lobe.

The path works by making the choice of certain daily routines which include studied respiratory training protocols, cognitive and attentional work, HIIT training protocols with activating and afferent body movements, as well as deactivating activities, with the aim of influencing stimuli and impulses, and gradually more and more in depth towards the executive functions and their ancestral substrate (high PFC functions). Our main objective is to asses skillls in 4 key areas: mobility, stability and balance, proprioception and neuromotor control (introception). Furthermore we will identify a personal profile with assessment of capabilities or deficits. Together we will create a routine of activities aimed at improving deficits and consolidating and efficiency of capabilities.

Training is divided in 5 different dimensions:

1. mobility exercises,
2. stability and balance exercises,
3. proprioception exercises,
4. neuro motor control and hemisphere switch exercises,
5. strenght exercises.

For each dimension, there are 3 exercises that can be can be easily performed at home. Examples of exercises:

- MOBILITY EXERCISES:

Kneel on one leg. Hold on to the chair or any other object to maitain you balance. Then push your pelvis back and forth in order to stretch your hip flexors. Repeat 10-20 times.

- STRENGTH EXERCISES:

1. EXERCISE: Stand on your feet and then rise up on your toes. Repeat the exercise 10 times.

2. EXERCISE: Stand on your feet. You lift the bent leg as shown in the picture. Repeat the exercise 10 times, then repeat 10 times with the other leg.

Literature:

The professional figure of the community coordinator

With the updated CrossCare® model, the care manager is given the additional role of community worker. His or her role as care coordinator for the individual is further enhanced by the community collaboration component with other organizations and care providers through the implementation of Community Covenants. The goal is to improve the quality of services for the individual, implement joint initiatives in the community to improve the situation of the elderly, and provide individualized services targeting the elderly in one place based on their needs and preferences.

The care coordinator ("care manager") can obtain a range of information from meetings and insights with the person and his or her family members. From all this information, the professional can get a better view of the individual's life and can offer the information and services that the individual needs most, based on his or her needs in the local environment.

If some services cannot be provided by the institution itself, the care coordinator contacts other local entities that offer such services. In this way, a support network is created, which is implemented through "community pacts," which are agreements between different organizations, service providers, and stakeholders with the common goal of improving the lives and living conditions of the elderly in the local area. Through these community pacts, a network is thus created with the aim of implementing joint initiatives in the community for the well-being of the elderly.

CARE MANAGER/COMMUNITY WORKER - COMMUNITY PACTS

Community Pacts are a tool through which administrations, associations, the voluntary sector, citizens, and third-sector organizations develop an integrated model for addressing community issues that affect the social territory in various ways, with the goal of improving the well-being of the citizens through concrete actions. The process leading to the creation of Community Pacts is expressed through different legal frameworks, aiming to create varied strategies depending on the project for each territory.

The definition of “Community Pact” summarizes and establishes an awareness action of the territory, in its various forms, carried out by the involved stakeholders.

In the initial stages of developing Community Pacts, it will be crucial to make visible the many faces and aspects that form the local context, either by introducing them anew or by reconnecting them, so that they act consciously, involving and stimulating the different individual realities within the community that carry value. This process, facilitated by an external agent who will oversee the process, will involve updating the geographical and social mapping of the territorial reality.

The goal of the COMMUNITY PACTS will be to initiate a shared path among the involved parties with certain confirmation stages and a final outcome. Among the initial stages of the process, we can identify the following:

- Observe the dynamics that regulate the context.
- Identify the needs of individual actors both separately and in relation to one another.
- Provide the involved parties with the results of the assessment in the most suitable forms for the context.
- Encourage the community to reflect, share problems, and search for solutions that best fit the context, the needs of the individual actors, and the needs of the community carrying value.
- Verify that the premises and outcomes align with the objectives identified by the community involved in the action.

At the time of verification, the group (possibly facilitated by a mediator) will assess whether the actions collectively established meet the perceived/identified needs and have achieved the necessary objectives. If these activities prove ineffective for the purpose, the group will gain the necessary awareness to make the required modifications or changes in direction.

In conclusion, upon achieving the objectives collectively established and communicated by the community, this process will be, to some extent, scalable in a context of sharing best practices.

Select the most appropriate legal tool for drafting the COMMUNITY PACTS

Specifically, the objective of its operation within the CROSSCARE 2.0 project translates into the following goals:

- Strengthen and spread an integrated and personalized care model for frail elderly individuals, so that they are not simply passive recipients of pre-packaged services, but the center of a network organized based on their needs, desires, and rights.
- Enhance community involvement and local networks to ensure the elderly person can remain in their home for as long as possible in a state of well-being.
- Propose a systemic and innovative approach to generative welfare, allowing a shift from a “collection and distribution of resources” perspective to a regeneration of the community, resulting from social cohesion and participatory planning.

CONCLUSION

The guidelines presented in this paper, represent a key step toward improving long-term care for older people across borders. The CrossCare® model offers an integrated approach based on expertise, innovative methods, and practical experience, and is aimed at both professionals and the general public. The inclusion of educational content, tailored to the specific needs of users, facilitates the transfer of knowledge and tools into practice, leading to better care for the elderly.

Our goal with this holistic approach is to improve the quality of life of the elderly, increase their involvement in the community, and provide support tailored to their specific needs. By promoting collaboration between institutions and professionals and introducing innovative methods such as Gentlecare® and Validation®, we aim to create sustainable and responsive care for the elderly to improve conditions for active and dignified aging.

The CrossCare 2.0 project has laid the groundwork for a major change in long-term care for the elderly. Through the establishment of integrated, person-centered approaches, we have helped to improve coordination of existing services, strengthen the skills of providers, and create community arrangements that support integrated care. We believe this approach can help increase the independence and autonomy of older people while strengthening community ties.

With the implementation of these Guidelines, we aim to contribute to better solutions for active aging that enable older people to receive quality care focused on their independence and dignity. The document aspires to serve as a tool to further develop and disseminate the CrossCare® model and as an inspiration to strengthen efforts in supporting older people in the community.