Common health promotion program for elderly people

Developed within the Project LT-PL-3R-253 „Strengthening of cross-border cooperation towards ageing and social services".

Project partners and its participants find that healthy aging is an ongoing process that occurs across the life cycle. Maintaining the health, wellbeing and support of older people, however complex, is essential to enable older people to continue to participate and feel good about themselves.

The Project takes a whole life approach to achieve the goal of healthy ageing. It finds that we age in different ways and have different needs at different times, and that our health is affected by our environment. This approach includes increasing growth and development, preventing disease, and ensuring that each person is able to function at their best throughout life.

Overall Program Vision

Elders live with dignity and comfort, age well, and end their lives enjoying respect in age-friendly communities.

Strategic Action Areas:

1. Aging with dignity

2. Medical care and rehabilitation

3. Better living with chronic diseases and conditions

4 Support for people with special care needs

5. A respectful end of life

Area 1: Ageing with dignity

- Older people are physically, mentally and socially active, lead healthy lifestyles and have greater resilience throughout their lives, which means they spend more time in good health and live independently.
- Older people are healthy and intelligent, able to make informed decisions about their health and know when and how to get help early.
- Everyone in the health system and the wider social sector understands what contributes to healthy ageing and actively works to achieve it.
- All groups of older people are supported to age well in ways that suit their needs and culture.
- Local communities are age-friendly, implementing initiatives aimed at their health, inclusion, independence, respect and full participation in family and community life.

Area 2: Medical care and rehabilitation

- Innovation and research supports best practice in triage, assessment, integrated care, discharge planning, rehabilitation strategies and follow-up support.
- Older people are supported during their recovery by specialists and general staff who are competent and prepared to manage the complex conditions inherent in old age,
- Family and carers are prepared and supported to ensure ongoing rehabilitation at home and in the community.
- The assessment of the quality of health services takes into account patient perceptions as well as clinical outcomes.

Area 3: Better living with chronic diseases and conditions

- Improved methods of early detection and prevention result in fewer older people suffering from long-term and chronic conditions.

- Older people with long-term conditions retain the highest possible level of mental and physical functioning; they enjoy life and the respect of society.
- Older people with chronic conditions are "healthy and intelligent", actively self-organise their living conditions to function practically and comfortably and are supported to do so closer to home.
- Workers who support older people with long-term health problems have the right resources, structures and training.
- Home and community support services are widely available and tailored to older people's needs and preferences and ensure their wellbeing.
- Health and care services for vulnerable older people with long-term health problems are equitable and have good outcomes for the whole population.

Area 4: Support for people with special care needs

Older people with special care needs:
- are able to live as independently and actively as possible,
- have the information and freedom to make good choices about care and support,
- know that health professionals understand their wishes and support their needs,
- have confidence that information about their situation and needs flows easily between health professionals,
- are covered by care plans that reduce the likelihood of their condition deteriorating,
- are able to access care and support regardless of their financial situation
- move easily to and through the care settings that best meet their needs.

Families and carers are given the necessary support, information and training to help the older people they care for and the stress of caring does not affect their own health.

Area 5: A respectful end of life

- The health care system responds to the goals and needs of older people at the end of their lives and to the needs of their families, carers and friends involved in their final stage of life.
- Health professionals coordinate palliative care to ensure full utilisation of all health system staff. All those who support the dying elderly are aware of the dying person's plans and know their role in making these plans a reality.

- People die feeling as comfortable and safe as possible.
- Expert advice and support is available to families, other carers and health professionals involved in end of life care.

Area 1: Ageing with dignity

This action area is aimed at:

- maximising the quality of people's physical and mental health and wellbeing throughout their lives,
- supporting smart and resilient older people, families and communities to help older people age positively
- equitable treatment of population groups with poorer health outcomes
- taking action to improve the physical, social and environmental factors of healthy ageing
- supporting the sustainable development of age-friendly communities and positive ageing.

Specific objectives

1. To build and support the development of age-friendly communities.

To promote the concept of age-friendly communities at national, regional and local levels.

To provide advice and a tool to support older people, local authorities and other stakeholders in the establishment and development of age-friendly communities and to build knowledge bases on best practices of age-friendly communities.

Building strong partnerships between public institutions and age-friendly communities for comfortable and healthy ageing.

2. Increasing the physical and mental resilience of older people.

Improve the availability of empowerment programmes for older people in homes and community settings.

Increase understanding and partnership in promoting older people's mental health at individual, organisational and community levels.

Encourage social service providers to promote healthy eating, physical activity and healthy lifestyles.

3 Cooperation at different levels of government to prevent harm, illness and disability and to improve the safety and independence of older people.

Collaboration between government agencies and social sector organisations to improve access to and coordination of support for socially isolated and other vulnerable older people and to develop initiatives that better address the physical and social determinants of healthy ageing.

Support initiatives that maximise healthy ageing through supported housing and age-friendly communities, where this will also contribute to regional economic and social development.

Promote volunteering, networking and paid work among older people as a way to support their sense of well-being and social connectedness.

Improving the accessibility of architectural facilities and transport services for older people

4 Improving health awareness.

Strengthen the capacity of health care professionals to understand the health literacy needs of older people and improve the availability of and responsiveness to services.

Improving the effectiveness of health information provided by health and social sector institutions.

Supporting older people's use of technology to communicate with health care providers and their families.

Increasing the availability of information about healthy ageing and health and social services via the Internet

Increase public and workforce awareness of care planning and use across the health sector, government and community agencies and among older people and their careers.

Area 2 Medical care and rehabilitation

This action area is directed at:

- ensuring appropriate hospital admission for older people with serious and/or urgent clinical/care needs
- coordinating care across specialties and between the social care and health sectors
- ensuring that hospital stays are safe for older people who are frail, vulnerable or suffering from dementia
- helping older people to recover, maintain or adapt to altered levels of functioning following a serious accident or illness
- exploring ways to weave family and wider social support into an older person's recovery and ongoing functioning

Specific aims

5 Reduce unnecessary admissions and improve assessment processes.

Support initiatives to reduce unnecessary advice and hospital admissions by, among other things, expanding pre-medical support, improving clinical support in care homes, using intensive home care, developing geriatric care pathways and using proven technology solutions.

Working with the healthcare sector to improve emergency assessment tools and processes and disseminate best practice.

6 Improve procedures and outcomes for older people in hospital for ill health or injury.

Promote and implement proven models of care for older people in terms of:

- improving transport of older patients,
- improving the quality of care for people admitted for falls and fractures, including hip fractures, improving early supported discharge planning.

Use data and experience of older people at risk of falls and fractures to target and coordinate investment and interventions.

7 Support effective rehabilitation closer to home by working across the system.

Work with the sector (including service beneficiaries) to identify and promote best practice in:

- partnerships for rehabilitation with primary care, community nurses, pharmacists, older people, home care providers, families of older people,

- home- and community-based models that support rehabilitation and recovery of older people
- facilitating rehabilitation workers to collaborate across specialist groups and work at the highest level.

Area 3: Better living with chronic diseases and conditions

This action area is aimed at:
- providing older people with the tools and support they need, including guidance, information and access to technology, to manage their chronic conditions and reduce their impact on their lives
- providing all health and social care professionals with the tools and support they need, including information and resources, training, models of care and access to technology, to detect chronic conditions at an early stage and to treat and rehabilitate them
- improvements in social support and care services, primary health care and care services for chronically ill older people
- to increase the capacity to slow down or halt the progression of chronic diseases and conditions leading to a more profound deterioration in the health of older people.

Specific objectives

8 To improve models of home care and community support services.

Identify and implement models of care that are person-centred, person-based, equitable and provide accessibility, high quality and improved outcomes through home and community-based support services. To this end, it is necessary to:
- involve service beneficiaries and their families
- review the system of needs assessment and service coordination

9 Ensure that those working with chronically ill older people receive directional training as well as substantive and technical support.

Ensure that university student curricula and staff training support an integrated model of care.

Develop strategies to improve recruitment and retention of those working in aged care.

Improve the use of health resources to improve care for older people in primary care, in family homes and in residential care homes.

Improve training and information for family carers to help them carry out their caring role safely and competently and maintain the health of older people.

10. improving cross-sectoral and intra-system working standards.

Better use of networks across the health, care and social care sectors to identify and support older people with health problems earlier.

Sharing educational resources and good practice on effective ways to increase physical activity levels among older people, including the chronically ill.

Improve medication management and encourage better collaboration between pharmacists and other health professionals.

11. use of new technologies to support older people, including the chronically ill

Include health apps aimed at older people with long-term conditions in the health app library currently under development.

Promote the use of modern technology solutions to monitor conditions and alleviate social isolation, especially among rural residents.

Promote the use of assistive technology for home care of the elderly.

Area 4: Support for persons in need of special care services

This action area is aimed at:

- ensuring people have the right place to receive the care and support that best meets their needs
- helping families to provide the best support while maintaining their own well-being
- coordinating, integrating and simplifying health and social services for older people with special care needs
- providing flexible home care and elderly care services that meet the needs of an increasingly diverse older population
- reducing avoidable emergency department visits and acute care among a potentially large user group

- enabling all older people with special care needs to have easy access to care and support, regardless of their financial situation
- to promote innovative models of comprehensive care that better support older people, their family and carers.

Specific objectives

12 To improve the physical and mental health of older people affected by long-term mental illness and addiction.

To improve access to physical health services for dependent people with mental health and addictions and to better integrate these services with residential or home care.

13 Better integration of services for people living in residential care for older people.

Development of standard referral and discharge protocols between home care facilities for the elderly, pharmacists, primary health care (including after-hours providers and medical advice), ambulance and hospital services.

Creating technological conditions for the provision of advice and discharge in care centres for older people, especially after working hours.

Develop solutions so that elderly care centres can become providers of a wider range of services for older people.

14 Build the resilience and capacity of families, voluntary groups and other community groups that support older people with special needs and those requiring palliative care.

Improve support for informal carers in a range of respite care, including advice and information and training.

Area 5: Respectful end of life

This area of action is directed at:

- respecting people's goals and preferences in the final stages of their lives
- tailoring care to the physical, emotional, social and spiritual needs of individuals and their families,

- continuing to provide high quality palliative care and preparing the health system for future palliative care needs
- providing coordinated care that meets the needs of all people, wherever they are
- engaging family and friends to support dying older people.

Specific goals

15 Increase palliative care capacity closer to home.

To ensure that core elements of palliative care (such as tailoring treatment to the patient's goals, basic symptom management and psychosocial support) are an integral part of standard practice for all relevant health and care professionals.

Better use of pharmacists, allied health and advanced nursing functions and specialist palliative care nurses as members of integrated palliative care teams.

Encouraging the use of new technologies to both support people at the end of life to remain at home and enable easy access to shared clinical records and specialist support and advice such as telecare, e-monitoring and assistive technologies at home.

16 Improving the quality and effectiveness of palliative care.

Development and agreement of quality standards for palliative care services.

Increase the number of places in palliative care centres.

Provision of equipment for palliative care services.

Carry out research into the experiences of patients, families and carers of end-of-life care with the aim of providing person-centred care.